PEOPLE'S HEALTH MOVEMENT

Hold Fast to the Vision of Health for All

People's Health Movement commentary on items scheduled for discussion at the WHO Executive Board (EB154) from 22 January 2024

18th Jan 2022

PEOPLE'S HEALTH MOVEMENT

Background and Commentary
on Items before EB154 January 2024

This analysis and commentary on items coming before the WHO Executive Board in Jan 2024 has been prepared by the People's Health Movement as part of WHO Watch, a civil society initiative directed to the democratisation of global health governance (more about WHO Watch).

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

This PDF version of the PHM Analysis and Commentary is taken from PHM's Tracker for EB154 which provides direct links to Secretariat papers as well as PHM's Item Commentaries.

This version of PHM's commentary is published 16 Jan 2024. Updates will be published on the Tracker.

Comment and feedback are welcome. Write to editor@phmovement.org.
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Item 5

Report of Standing Committee on Health Emergency Prevention, Preparedness and Response (SCHEPPR)

In focus

The DG's Report of the third meeting of the Standing Committee on Health Emergency Prevention, Preparedness and Response (SCHEPPR), held on 13 and 14 September 2023, is being submitted to the EB for noting (EB154/5) . As the committee meeting was held before October 7, the report contains no reference to the ongoing conflicts in Gaza and the West Bank, or recent natural disasters, e.g. the recent earthquake in Japan. The report is being submitted in a context where, according to the secretariat's estimates, there are currently "42 graded emergencies", including "infectious diseases, natural disasters and humanitarian emergencies", and "more than 340 million people in need of humanitarian assistance".

The report notes a change in composition to the standing committee: Professor Christian Rabaud (France) was elected as Vice-Chair of SCHEPPR, and will hold this position until the closure of WHA77. Dr Abdelkrim Meziane Bellefquih (Morocco), who had also put forward his name for this position, withdrew his candidacy and in turn expressed interest in serving as the Committee chair from June 2024.

The report notes that the WHO secretariat provided SCHEPPR with:

- A presentation on the status of three public health emergencies of international concern (PHEICs), one ongoing (poliovirus) and two recently terminated (mpox and Covid-19);
- Updates on the working group tasked with amending the IHR (2005);
- A description of the criteria for convening extraordinary meetings of SCHEPPR after a PHEIC has been declared, and proposed modalities for such a meeting;
- A briefing on the framework for strengthening health emergency preparedness, response and resilience which is intended to respond to pandemics, as well as " multidimensional, multi-year crises"; and
- A "review of the number of event signals currently being managed at WHO headquarters."

Background

Tracker links to previous discussions of Emergencies

WHE index web page

PHM Comment

The report notes with concern "decreasing surveillance and increasing transmission of COVID-19" and "ongoing challenges with the mpox response", and during the discussion member states emphasised the need to ensure "ongoing surveillance, testing and reporting for mpox and the elimination of human-to-human transmission as a key public health objective." This is a commendable objective, although it is ironic that the elimination of human-to-human transmission of mpox has only achieved political visibility after the disease became a public health concern in the global north. In December 2023, the NY Times reported a "surge" of mpox in the DRC, where mpox is endemic and access to mpox vaccines remains extremely limited.

We welcome the committee's report on the need for member states to "study post-COVID conditions (including long COVID) and the future impact of repeated infections", though unfortunately the committee gives no guidance on how this can be managed in light of the "shrinking fiscal space" being allocated to Covid-19 now that the pandemic has abated.

Polio elimination was discussed, and the committee again noted the difficulty of achieving the goal of eradication in the context of polio humanitarian emergencies.

The SCHEPPR's request for further consultation with member states, on an interim coordination mechanism for medical countermeasures (i-MCM) platform, is welcome, as is its acknowledgement of the "inequity experienced during the COVID-19 pandemic" and of "the limitations of COVAX". Given that developing country member states were sidelined in the decision-making structures of COVAX, which did not actively engage them in decisions about the types of MCM (vaccines in particular), delivery timelines, and volumes and expiration dates of MCM they received via Covax, PHM encourages WHO to develop an i-MCM mechanism that addresses this governance failure.

The SCHEPPR expressed a need to "benefit from a deeper understanding of the finances of the WHO Health Emergencies Programme, both in terms of core programme and emergencies operations", and a need for more information on "mental health and psychosocial issues related to emergencies and emergency response." These issues overlap with other WHO areas of work, notably the work of the WGIHR and the Global Health for Peace Initiative, and it remains to be seen how the committee will engage with developments in these areas.

Item 6

UHC

In focus

The Director-General will submit a report (EB154/6) that summarizes the present situation for universal health coverage and the outcomes of the seventy-eighth session of the United Nations General Assembly, with the release of the global monitoring report for 2023, published jointly with the World Bank, and the second High-level Meeting on Universal Health Coverage, with the adoption of a new political declaration on universal health coverage. The report (EB154/6) will highlight the commitments made to achieve universal health coverage by reorienting health systems and investments to a primary health care approach. The Board will be invited to note the report and identify ways to implement the political declaration before the third high-level meeting scheduled to be held in 2027.

Background

Link to previous discussions (WHO and UNGA) about UHC.

Priority setting for UHC (2016)

PHM Comment

This report by the DG on progress towards the achievement of UHC is made at the halfway point of the commitment made in 2015 to reach UHC by 2030. This Report is also a repeat and reiteration of the Political Declaration on UHC that was adopted in the High Level Meeting on UHC, adopted by the United Nations General Assembly at its 78th session on 5th October, 2023.

Based on the WHO's global monitoring report for 2023 on tracking UHC, released on 18th September 2023, the world is well off track on the road map to achieving the 2030 targets and the report spells out clearly how far off it is. Almost 2 billion persons, or about one fourth of the world's population, experienced catastrophic health spending or impoverishment due to healthcare costs according to the most recent data available (2019). When it comes to universalization of essential services that can be accessed, there has been a stagnation since 2015. This means stagnation on the objective of increasing access since 2019 and consistent worsening with respect to financial protection since year 2000. The report adds that this dual lack of progress on service coverage and financial protection is consistent across all geographic regions and

countries (see para 3 to 12 of the report). In para 14 of EB154/INF./1 the document warns*:* *"*Emerging evidence shows increased financial hardship, especially among the poorest, with an uneven recovery post-2020/2021. A notable concern is the higher public spending on national debt over health in developing countries."

Clearly the Covid 19 pandemic was one cause of this lack of progress. That is itself a problem, since one of the reasons for achieving UHC is to better cope with pandemics. But the pandemic is not the entire story. The worsening of financial protection has been a constant, before, during and after the pandemic. The policies that are called for, include: (a) an increase in health funding, (b) the efficient and equitable use of such funding, (c) the strengthening of the health and care workforce, and (d) the expansion of primary health services and the orientation of health systems towards a primary healthcare approach. These have not been put in place or taken to the scale required.

The report does not dwell on why such a failure occurred. It contents itself with a call for "re-doubling efforts to accelerate progress towards UHC" and repeats all the earlier policy calls and concludes with a report on the next round of progress reports to the UN at its 2024 session and the next high-level meeting to be convened in 2027 (referring to paras 13 to 21 of the report). Implicitly, it is stating that the WHO and global agencies have done what they can do, and now it is up to the member states to take it further. It explicitly asks member states to spell out how better WHO can help. Further in paragraphs 24 and 26 it names a number of mechanisms it is putting together in partnership with other global institutions allegedly to strengthen primary health care and UHC.

PHM holds that this is not just a failure of implementation but a failure of strategy as it was rolled out in practice across most low- and-middle-income countries. What was required was strengthening publicly funded and publicly administered healthcare services, where the services are provided as public goods. Such a strategy finds little space in the UHC discourse. Instead 'universal coverage' has been used to promote publicly sponsored health insurance with strategic purchasing of a very selective package of essential services from a mix of service providers, complemented by a marketplace of private health insurance plans and private providers for services beyond the package. The drive for UHC, (rather than universal access) is also about restricting the need for public spending by imposing limits on the basic package and this in turn reflects the reality of very limited public funding for health care generally. A large part of the limited funding available is then dedicated to vertical programs of disease control, most of which involve the purchase of large quantities of increasingly expensive medicines, diagnostics and vaccines from big pharma. This leaves less and less funding for strengthening comprehensive primary healthcare. The collateral consequences of such policies are that financially protected care that the poor can access remains limited and there is a huge growth of an unregulated private sector. This then is the rational explanation for the figures and trends that the report places before us. What we need is a change of strategy, not more of the same.

In an apparent response to the lack of financing for PHC, para 26 presents a new initiative called Health Impact Investment Platform. This is being rolled out as a solution when in fact it is only likely to aggravate the problem. This initiative consists of four banks, the African Development Bank (AfDB), the European Investment Bank (EIB),

Islamic Development Bank (IsDB) and the Inter-American Development Bank (IDB), joining hands to make an initial €1.5 billion available to LICs and LMICs in concessional loans and grants to expand the reach and scope of their PHC services. WHO country offices are being incentivized with liberal project funds to write-up financing proposals that countries will then sign on to. While it comes with very high sounding politically correct descriptions of the importance of primary healthcare, it overlooks the fact that most LMICs are already deeply indebted, and this will only add to their indebtedness. Most countries are paying more for debt servicing than on welfare.

We also remind member states of the experience with structural adjustment and its associated health sector reforms, when all such loans were linked to overt and covert conditionalities, many of which have led to the problems we face today. Past policies having successfully privatized secondary and tertiary care, the game now is to move publicly funded and administered primary healthcare into the very same failed strategic purchasing options, that we hold as contributory to the lack of progress towards UHC. Instead, member states should call for the cancellation of debts, which could be linked to national governments investing more in primary healthcare on their own terms. We note that some of these banks are supporting corporate investment in healthcare, through private sector arms – like IFC for the World Bank. We also note that in many bilateral and plurilateral treaties, investor state dispute settlement clauses are applicable to healthcare services. This can greatly reduce the policy space available to governments for promoting quality, efficiency and equitable resource allocation. Under such conditions an open door to foreign for-profit investment for primary healthcare, which is in the nature of a public good, is most undesirable and needs to be opposed.

PHM also cautions against a number of international consultancy agencies, some of whom also occupy the civil society space, like ACCESS - Health International, as being promoters of some of these privatizing strategies that we hold responsible for the failure to progress towards UHC. The very fact that a platform like UHC 2030 (mentioned in para 26) runs in collaboration with OECD and World Bank gives reason to be cautious. Moreover it is the multinational commercial consultancy agencies, whose main income is from corporate clients, who are increasingly hired by such initiatives to plan the country strategy. While member states are primarily accountable for progress towards UHC or the lack of it, one must also measure and comment on the accountability of promoters of these failed strategies, even after they have been shown to fail.

The UHC Report is also remarkable for its silences. The most notable of these is in the challenge of access to essential medicines at affordable rates within the current global policy structure.

PHM calls on EB members to initiate a re-examination of WHO's rhetoric on UHC and its efforts to shape the role of government away from the provision of services as a public good, to one of purchasing services from a mix of providers based on market mechanisms. This has not worked for secondary and tertiary care and for primary healthcare it is a non-starter with almost no examples of success. We caution Member States that given the past experience with development bank loans for health care, the Health Impact Investment Fund could become a vehicle to persuade nations to accept market based solutions for primary health care which are unlikely to work, but could pave the road for corporate penetration into public services. Primary health care is NOT a

bankable investment. What LMICs require is debt cancellation and debt swaps; not more debt in the name of PHC and UHC.

MS should also call upon WHO to work on alternatives that progress towards universal coverage based on a conceptualization of primary health care as a public good. This will require the delivery of care being dominated by public providers with public accountability for promoting quality, efficiency, equitable resource allocation and population health-oriented health care. Financing must remain tax based or social insurance with a progressive movement towards single payer funding.

Item 7

Follow up political declaration of the third HLM of the UNGA on the prevention and control of non-communicable diseases

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In focus

In response to decisions WHA72(11) (2019) and WHA75(11) (2022), as well as to resolutions WHA66.10 (2013), WHA74.4 (2021) and WHA74.5 (2021), the Director-General submits a consolidated report (EB154/7) on the progress on the follow-up to the political declaration across several priority areas and, as a complement to EB154/7, a comprehensive overview of the Secretariat's technical work on the prevention and control of noncommunicable diseases.

The Board will be invited to note the report and provide further guidance. EB154/7 invites the Board to provide guidance on:

- How can Member States, with the support of the Secretariat, accelerate progress towards Sustainable Development Goal target 3.4 to reduce by one third premature mortality from NCDs by 2030, noting that global progress has slowed in recent years? How can the implementation road map be optimized, together with the WHO guidance on best buys and recommended actions for prevention and control of NCDs?
- How can the Secretariat support Member States to prepare for the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases due to be held in September 2025? What further strategic support from the Secretariat do Member States deem crucial in order to ensure adequate attention and focus on this pivotal event?
- How can NCDs be more fully integrated into ongoing work on health system strengthening, primary health care/universal health coverage approaches, universal health coverage benefit packages and other mechanisms to improve financial protection, and emergency preparedness and response plans?

Not foreshadowed in the annotated agenda is the Comprehensive Overview of the Secretariat's work on NCDs that "complements document EB154/7 and details key actions, approaches, initiatives and global assignments delivered by the three levels of WHO, across the three strategic shifts of the Thirteenth General Programme of Work, 2019–2025 that support Member States in implementing the global action plan for the

prevention and control of noncommunicable diseases and achieving the nine voluntary global NCD targets by 2025 and fulfil the relevant commitments made for such prevention and control and the promotion, protection and care of mental health by the United Nations General Assembly, including SDG target 3.4, as well as other key targets, such as SDG 3.5, 3.8 and 3.A."

In WHA76(9) (May 2023) the Assembly requested the DG *inter alia* to "to incorporate revised interventions to Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030 on a continuous basis, when data are available".

Background

A/RES/&3/2 (10 October 2018) Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

Tracker links to previous discussions of Political Declaration of Third HLM on NCDs

Tracker links to previous discussions of NCDs generally

PHM Comment

Overview

This report is tabled in accordance with the request to the Secretariat in WHA72(11) to present an annual report on progress in addressing NCDs and as follow up to the UN HLM on NCDs. It also fulfills commitments to reporting on the global action plan on oral health and cancers (para 1 to 4).

The next section (paras 5-23) is a situation analysis with respect to the NCD and mental health agenda. After an overview statement that NCDs are still a growing problem and that the program is not on track (paragraph 5 to 7), the report spells out the situation in each of 15 WHO strategized areas of interventions with a paragraph for each (paras 8 to 23) Those mentioned are diabetes (8), cancers, cervical and breast (9, 10,11), the control of hypertension (12), progress on tobacco (13), alcohol (14), physical activity (15), overweight and obesity (16), air pollution (17), visual impairment (18), oral diseases (19), screening for the 4 NCDs (20), mental health (21), neurological disorders (22), and post-covid illnesses (23). In each of these, the report points out that the burden of disease is still large, and that progress is either behind expectations or the disease burden is worsening.

In paragraphs 24 to 26 the global strategy on oral health is summarised. This has 100 activities and a set of 11 core indicators across 8 strategies. The report presents the baseline readings on these indicators as of 2023 and highlights that although 45% of the

population have oral health needs, only 31 percent of countries have an action plan and even fewer (21 percent) have implemented core components of it.

In paragraphs 27 to 79, the Report presents the relevant activities of the WHO Secretariat. Each paragraph relates to a disease condition or disease category. This is a summary of the much more comprehensive overview of the secretariat's technical work on NCDs. The types of activity reported on include hosting conferences and consultations, the adoption of resolutions, the presentation of reports, the development and dissemination of strategies, work plans and frameworks, and the adoption of technical guidance documents.

The Challenges

While the report documents faithfully the limitations in progress and the measures taken, it does not adequately address the reasons for the limited progress, even a decade after the world had accepted NCDs as a major public health issue. We list four key challenges that this report should have addressed:

Fragmentation of care and the integration challenge. It is apparent that, so varied and scattered are these interventions, that the challenge of fragmentation that besets member states is also a challenge for the WHO Secretariat.The challenge is particularly evident in moving from selective care to more comprehensive health care services. For two decades selective healthcare has often de-skilled health professionals and limited the conceptualization of what are primary care priorities and even what it means to say primary health care.

The health systems strengthening challenge. The issue of health systems strengthening is critical to achieving every one of these objectives. We need to think how WHO could strengthen the political constituencies which care about comprehensiveness, quality, efficiency, resource allocation, evaluation in health care. In part, this boils down to resources (fiscal capacity and all the related issues) but also to the organization of service delivery and human resources policy. Health system strengthening also needs to address the values or ethics on which public services are organized and, as part of this, to build a different set of incentives, free of market pressures (including the pressure to focus solely on episodic sick care), within which health care managers and practitioners could work.

The inter-sectoral and international dimensions. The intersectoral and international dimensions of NCDs control are critical, including the regulation of ultraprocessed foods, unhealthy diets, tobacco, alcohol, air and water pollution, and occupational health. WHO has produced a great deal of policy advice here but the task of building national constituencies to drive domestic intersectoral action and address the social and commercial and environmental determinants of health through foreign affairs engagement with finance, industrial policy, urbanization, natural resource management

etc. and their governance frameworks lags. This has close links with the agenda item on economics and health for all and the promotion of well-being and health. It also must address the role of the commercial determinants of health and the role of corporate influence that puts profits over health in shaping policy.

Health care personnel can play a major role in advocacy for health systems strengthening and for effective intersectoral/international action. The dramatic upscaling of the CHWs workforce which is called for could help to strengthen such advocacy.

The inequity challenge. The report is almost silent on the issue of inequity. Inequity impacts on the causes, consequences and response to NCDs. The focus on particular diseases and specific risk factors has obscured the inequality dimension. This includes inequality in terms of accessing decent healthcare which includes attention to NCDs, but it also includes social and economic inequality and discrimination and a greater exposure to all the specific risk factors described. We know that poorer and more marginalized sections are more prone to NCDs than others. Applying the inequality lens points also to the role of social and cultural environments which mediate the influence of inequality and discrimination on community attitudes which may discount health care utilisation and health promoting behaviours. Consider the role of junk food for people who need comfort or the role of alcohol in forgetting social realities.

Actions Required

Achieving Integration in inter-sectoral action

One area where integrated action is required pertains to inter-sectoral determinants where policy and strategy changes as well as regulation is required from different sectors.The main accountability for addressing many of these determinants lies with different ministries and different levels of government. Member states need to look at inter-sectoral policy actions that are required for health, and these cut across diseases and risk factors. This has been called the Health-In-All Approach. Legal instruments like preventive health laws, or labour and environment laws have a big role to play.

However, the health ministries need the institutional capacity to plan, to advocate and to measure health impacts across all these varied determinants, and they should be accountable for this. Countries require a well equipped capable institutional framework under the ministry of health to continuously monitor and intervene on the health consequences of development policies across sectors. Building capacity and accountability for such a role for health ministries is one key challenge that WHO must address.

Achieving integration at the level of local communities

Integration is also driven at the level of local communities. This is the level where the bureaucratic logic of institutional 'sectors' makes least sense. Community advocacy is a critical driver for encouraging intersectoral collaboration. It is often the primary health care providers who can see the need for intersectoral action most clearly but who are often working in incentive environments which discourage the necessary advocacy.

There is a need for public health and social security laws which empower local governments to ensure the appropriate working and living conditions of the population and build the necessary social support, social security and affirmative actions required to reach poorer and more marginalized sections. Interventions at this level are largely related to nutrition, water and sanitation, pollution, access to health and all health-related services, healthy neighborhoods, housing, etc. Local government needs the necessary finances and capacity to implement these interventions. In communities where local elites dominate, the state may need to step in to ensure equity.

Achieving integration through health systems strengthening:

Health systems strengthening and (re)organization is necessary to ensure delivery of the required services in an integrated manner, including necessary health education and preventive and promotive health care services and continuity of care across levels. It is neither possible nor desirable to address this large range of health conditions through a vertical program for each. Neither the 5*5 approach and the best buys model lend themselves to integration. They expand the current highly selective packages with a few additional interventions but continue with the selective and vertical mindset. Best buys based on cost-effectiveness of individual interventions could be misleading. The results would differ when they are assessed as elements of comprehensive integrated health care that makes full use of human resources and health facilities deployed.

Reducing fragmentation across disease specific services is an important goal. Efforts at integration in health service delivery would include measures to,

1. Promote research into health system models and share best practices in terms of how well NCD's can be addressed in an integrated manner. Some of the questions are : What would be the composition and skills of primary care teams? How would logistics of consumables and diagnostics support primary care teams and what innovations in technology would help? How would referrals to a larger pool of diverse specialists and continuity of care be addressed? How is monitoring and supervision to be organized in an integrated manner, without separate supervisory structures and separate e-platforms for each of these health conditions and risk factors so that we do not have a separate system for each disease condition taken up? Prevention and care for the expanded range of

disease conditions addressed have to be built into ongoing operations including at the resource levels, logistics, workforce profiles, and incentive structures;

2. Encourage health ministries and departments to strengthen community involvement in health planning, health system accountability and health promotion
3. Expand the fiscal envelope for health care through more responsive public financing mechanisms that can support the expansion of the variety and quantum of services provided.
4. Focus on inequality and discrimination as drivers of poor health and barriers to action on health, and plan affirmative action to reach poor and marginalized communities for all health needs. Identify and reform the incentives which currently prioritize wealthier and more affluent sections but are exclusive of poorer and more marginalised sections for sick care delivery;
5. Strong policy-implementation capacity including regulatory and fiscal levers; moving towards single payer funding;
6. Invest in human resources for health, especially in CHWs and midwives.

Item 8

Draft global action plan for infection prevention and control

In focus

In response to a request in resolution WHA75.13 (2022) on the global strategy on infection prevention and control, the Director-General will submit a draft global action plan (in EB154/8) to translate the WHO global strategy, adopted in decision WHA76(11) (2023), into an action plan, including a framework for tracking progress with clear measurable targets, for consideration by the Seventy-seventh World Health Assembly, through the Executive Board at its present session. The Board will be invited to note the report and consider a draft decision to adopt the action plan.

Background

Tracker links to previous global GB discussions of IPC

Global strategy on infection prevention and control and Executive summary (EB152/9).

Supplementary annexes 1-4

PHM Comment

The proposed action plan, presented in EB154/8, identifies actions, indicators and targets, for each of the eight strategic directions in the global strategy.

The proposed action plan also assumes the implementation of the provisions of the WASH plan, the global patient safety action plan and the global action plan on antimicrobial resistance (AMR). The supplementary annexes 1 to 4 accompanying this report provide further detail, including the theory of change. The annexes are essential resources for Member States to formulate and implement their own action plans (refer paragraphs 1 to 11 of the report).

Appreciation

The proposed Action Plan is to be welcomed. The issue is critical and the provisions of the plan are generally very practical and useful. However, we are critical of the vertical thinking which characterises much of the action plan and the failure to fully acknowledge

the wider range of generic resources and capacities needed for infection prevention and control.

Scope: need to encompass community as well as facility

Whereas, EB154/8 focuses on IPC in the facility, Item 13 on AMR, which includes IPC as a key strategic priority, addresses infection prevention in the community as well as in the facility. There is a strong case for doing so since it is difficult and inadequate to achieve safe water, sanitation, hygiene, and waste disposal in only the facility, without consideration of the urban environment in which it is situated. However, addressing infection control in the community calls for public health legislation that can enforce citizens' rights with respect to safe water, sanitation, and hygiene measures in the community. Many countries do have such laws, with local government institutions as their duty bearers but local governments are generally not provided with the capacities and financial powers needed to play this role. In accordance with the colonial mind-set, in which public health legislation has commonly originated, many public health laws shift accountability onto individual citizens and in practice target marginalized communities, especially migrants, as sources of infections. Since these communities are the main victims of poor hygiene, such victim blaming only adds insult to injury and compounds the problem. However if this strategy is interpreted as only pertaining to the facility, it would excuse the report skipping the larger concerns.

PHM calls on the EB to ask the Secretariat to rework this Action Plan to encompass IPC in the community as well as in the facility.

Vertical thinking

The first strategic direction ('political commitment and policies') calls for a national action plan for IPC integrated in national health plans. However the strategic direction also calls for a dedicated IPC budget and for the development of a national financial investment case for IPC.

The case for a dedicated budget allocation for IPC at the national and facility levels is not made.

In most countries there are existing institutional mechanisms which are set up to encompass IPC prevention and control alongside other related purposes. The need to create de novo institutional structures for IPC should be context dependent. Much of the regulatory framework for IPC should be incorporated in public health laws and facility level clinical governance systems (which go beyond infection prevention as narrowly interpreted but are essential for IPC). IPC requirements must be a sub-set of national public health standards and should not be presented as stand alone provisions.

Infection, prevention and control at the facility level is closely related to AMR prevention and control and many of the strategies and activities required are equally required for addressing both.

The need to have a separate “investment case for IPC” as different and distinct from the wider issues of public health standards sends a signal that donors should invest in IPC as distinct rather than investing in raising public health standards.

The indicators specified in relation to IPC are needed for IPC but would also be useful as elements within a wider surveillance and monitoring system.

Strategic Direction 3 is all about integration and is welcome. The programs with which integration is sought include “those on antimicrobial resistance; occupational health; patient safety; public health emergencies; quality of care; water, sanitation and hygiene and health care waste; and specific infectious diseases (such as HIV infection and tuberculosis).” This is well said but the problem that most LMICs will face is that except for the last, on HIV and TB infection, they currently have no established program on scale for any of the others.

Human resources

Strategic direction 4 relates to capacity building and it correctly highlights the scale of interventions required for capacity. The main limitation remains its vertical orientation. For example it calls for a full time IPC professional in every hospital whereas many hospitals do not have a full time person qualified in hospital administration or a full time microbiologist. It would be better to insist on the latter two, along with a stipulation that all hospital administration programmes include adequate instruction around IPC and that microbiologists working in hospital settings be required to be trained and certified in IPC either as integrated into their post-graduation programme or separately.

Data for action

In Strategic Direction 5, the plan makes a welcome call for data for action. However, the plan should acknowledge that this would need to have in place disease surveillance systems, IPC monitoring systems, and adequate hospital information systems all of which are critical for effective, affordable and sustainable data for action for IPC.

Acknowledging the wider range of generic resources and capacities needed for IPC

The second strategic direction (Active IPC programs) repeats the call for programmes and plans for different levels but fails to acknowledge the wider range of capacities that these will call on. It includes a target which measures “the proportion of facilities with implemented interventions based on multimodal strategies to reduce specific Health-care Acquired Infections (HAI) according to local priorities.” This is much easier

said than done. Without a good level of microbiological laboratory and specialist capacity and hospital/healthcare facility-based information systems, this is just wishful thinking.

The Global Action Plan needs to acknowledge these requirements as pre-conditions. These conditions cannot be met if the overall understanding of UHC is through purchasing minimalist cost-effectiveness defined essential packages of services.

Strategic Direction 3 calls for an indicator, "proportion of bloodstream infections due to methicillin-resistant Staphylococcus aureus, Acinetobacter spp., Klebsiella spp. and Pseudomonas spp. resistant to carbapenems." However, this calls for a laboratory, specialist capacity in microbiology and a hospital information system that can acquire, process and provide information on resistance patterns, in every facility, public and private.

In summary

Neither IPC nor AMR can be addressed in isolation from the need for:

1. Well functioning healthcare information systems that are able to document and analyse infection and AMR patterns and trends;
2. Well functioning disease surveillance programmes that include recognition of patterns of infection and antibiotic resistance adequate to guide providers;
3. Quality assurance systems which include all requirements, for IPC and AMR, including WASH standards and the adoption and use of standard treatment protocols;
4. Adequate microbiological capacity for identification of infection, its source and resistance patterns; part of ensuring access to ensuring good quality, primary, secondary and tertiary care as distinct from purchasing minimalist packages of care from private providers;
5. Adequate support staff required for ensuring WASH standards (water, sanitation, hygiene and waste disposal) and for the many IPC associated functions with proper terms of employment that would ensure performance;
6. Adequate procurement of the consumables required, including PPEs for ensuring good hygiene and other aspects of PPP;
7. Adequate regulation of private clinical establishments so as to ensure that all of the above standards are assured in the private sector also; governments can achieve the above by administrative action but for the private sector, legal provisions are essential; these must also be built into all purchasing of care from the private sector;
8. The creation of institutional capacity for national public health standards and quality assurance and improvement, including provisions which ensure all of the above actions as required for IPC but also include patient safety, AMR, effective clinical care, evidence-based public health planning, provider satisfaction, and patient satisfaction.

This package would definitely require more funds, but the funds would result in better outcomes. Member states should see the achievement of IPC as a subset of achieving good quality universal comprehensive healthcare rather than as distinct from it.

Item 9

Immunisation Agenda 2030

In focus

In decision WHA73(9) (2020) endorsing the Immunization Agenda 2030 the Health Assembly requested the Director-General to continue to monitor progress and to report biennially as a substantive agenda item to the Health Assembly, through the Executive Board, on the achievements made in advancing towards the global goals of the Immunization Agenda 2030.

This second report on achievements (EB154/9) will summarize the progress towards the goals and targets of the Immunization Agenda 2030. The Board will be invited to note the report and provide further guidance, in particular:

- What actions can global partners take to support countries to accelerate progress in the six priority areas highlighted above?
- How can countries strengthen their political and financial commitments to immunization within integrated primary health care systems, which is a key enabler of universal health coverage, improved population health and pandemic preparedness?

See PHM responses to these questions below.

Background

Tracker links to previous global GB discussions of immunisation.

WHO Immunisation team page and topic page.

PHM Comment

Short summary

The report from the DG summarizes the IA 2030 global vision, its overarching strategy, and progress toward achieving its objectives. The report identifies the impact of the COVID-19 pandemic on immunization, including setbacks in coverage and disruptions in essential services. While some recovery was seen in 2022, progress varied across regions and countries, with challenges in reaching zero-dose children and disparities in coverage persisting, especially in low-income countries and the African Region.

The report stresses the urgent need for coordinated action, emphasizing six priority areas (strengthening national programs, promoting equity, control of measles, advocacy for integration into primary health care, vaccine introduction, and papillomavirus vaccination in adolescence). The IA 2030 encompasses three impact goals and seven global-level indicators tracking progress. Despite some improvements, challenges persist in meeting coverage targets, eliminating diseases like polio and measles, and preventing large outbreaks.

The report highlights efforts to implement the agenda, including the development of national strategies and regional initiatives, supported by private global partners and working groups. The "Big Catch-Up" initiative aimed to bridge gaps caused by missed vaccinations during the pandemic years and restore immunization trajectories.

Geopolitical context and a disputed concept of primary health care

The IA 2030 and its implementation must be understood within a broader geopolitical context that significantly shapes its strategies and content. Despite multiple calls for integrating primary healthcare and strengthening national immunization programs, the IA2030 is rooted in a vision of universal health coverage (UHC), largely influenced by major global players like USAID, the World Bank, and the Gates Foundation. These entities advocate a health system framework that prioritizes private sector strengthening over public healthcare.

The concept of UHC tends to limit state involvement to providing a defined package of basic services through the private sector, opening opportunities for private healthcare providers and health insurance companies. This approach risks weakening overall health systems, reducing primary healthcare to a mere initial layer of private care, often acting as a gatekeeper to specialized care.

For national immunization strategies, robust public primary healthcare, centered on communities and territories, holds pivotal importance. These strategies demand a high level of state capacity for planning and collecting vaccination data, which is hindered by both privatization and the erosion of public health systems.

Addressing this agenda item necessitates this broader perspective and reaffirming the concept of primary healthcare present in the Alma-ata Declaration, which is crucial for adequate immunization strategies. Good primary health care is the best way to achieve isolated and impoverished communities, that are usually the ones not receiving vaccine coverage.

Also, community-centered primary health care is necessary in evaluating new technologies to be incorporated into immunization programs. Often, a technology-centered approach leaves behind a broader view of the health systems and the social and economic factors that frame what is possible.

Health workers

Health workers form the backbone of the health system, especially in areas where vaccination coverage is low, like non-urban and impoverished communities. The report's lack of emphasis on health workers and their role within the Immunization Agenda needs attention. It's crucial to acknowledge the need to build and value this workforce. This is particularly critical in conflict zones, where barriers to vaccination coverage are exacerbated by war and conflict. Understanding the interplay between war and health within a larger geopolitical framework is essential.

Pharmaceutical market: price transparency and pooled procurement

The IA 2030 and the DG's report insufficiently address issues concerning corporate power and vaccine affordability and availability. Over recent decades, vaccine production has increasingly fallen under the control of major pharmaceutical companies primarily based in Western Europe, the USA, Japan, and more recently, China.

The monopolistic strategies employed by these companies - utilizing intellectual property rights, including patents and industrial secrecy, restricting access to biological samples, and advocating for data exclusivity in clinical trials - result in high prices and shortages. The Covid-19 pandemic underscored the limitations of this model, revealing difficulties in scaling up production. The pandemic also left clear that vaccine innovation is heavily funded by public resources.

The analysis of this topic should include matters of affordability and access to health technologies, such as compulsory licensing of patents and transparency regarding innovation and manufacturing costs. Crucially, technology transfer, including the sharing of biological material samples, is pivotal for access to vaccines.

Strategies like pooled procurement have proven effective in bolstering states' bargaining power and their capacity to support national immunization strategies. For instance, the PAHO Revolving Fund in the Americas serves as a commendable model to strengthen and replicate within the IA 2030 framework.

Responding to Secretariat's questions

PHM urges Member States to include in their comments regarding the first question that the EB is invited to address:

- including capacity-building for National Immunization Technical Advisory Groups (NITAGs) and its regional counterparts (RITAGs), including in particular, methodologies for estimating the opportunity costs of introducing new vaccines, considering social and economic factors of the country and the region;

- recognising the need for WHO to assess the possibilities of implementing other pooled procurement mechanisms beyond the PAHO Revolving Fund, in partnerships with NITAGs and RITAGs.

PHM urges Member States to include in their comments regarding the second question that the EB is invited to address:

- requiring WHO to dissociate itself from the flawed 'universal health coverage' model promoted by the World Bank, USAID and the Rockefeller network and the consequent private-oriented primary health care concept;
- recognising the importance of a strong IA2030 considering the issues highlighted by the broader geopolitical context;
- recognising the need to address corporate power for ensuring proper access to vaccines, including IP barriers and the strengthening of local production; and
- the importance of health workers in immunization strategies.

Item 10

End TB Strategy

In focus

In resolution WHA73.3 (2020) the Health Assembly adopted the global strategy for tuberculosis research and innovation. In response to a request in the resolution, the Director-General will submit a report (EB154/10) on progress in respect of the End TB Strategy, including implementation of the global strategy for tuberculosis research and innovation, for consideration by the Seventy-seventh World Health Assembly, through the Executive Board. The Board will be invited to note the report and provide further guidance.

Background

Tracker links to previous global GB discussions of TB

WHO TB activities page and topic page

Hoffman (2023) 'Tuberculosis and inequality: how race, caste and class impact access to medicines', HPW 16 Dec 2023

UNGA HLM on TB 2023

PHM Comment

Overview - slow progress

The present report is submitted as fulfilment of the commitment of the DG WHO to report once in two years until 2030, on progress with regard to the End TB strategy. These strategies and the follow up reports are endorsed in the Political Declarations adopted in two high level UN Meeting on Tuberculosis (2018, and 2023) and in two World Health Assembly resolutions (2014, 2020) .

The report in its first seven paragraphs covers the targets set under the strategy, the current level of achievement and the trends. These could be summarized as stating than on every indicator the current levels of achievement are far behind what it takes to achieve the objectives. Incidence and mortality continue to be high, treatment coverage stagnates and preventive treatment rises too slowly. A considerable proportion of symptomatic cases are missed. The objective of 100% financial protection is still far with

over half the patients experiencing catastrophic health expenditure (CHE). In drug resistant TB, over 80% experience CHE. No country reports putting in place a comprehensive health and social benefits package though some financial and nutritional support is included in some of the national programs. The use of rapid diagnostic tests that were projected as becoming the first line of diagnostics for 100% of cases, has a coverage of only about 47%. Only two out of five drug resistant TB patients are enrolled in treatment. In terms of funding, the present budget available for TB in LMICs would have to quadruple to meet the target of $22 billion funding, and as of now over 80% of this funding is coming from domestic financing.

There has been progress on all three strategic pillars but the extent of progress is about half of what was expected. The first of these three pillars is "integrated prevention and care" under which the issue of updated technical guidelines, the scaling up of testing and treatment for tuberculosis as a co-morbidity with HIV and the introduction of six month all oral regime for tuberculosis in 40 countries are reported. The report notes that the treatment success rate for TB with HIV was only 63%. Under the second pillar the slow rate of progress to UHC and on the adoption of the multi-sectoral accountability framework is reported.

On research and innovation

With regard to the strategy for research and innovation which is termed the third pillar, the report concludes: "Overall, the development of novel tuberculosis vaccines, diagnostics and medicines and critical research projects is advancing slowly mainly due to inadequate funding. The Treatment Action Group reported tuberculosis research and development investment of US$1 billion in 2021-2 far below the United Nations global target of US$ 5 billion per year by 2027." PHM notes that the projection of how the End TB strategies would be achieved included assumptions that a new range of technologies would be introduced that would improve outcomes. Of this the greatest expectation was the vaccine. Though work is underway, these timelines are clearly unrealistic.

On the area of social consequences, especially the target of 100% coverage with health and social benefits package, there is no mention of what is the coverage achieved or even of how many countries have put in place any package. This is particularly unfortunate because some recent studies published in Lancet have demonstrated that nutrition supplements lead to better patient outcomes and prevent the development of disease in contacts (Bhargava et al, 2023a and Bhargava et al 2023b).

Reasons for the slow progress

The positive feature of the report is its clarity in describing the current situation. Its weakness is in the lack of any analysis on why progress is so limited in most countries. One reason for the poor progress that the report does highlight is the set-back due to

disruption of services due to the pandemic. However specific measures to prevent such disruptions in the future are not mentioned.

One reason for not being able to go to scale with new technologies are problems related to supply chain and intellectual property rights. The report acknowledges this. To quote: "Wider availability of these (new) regimens requires improving supply and access to the drugs central to them, including through approaches that harmonize the interplay between trade, intellectual property and health." However it lacks a clear commitment by WHO to intervene in the current trade and IPR regime or with the big powers to achieve such a harmonization. These barriers present to the program as reports of stockouts of anti-TB drugs for both preventive treatment and for active disease. The stockouts of drugs for drug resistant tuberculosis is a matter of deep concern. Many of the drugs meant for MDR & XDR TB are under patents and the high prices are unaffordable for governments as well as societies working in the area of tuberculosis care. Though there are provisions under TRIPS flexibilities it is difficult to use these. A TRIPS waiver on the lines of what was put in place for the Covid pandemic would be very useful.

Similarly the failure to shift from sputum microscopy to rapid molecular testing as the first line of TB diagnostics and further add in genomic testing for multi-drug resistance in all cases put in treatment, while welcome would require considerable health systems strengthening and financial support to be scaled up.

Addressing the two main causes of persistence of the TB epidemic:

Whereas the introduction of new technologies and deploying them on scale is most welcome, these do not address the two main causes of persistence of the TB epidemic despite so many periodic strategy changes.

The first challenge is the need to strengthen and universalize access to primary health care so that fewer cases of infectious tuberculosis are missed and so as to ensure follow up and medication compliance. Recent prevalence studies across nations indicate that as many as 50 percent of those with symptomatic lung tuberculosis may not have sought appropriate care. Whereas active case finding will help, this needs to be done as part of routine work where health workers are in close solidarity and support of all families through regular visits, rather than a reliance on sporadic campaigns. Technology improves care for those who have entered the care cascade but does not touch the problem of the many who have not entered it.

The second major requirement is effective action on social determinants taken to scale. This is not a sectoral issue. It is a whole of government approach that chooses a path of development that would reduce inequities and include welfare measures that proactively reach out to the poorest and most marginalized. Government must choose programmes and development pathways that eliminate hunger and malnutrition in the entire population. Both pandemics and wars aggravate the food crisis and create nutrition

insecurity. Climate changes worsens with respect to food production, procurement and distribution. Mitigation and adaptation strategies that address these crises. Other social determinants that inter-sectoral action can address are housing (overcrowded shelters), poor working conditions with low wages, and occupational lung disease. While introduction of new technologies are welcome, the impression created that one could eliminate the disease without addressing social determinants is not likely to work for tuberculosis. It may have worked for small-pox or for Covid, but not for tuberculosis.

In conclusion

The final outcomes are going to be largely dependent on these two areas of intervention. In the absence of addressing these two dimensions, the introduction of a new round of much costlier technologies is only going to occupy a larger part of the available public health budget, giving medical industry higher profits, but with the persistence of slow progress towards objectives that this report presents.

It is possible that the introduction of an effective vaccine could change the above narrative. It is equally possible that it would not. But we are not there yet.

Item 11

Roadmap for NTDs 2021-2030

In focus

The Director-General will submit a report (EB154/11) in response to decision WHA73(33) (2020), in which the Health Assembly endorsed the road map and requested biennial reports, through the Executive Board, on the implementation of the road map for neglected tropical diseases 2021–2030. The Board will be invited to note the report and provide further guidance.

Background

Tracker links to previous GB discussions of NTDs

'Global update on implementation of preventive chemotherapy (PC) against neglected tropical diseases (NTDs) in 2022 and status of donated medicines for NTDs in 2022–2023', WER 51(98),681, 29 Dec 2023

WHO topic page regarding NTDs

PHM Comment

This biennial report on NTDs holds its most critical finding until Paragraph 18, which notes that funding for NTDs has collapsed since the onset of the Covid-19 pandemic in 2020. None of the uneven 'progress' assessments in the report will lead to improvements in the lives of nearly one billion people susceptible to NTDs without a reversal of the 'rapid decrease in funding to combat NTDs.'

The EB must make a clear statement either that neglected tropical diseases should continue to be neglected and the suffering of those affected should continue or that past resources committed to ending NTDs should not be wasted by the current cutback in financial support, and that the global community will restore its funding to support WHO in eliminating NTDs and protecting nearly one billion people from suffering from preventable disease.

Paras 4-5 cite reductions in the numbers and percentages of people with NTDs, as well as NTD-related DALYs, but do not assess those reductions against the NTD Road Map or provide member States with enough information to assess whether the trend will result

in meeting the ambitions of the road map, nor whether the trend varies by gender, region or marginalized status. On seven of the NTDs, even this basic information is not available.

The persistence of NTDs undermines efforts to achieve UHC, understood as achieving universal access to all essential services to meet healthcare needs without financial hardships. Put another way, universal coverage for each of the 21 diseases on the NTD list, both in terms of preventive measures and in terms of treatment without financial hardship, is an important component of progress towards UHC. However, curative treatment for NTDs drive up out-of-pocket expenditures on health care services and treatments, while prevention is radically more cost-effective.

The report does not deal with the need for nor the progress made in addressing the wider social determinants of NTDs, including urban development, water management, and occupational health and worker rights. Each NTD has its set of proximate and intermediate determinants and addressing these require planned action at both the primary care and the community level, as well as intersectoral action. These cannot be constructed as 21 vertical programmes. There is a need to build successful models for addressing NCDs which is well integrated with comprehensive primary healthcare (see para 7). The prioritization of preventive chemotherapy shifts a burden to individuals and households suffering from NTDs, rather than social interventions. We note that coverage of preventive chemotherapy has also sharply decreased, probably due to the Covid pandemic (para 8). Migration and conflict are emerging threats to the control / elimination of NTDs, and are not addressed in the report.

Para 11, describes a policy towards access to medicines which has a considerable dependence on pharmaceutical partners to expand donations. This may work where elimination is an immediate goal, but in most cases this is not sustainable and not a substitute to affordable local manufacture and procurement. It is also uncertain whether appeals to big pharma is going to be enough for innovations of new medicines or new combinations of existing medicines and their progressive introduction and scaling up. The report should have noted that current intellectual property rights regimes stand in the way of innovation of the next generation of necessary diagnostic tools and medicines to prevent and respond to NTDs. There are also dangers that the current structure of innovation and manufacture would lead to driving up costs, creating dependency on donor-funding, and denying LMICs a role in developing local manufacturing of diagnostics and treatments for NTDs. In NTDs like snake-bites both diagnosis and care is based on approaches which are close to a century old.

Large populations across Asia, Africa, South America and the Caribbean continue to be denied access to medicines, health products and relevant diagnostic technologies relevant to the prevention, treatment or cure of NTDs.

Para 12 asserts that "Action to tackle antimicrobial resistance has been taken … ." However, such action has clearly been insufficient in numerous aspects. While EB154/11 cites programme monitoring for schistosomiasis and soil-transmitted helminthiases, sentinel surveillance for leprosy and awareness raising for NTDs (generally) during World Antimicrobial Resistance Awareness Week (WAAW) on 16-20 Nov 2022, those actions are not supported by dedicated actions to prevent or treat NTDs. Indeed, WHO's own webpage overviews related to both WAAW 2022 and WAAW 2023 is silent on NTDs, nor does the Director General mention NTDs in his video briefings for WAAW 2022 or WAAW 2023. [Note: EB154/11, refers to WAAW 2022, perhaps due to a typographical error as it is likely that the intention was to report on WAAW 2023.]

PHM notes that on 23 November 2023, during WAAW 2023, WHO held a webinar that included discussion of the effects of AMR on NTDs along with other pandemics (TB, HIV, malaria, STIs). Further WHO's fact sheet included limited notes on the interactions between AMR and NTDs, though restricted to only four of the twenty NTDs.

(Source: https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance; accessed 4 Jan 2024) Other citations:

- https://www.who.int/campaigns/world-antimicrobial-awareness-week/2022#
- https://www.who.int/news-room/events/detail/2022/11/18/default-calendar/world-antimicrobial-awareness-week-2022
- https://www.who.int/multi-media/details/world-antimicrobial-awareness-week-2023-video

Paras 13-15 focus on biomedical approaches to the prevention or treatment of NTDs, but ignore the policy, social and community actions that are necessary for effective NTD elimination. The notes on improved monitoring of NTDs are useful, particularly the GNARF, but no mention is made of how the new data systems are to be used by country and sub-national authorities, nor by civil society actors.

Para 18 states: "There is a general consensus that the rapid decrease in funding to combat neglected tropical diseases since 2020 is now the most urgent barrier to progress." This critical issue on resources for NTDs is buried inside the report, obscured by alternating positive and negative language and statistics regarding progress on NTDs. Instead, the erosion of the funding base for NTDs is among the most important of the issues for the Executive Board's discussion, as it represents a clear waste of previous financial commitments and a prolongation of the suffering of nearly one billion people from diseases with known preventions and treatments.

Two questions are posed for discussion, relating to operational/technical challenges and implementation of a new set of strategic priorities. Instead or alongside these issues, the EB must decide if NTDs are to be continued to be neglected with insufficient resources or if WHO is to be supported with sufficient funding for implementation of the NTD Road Map.

PHM urges member States to undertake the following steps related to NTDs:

- Support WHO with resources necessary to enable the elimination of all 20 NTDs by 2030 (21 with the recent addition of Noma) and to build on the decision in WHA73(33) in 2020 regarding the Road Map for Neglected Tropical Diseases 2021–2030, so that previous funding is not wasted by the ongoing rapid decline in resources to eliminate NTDs;
- Prioritize social interventions to prevent or address NTDs, alongside chemotherapies and other biomedical interventions;
- Request the DG to include NTDs as a priority action in the AMR Global Action Plan, to ensure that emerging anti-microbial resistance to available medicines for the prevention or treatment of NTDs do not undermine the existing efforts to eradicate those twenty diseases that disproportionately affect the poor globally, resulting in loss of livelihoods and increase in poverty.

Item 12

Acceleration towards the Sustainable Development Goal targets for maternal health and child mortality

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In focus

Progress to reduce the global maternal mortality ratio to less than 70 per 100 000 live births by 2030 (SDG target 3.1) stagnated between 2016 and 2020; in addition, 54 countries are off track to end preventable deaths of newborns and children under 5 years of age by the same year (SDG target 3.2), and to achieve the target of lowering neonatal mortality to at least 12 per 1000 live births and under-5 mortality to at least 25 per 1000 live births).

The Board will be invited to note the report (EB154/12) and provide further guidance, in particular, with respect to the following questions:

- What actions do Member States recommend for accelerating progress towards achieving:
    - Sustainable Development Goal target 3.1 (on reducing maternal mortality)?
    - Sustainable Development Goal 3.2 (on ending preventable deaths of newborns and children and reducing neonatal mortality)?
- What do Member States propose should be the role of the WHO Secretariat in supporting these actions?

Background

Tracker links to previous discussions of the SDGs

WHO Global Health Observatory / SDGs

PHM Comment

Appreciation

The absolute disease burden and inequalities in maternal and child health as described in EB154/12 are very distressing. The analysis of current trends (paras 2 - 12) is very clear and should be circulated widely.

PHM notes that the statistics presented regarding maternal mortality are all are up to 2020, ie before the COVID 19 pandemic, which had a notable impact on increasing maternal mortality (by about 30% in several settings) and stillbirth rates in many countries. The impact on DPT vaccination in para 23 is the only impact measure mentioned.

Current trends are mostly described in terms of mortality with limited assessment of both maternal morbidity (eg strokes) and newborn morbidity (eg hypoxic ischaemic encephalopathy). Such indicators need to be developed and measured going forward.

Although the lack of progress in reducing stillbirths is described in para 3, these deaths remain uncounted and unrecognised in many countries; this needs to be remedied.

There is no attempt to describe the number of pregnant women, mothers, newborns and children currently displaced due to migration and conflicts or to enumerate other hidden groups such as street and working children. PHM urges that such measures should be included, even if only estimates.

The paper approaches its analysis of causation in two ways: first, a review of the reach of key service interventions (clinical and preventive) necessary for maternal and child health; and second, a more general exploration of obstacles to achieving the maternal and child mortality targets.

In paras 13-17 the report documents large shortfalls in the availability of key interventions for maternal and child health as well as wide inequalities within and between countries. While equity comparisons are presented for the coverage of interventions similar data are not shown for outcomes and would show wide disparities between top and bottom income quintiles for morbidity and mortality. Among the shortfalls, sexual and reproductive health services stand out (including free safe abortion for girls and adolescents). Breast feeding (early initiation and exclusive for six months) is also cited as one of the largest gaps.

In its exploration of obstacles to maternal and child health (paras 18-23) the report lists health system weaknesses as well as wider socio-economic barriers.

In terms of health system weaknesses the report cites:

- community awareness;
- out of pocket payment as a barrier to access;
- distance and travel barriers;
- access to quality medicines, equipment and commodities; and
- the shortage of a competent health and care workforce.

The report's discussion of workforce shortages (para 18) is particularly useful, citing in particular the under-use and under-supply of community health workers and midwives.

Para 18 falls short in not calling for full recognition of community health workers as regular workers to be properly remunerated and provided with social security accordingly.

The report also highlights shortfalls with respect to quality of care (para 22). This should explicitly include disrespectful care which is a major issue. Quality of care is not just a technical issue involving skills, resources and governance. It is also a question of patients rights which need to be respected, promoted and protected throughout the care process and administration (eg data protection).

The report acknowledges growing evidence that persistent inequities in socioeconomic development contribute significantly to poor maternal health (para 21). This underlines the need for disaggregated data and the use of such data in program development.

The report also notes 'a growing body of knowledge' linking climate change to adverse maternal and child health outcomes (para 23); not just heat and air pollution but others such as floods and landslides.

The paper concludes with a return to the program / intervention focus, listing a range of strategies, roadmaps and action plans which, if implemented at scale, could put countries back on track to reach the 2030 maternal and child mortality targets.

Critique

Secondary health system capacity

The emphasis on community health workers and midwives in paras 18 and 19 is appreciated. However, it is also important to highlight the importance of referral support and outreach from the secondary level of the health system. Is there a secondary capacity to ensure that primary care practitioners can fulfill their potential. The availability of Comprehensive Obstetric and Newborn care facilities (eg in district hospitals) is essential.

Secondary support capacity includes emergency care (including neonatal intensive care), surgery, blood, anaesthesia and continuing technical support. This demands integrated comprehensive capacity; not the narrow range of skills and facilities defined by vertical intervention programs. It also requires inter-facility transport as well as transport from home to care. Secondary support capacity is also needed for mental health conditions, including autism spectrum disorders and ADHD.

Improved health system leadership and governance at regional, district and facility levels are critical. This includes understanding the health needs of the populations being served and service availability within its catchment area. (PHM comment under Community awareness).

Community awareness

In para 19, EB154/12 makes a vague reference to "limited awareness of the needs and available care" but with no elaboration.

The context suggests that in some settings, families and communities are unaware of the risks of pregnancy and early childhood or of the efficacy of available clinical and preventive interventions. Perhaps 'awareness' does not wholly capture the range of constraints on the full utilisation of such services. In many cases communities are aware of risks and needs but face steep access barriers. The same may apply, in some settings, to food distribution in the household and community.

The emphasis on the need for community health workers and midwives elsewhere in the paper is a necessary part of any response to the problems of 'limited awareness'. However, it would also be appropriate to look towards strengthening the understanding and sensitivity of health system managers and policy makers regarding knowledge of, and demand for, services and resources.

Privatisation and marketisation

In its discussion of health system obstacles, there is no mention of the pressures to privatise health care delivery and marketise health insurance (a common consequence of 'universal health coverage' policies).

Promoting quality of care, efficiency of resource use, more equitable distribution of resources and the development of comprehensive primary health care requires a strong regulatory framework and publicly accountable single payer financing.

Privatisation reduces the reach of clinical governance and the promotion of quality of care. Privatisation and marketisation weakens the policy leverage available to ministries of health for efficient resource use and equitable distribution of resources. Competitive marketised health insurance is too often associated with stratified levels of health cover ranging from generous to minimal (with heavy OOP costs for those on very basic plans).

Of particular concern in relation to prematurity is the increasing number of cesarean deliveries, which in many countries is excessive in the private sector.

WHO has been too cautious in terms of critiquing the campaign for the privatisation of health care, driven in particular by the World Bank and the Rockefeller Foundation. Privatisation of health care and health care financing is also driven by the IMF and international finance markets through their demands for fiscal austerity. Fiscal austerity is also a consequence of tax avoidance and the conditionalities of foreign investment.

PHM urges EB members to request that EB154/12 be reworked before presentation to the Health Assembly to give proper attention to the development of strong publicly

funded and administered health systems and to the wider macroeconomic context to be addressed as a condition for health system strengthening.

Climate change

EB154/12 mentions climate change as an obstacle to achieving maternal and child health targets. However, it is perplexing that the report only mentions heat stress, infectious disease and air pollution as mediators, overlooking issues such as the nexus with food security.

PHM urges EB members to also highlight floods, drought, displacement, and conflict in the next iteration of this paper. In view of the continuing resistance to curbing fossil fuel use, evident in particular at COP28, WHO must continue to contribute to building the case for effective action for mitigation and adaptation.

Inequalities and discrimination

The report acknowledges persistent inequities in socioeconomic development which contribute to poor maternal and child health. However, there is no elaboration on the underlying obstacles to development. There is no mention of unsustainable debt, the imposition of austerity, and the role of trade liberalisation in driving unemployment, underemployment, and precarious employment. Gender-based violence and discrimination need to be recognised as a paramount priority.

Migration, conflict and war are major obstacles to achieving the SDGs including better health outcomes of mothers, newborns and children. Such disruptions have got worse since 2020 and remain an ever-increasing public health disaster.

Obstetric violence should be highlighted because this is a factor linked to maternal morbidity and mortality, not only because of inadequate care, but also because it prevents women from searching for appropriate and timely care because of FEAR of being mistreated. This of course is subject to variation by race and social class.

Malnutrition

It is unfortunate that maternal anaemia is not mentioned in the report, both as a reflection of health system weaknesses and inequality and discrimination. Anaemia is a major factor in maternal health outcomes; it relates to poor infant nutrition and the nutrition of adolescent girls including failure to address adolescent health needs such as heavy menstrual bleeding.

EB154/12 mentions the continuing prevalence of stunting in under fives, particularly in South Asia and Africa. It should be emphasised that child stunting is an indirect indicator of levels of poverty and reflects food insecurity which in turn is shaped by the

intersections of economic inequality, inequitable trade agreements and the corporate control of agricultural value chains, as well as climate change.

EB154/12 also mentions wasting which is a much more acute indicator of catastrophic hunger, commonly driven by climate-related 'natural' disasters and political conflict and displacement. These associations need to be mentioned as part of reinforcing the need to address the underlying drivers with the full participation of affected communities.

Malnutrition is an underlying condition for up to 50% of all child mortality. Overweight and obesity in children may also contribute to morbidity in later life..

If WHO is serious about the social (including commercial) determinants of health or the 'economics of health for all' these underlying obstacles must be explicitly identified and challenged.

Acceleration to reach SDG targets

In para 24 the report returns to the intervention mindset, positioning a range of WHO strategies, action plans and roadmaps as the key to accelerating maternal and child health improvement.

The implementation of these strategies, action plans and roadmaps cannot be separated from the challenges of addressing health system weakness, economic inequality and discrimination, global warming and conflict.

More detail is needed on translating global initiatives to actual policies and practices at district, facility and community level, including the provision of secure (equitable) funding. For example, the WHO Road Map for PPH mentions the EMOTIVE approach whereby use of plastic collection drape to accurately measure blood loss at birth reduces severe outcomes by 60%; but it needs a clear implementation strategy of how the tools can be sourced and distributed at low cost, and their use initiated at all levels of care.

Civil society

Completely missing from this report is any recognition of the agency of civil society in promoting maternal and child health, whether through challenging community assumptions, demanding health policy changes as well as holding institutions to account. Measures such as social audits of services illustrate the potential contribution of community participation.

As a member state organisation WHO has been too cautious about recognising the potential contribution of civil society, including social movements, in the struggle for Health for All. PHM calls upon the Secretariat to provide more leadership researching and

documenting the potential roles of civil society and building relationships with civil society at the country level.

Item 13

Antimicrobial resistance: accelerating national and global responses

In focus

In line with resolution WHA72.5 (2019) and in preparation for the high-level meeting of the United Nations General Assembly on antimicrobial resistance, scheduled to be held in September 2024, the Director-General will submit a report (EB154/13) on WHO's strategic and operational priorities to address drug-resistant bacterial infections, for the period 2025–2035. The Board will be invited to note the report and provide further guidance.

Background

Tracker links to previous GB discussions about AMR

UNGA 2016 Political Declaration on AMR. SG Follow Up. Quadripartite

PHM Comment

(Please read this report and comment along with those for agenda item 8 on Infection Prevention and Control)

1. The first five paragraphs of the Report on antimicrobial resistance (AMR) sets out the magnitude of the problem and the pervasive harm it does across the health system and other sectors and the excessive mortality and morbidity that it leads to. The Report then notes that whereas most countries have adopted national plans, only 27% report progress on effective implementation of these (para 6). The Report then reiterates the call for implementing these national and global plans (paras 7 to 10).

2. In 2015 the 68th World Health Assembly adopted the global action plan on antimicrobial resistance and (in WHA68.7) urged Member States to develop and implement similar national action plans. Since antimicrobial resistance requires a comprehensive One Health response, WHO and the other Quadripartite organizations, namely the Food and Agriculture Organization, the United Nations Environment Programme and the World Organisation for Animal Health, all endorsed the global action plan and agreed on multisectoral actions for its implementation. The other three have

adopted sector-specific strategies against AMR. In 2023 at the 76th WHA, the DG WHO made a proposal for the development of a WHO strategic and operational framework to address drug-resistant bacterial infections in the human health sector.

3. In 2024 a high level meeting of the UN on the theme of AMR is scheduled. This current report (EB154/13) is a part of the build up towards the UN Meeting on antimicrobial resistance scheduled for later this year.

4. This report proposes three urgent strategic priorities and two operational priorities for a comprehensive public health response to antimicrobial resistance in the human health sector. The first is the prevention of all infections that give rise to the use of antibiotics, noting that viral and other infections also contribute to inappropriate antibiotic use. The second strategic priority is universal access to quality diagnosis and appropriate treatment of infections. The third priority is strategic information and innovation, notably surveillance of both antimicrobial resistance and antimicrobial consumption/use; the development of new vaccines, diagnostics and antimicrobial agents; and measures to make these accessible and affordable. These strategies are intended to guide efforts to tackle the causes and consequences of drug-resistant infections for people, communities and health systems. They represent a shift in focus from pathogens to health systems.

5. However, the shift to a health systems approach raises more clearly the overlaps with other health systems interventions. Para 14 mentions infection prevention and control; water, sanitation and hygiene; immunization; maternal and child health; diagnostics and laboratory strengthening; primary health care; universal health coverage; health emergency preparedness and response; the health workforce; and various disease-specific strategies. These areas are all the subjects of separate WHO resolutions, strategies and plans but at the national and facility levels the genesis of AMR needs to be assessed in relation to these different areas and action must integrate the principles and requirements of these different areas. The challenges of integration at the national and facility levels is recognised in the document but practical ways of addressing these challenges are not provided. Under these circumstances the lack of progress on national plans reported in this document is likely to continue.

6. Given the high degree of overlap between this agenda item at the one on infection, prevention and control in agenda item 8, we would urge the Secretariat to bring these two initiatives into much closer integration, rather than launch two vertical programs and create confusion down the line at every regional and country level. The first of the three strategies proposed for AMR is Infection prevention and control. However, whereas, agenda item 8 focuses solely on IPC in the facility, this item encompasses infection prevention in the community as well as in the facility. In our comment on Item 8 we have called for the Action Plan on IPC to be broadened to include infection prevention in the community as well as the facility. There is a strong case for doing so since it is difficult

and inadequate to achieve safe water, sanitation, hygiene, and waste disposal in only the facility, without consideration of the urban environment in which it is situated. However, addressing infection control in the community calls for public health legislation that can enforce citizens' rights with respect to safe water, sanitation, and hygiene measures in the community. Many countries do have such a law, with local government institutions as their duty bearers but local governments are generally not provided with the capacities and financial powers needed to play this role.

7. This report is surprisingly silent on the role of antibiotic use in the animal husbandry/agricultural/veterinary sectors, though it is well known that much of the antibiotic resistance that arises is from the commercial pressures on this sector that leads to high levels of inappropriate antibiotic use. Perhaps this is because this issue is addressed in the sector-wide strategies of the other Quadripartite partners, especially the Food and Agriculture Organization of the United Nations, and the World Organisation for Animal Health. However, documents provided to WHO governing bodies should provide the cross-references and linkages to the relevant documents and showing the points of convergence. Ignoring one of the main sources of development of AMR is not acceptable; member states must demand its inclusion.

8. The second strategy of "Universal access to affordable, quality diagnosis and appropriate treatment of infections" is most welcome, especially since it integrates concerns of ensuring access to essential antibiotics with restraints on inappropriate use. We also welcome the statement that "this priority requires integration of specific interventions – notably for diagnostic and antibiotic stewardship based on WHO's AWaRe (access, watch, reserve) classification and the WHO AWaRe antibiotic book. It includes ensuring gender-equitable access and addressing the specific needs of vulnerable groups including migrants and refugees." AWaRe is most welcome. We must however point out that this paradox: on one hand major population sub-groups are experiencing serious problems of access to essential antibiotics (and other medicines) while at the same time the entire population is experiencing high degrees of wasteful, irrational, unscientific and even hazardous use of antibiotics. The roots of this paradox are in the nature of capitalist production, and whereas state action can mitigate and adapt to this problem, it cannot do away with it altogether.

9. Notwithstanding measures for mitigating inappropriate antibiotic use, the silence on some of the drivers of inappropriate use is a major weakness of this strategy. Much of inappropriate use of antibiotics is because of commercial pressures and the nexus it has with professional behaviors. These pressures lead to shaping public demand in favour of inappropriate use and leads to a legitimizing vicious cycle. This report addresses this entire problem as an issue of consumer behavior and somewhat implicitly of providers, but completely leaves out the political economy considerations which include the commercial and unethical marketing of pharmaceuticals. This problem is not limited to antibiotics, but here there is harm from individual provider-patient transactions that have

an effect on the entire population. There is no mention in the report of the need for controls over marketing of antibiotics, through regulatory restraint over unethical marketing and prescription practices. There is no mention of the need for better access to good quality prescription information for doctors from institutions which are free of conflict of interests. There is no mention of the complicity of professional associations in such unethical marketing both for reasons of professional power and for financial gain. There is no mention of the use of generics as different from brand names. There is no mention of the difficulty of restraining use of third and fourth generation antibiotics in a setting of almost no regulation of the private sector in healthcare.

10. When it comes to stewardship, there is a need for more practical and affordable solutions to making appropriate prescription choices rather than calling for a massive expansion in microbiological and genomic diagnostics where every individual infection episode requires heavy expenditure on diagnostics. The central challenge to stewardship as of now in most LMICs is in ensuring the minimal essential access to microbiology capacity (viz laboratory, microbiologists, standard treatment guidelines) and appropriate public health informatics and disease surveillance. This problem of access to bacteriological capacity gets mentioned only as one of the indicators. This report does not even acknowledge the problems of developing these capacities. (For further discussion on health systems strengthening required for effective antibiotic stewardship see also PHM comment on agenda item 8 at this meeting.)

11. The current challenges of innovation underpin the third strategy proposed in this report. The current innovation and knowledge regime is bad for all essential medicines of public health importance, but when it comes to antibiotics it is terrible. By definition third and fourth generation antibiotics have to have very restricted use, which means a very limited market size and very high price mark-ups. It is not possible to create an intellectual property regime and a financing model just for newer antibiotics. Public financing of antibiotic research would help, but without control over patents and distribution we will see the same outcome as we saw with Covid vaccines, a huge profit to big pharma with high inequities in access, despite the public finance. The minimum measures for an effective innovation regime are a) delink the price of innovation and development from the price of marketing the drug, the latter reflecting only manufacturing costs and b) where public financing is involved, public acquisition of IPRs and mandatory licensing of multiple generic manufacturers to undertake production including where possible public sector manufacture.

12. In summary though there are many welcome measures in these strategies it is too incomplete to succeed. In many of our local communities there is a saying, “like jumping across a well and being almost successful.” Good try, but you still fall in. The magnitude of the problem is well described- but it needs a more comprehensive response.

Item 14

WHO's work in emergencies

In focus

The Director-General will submit a report (EB154/14) that provides updates on all public health emergencies of international concern, Grade 3 and United Nations Inter-Agency Standing Committee level 3 emergencies in which WHO took action in 2023 (up to 30 September) and on the progress made to improve research and development for potentially epidemic diseases. A second report (EB154/15) will describe the work that WHO is undertaking at global, regional and country levels in order to strengthen health emergency prevention, preparedness, response and resilience. The Board will be invited to note the reports and provide further guidance.

Background

Tracker links to previous governing body discussions of Emergencies

WHO Emergencies Program overview

Emergency health care in crises (Bull WHO, 2024;102:5–6)

PHM Comment

Public health emergencies: preparedness and response

Overview

The DG's report on "Public health emergencies: preparedness and response" (EB154/14) focuses on humanitarian emergencies attributable to climate disasters, infectious diseases, and conflict.

This is a regular annual report on WHO involvement in public health emergencies. It was mandated in EBSS3.R1 in Jaunuary 2015 and in WHA68(10) in May 2015. These are both significant documents in the development of WHO's emergency preparedness and response work.

EB154/14 identifies the MENA and AFRO regions as the worst affected regions. Food insecurity, "heightened insecurity and impaired safety"of health workers and facilities, and "weakened health systems in the wake of the COVID-19 pandemic" are mentioned as additional factors complicating provision of health services in emergency, humanitarian

and conflict-affected settings. During the reporting period (1 Jan-30 Sep 2023) the report notes that WHO responded to 66 graded emergencies, including 17 Grade 3 emergencies.

The report notes an escalation and intensification of humanitarian crises during the reporting period, acknowledges that this shows little indication of reversing, and in light of this, expresses concern about the difficulties it has experienced in securing funding for its work in humanitarian emergencies. The natural disasters in Libya (floods), Morocco, Syria, and Turkey (earthquakes), and the conflict in Gaza, all of which occurred after the reporting period, are mentioned in the report as indicators that the Emergencies Programme will face an increased burden of work for the foreseeable future.

The Secretariat's concern about the fact that "[t]he anticipated exponential increase in vulnerability and people in need is paired with diminishing funding for humanitarian operations" is captured in the first sentence of the "Outlook" section: "Current trends are not sustainable". Funding constraints that limit WHO's effective engagement in humanitarian crises include:

- Funding gaps in the WHO Health Emergencies Programme budget (40%) and the emergency operations and appeals segment of the budget (25%);
- Approval of exceptional budget increases for the Health Emergencies Programme in May 2022, but no "material increase[s] in funding" matching these increases yet

PHM Comment

EB154/14 describes a shocking increase in global emergencies. It bears reiteration:

> *The overarching trend during the reporting period was a steep increase in humanitarian health needs on a global scale, driven by overlapping and interacting aggravating factors, including accelerating climate change, increased conflict and insecurity, increasing food insecurity, weakened health systems in the wake of the COVID-19 pandemic, and new infectious disease outbreaks. (para 8)*
>
> *Year on year, WHO is responding to more frequent, more complex and longer-lasting health emergencies than at any time in its history. At the end of 2022, the United Nations estimated that 339 million people – almost 5% of the world's population – would require humanitarian assistance in 2023, with many facing urgent threats to their health. This represents about a 25% increase in the scale of humanitarian health needs compared with 2022, and a more than 100% increase compared with 2018. (para 11)*

Current trends are not sustainable. The steep increase in humanitarian needs during the first nine months of 2023 reflected a global landscape of intensifying and mutually reinforcing risk factors and threats, such as conflict and climate change. [...] The anticipated exponential increase in vulnerability and people in need is paired with diminishing funding for humanitarian operations. (para 19)

The causes of the causes

The report highlights climate change, increased conflict and insecurity, food insecurity, weak health systems. These are significant, inter-related and mutually reinforcing.

However, missing from this list are the barriers to equitable and sustainable economic development, associated with neoliberal globalisation, and the barriers to social and economic self-determination associated with recurring imperial intervention.

The principles underlying WHO policies on the social determination of population health demand a focus on the causes of the causes. The list of Grade 3 emergencies provided in EB154/14 provides a rich data set for exploring the drivers of humanitarian emergencies and their health consequences.

If the politics of WHO as a member state institution do not allow it to inquire into the causes of the causes it should at least collect and publish the relevant contextual data. However, WHO's work in and reporting on politically sensitive ongoing conflicts (such as in Ukraine, Tigray and Gaza) exposes the organisation to accusations from MS (as at EB152) that it is veering from its mandate as a 'technical agency' and taking on political positions. With such accusations come the threat of defunding WHO's work in health emergencies, or indeed, other line items in WHO's budget.

PHM calls upon member states to recognise that health is political and that restricting the work of WHO to a narrowly defined technical mandate is equivalent to refusing to allow it to inquire into the causes of the causes.

(The Secretariat reports, in EB154/15 (para 13), that WHO is working with the World Bank, International Monetary Fund and European Investment Bank as part of the G20 Joint Finance and Health Task Force to develop a framework for economic vulnerabilities and risks to pandemics. Might be a move in the right direction, albeit with the wrong partners.)

Responding to humanitarian emergencies

We welcome the secretariat's call for "a more strategic and holistic approach in responding to all health emergencies [that] would help to break the cycle of panic and neglect that often leaves communities in positions of entrenched vulnerability and fragility", and for "targeted measures to strengthen core capacities at the health security,

primary health care and health promotion interface". These kinds of systemic changes, especially when focusing on investment in "resilient" and functional public health systems, can contribute to strengthening equitable access to care in normal and emergency settings.

PHM calls upon member states to endorse the call by the Independent Oversight Advisory Committee for the WHO Health Emergencies Programme in a May 2023 report (cited in EB154/14) for the Health Emergencies Programme to be provided with "enough authority and [to be] capacitated with all needed financial and human resources, to make it fit-for-purpose".

Strengthening the global architecture for health emergency preparedness, prevention and response and resilience

EB154/15 reports on a number of ongoing initiatives - regulatory, administrative and financial - directed to "Strengthening the global architecture for health emergency preparedness, prevention and response and resilience". Many of these initiatives will come under further consideration at WHA77 in May,

EB154/15 notes that the ongoing negotiations around amendments to the International Health Regulations and the negotiation of a new 'pandemic treaty' aim to "balance sovereignty with the promotion of mutual accountability" (para 6) among MS and are due to conclude in May 2024. While the document explicitly mentions that the IHR revisions are to be informed by the principles of "equity, sovereignty and solidarity" (para 3), these principles are not explicitly acknowledged in reference to the INB process (para 2).

See also TWN (9 January 2024): WHO: Upcoming IHR amendment negotiations to focus on equity proposals and TWN (19 October, 2023): WHO: INB Bureau proposes unbalanced draft negotiating text; no concrete deliverables on equity

The report notes the launch of the Pandemic Fund in November 2022, its allocation of funding to applicants in July 2023 (75% of which benefits LMICs), and the fact that WHO is the implementing agency for 15 of the 19 proposals selected. Nonetheless, it also mentions the September 2023 UNHLM on PPR's acknowledgment that the "scope and coordination of current financing mechanisms" for PPR are inadequate and that more needs to be done to identify "sources of funding to rapidly surge more effective and equitable responses" (para 5). The report mentions that WHO is working with the World Bank and the G20 Joint Finance and Health Task Force on these issues, and with these partners as well as the IMF and European Investment Bank PPR "to develop a framework for [understanding the] economic vulnerabilities and risks [related] to pandemics" (para 13).

As in several other documents for this meeting, the secretariat acknowledges the significantly more complex, frequent and wide-ranging health emergencies it has been dealing with in recent years. It acknowledges that the proliferation of PPPs and increased CSO involvement in emergency response efforts "increases the risks of fragmentation, duplication and competition" (para 16) but that "WHO continues to forge new ways of connecting and coordinating partners to harness collective strengths" for health emergency PPR (para 17).

EB154/15 also reports on work currently being undertaken within the Secretariat to support member state capacities across a number of emergency-related fronts, including:

- Strengthening surveillance through the work of the WHO Hub for Pandemic and Epidemic Intelligence;
- Combatting Infodemics through the WHO Information Network for Epidemics and the WHO Initiative on Trust and Pandemic Preparedness;
- Developing an interim medical countermeasures platform (i-MCM); and
- Building an enhanced platform aimed at ensuring effective coordination between MS and partners in the Global Health Emergency Corps during health emergencies.

The EB is requested to note the report and offer guidance on two questions:

- How can the Secretariat continue to support Member States in the continued work of the WGIHR and the INB, including in efforts to facilitate the synergies and complementarity of these two processes?
- How can the Secretariat work with Member States and partner organizations to improve coherence among all the global, regional and national initiatives and strategies aimed at strengthening health emergency preparedness, response and resilience?

The WHO's emphasis on increasing the sufficiency, flexibility and sustainability of financing for PPR is important. However, the partner institutions mentioned in the report (WB, IMF, G20) are dominated by the voices, financial contributions, and neoliberal policy orientations of developed countries. Developing countries, presumably the intended beneficiaries of these new financing mechanisms, are thus unlikely to play a determining role in designing the new PPR financial architecture.

Item 15

Implementation of resolution WHA75.11 (2022)

In focus

The Seventy-sixth World Health Assembly adopted decision WHA76(8), requesting the Director-General to report to the subsequent Health Assembly in 2024, through the Executive Board at its 154th session, on the implementation of resolution WHA75.11 (2022), including an assessment of the direct and indirect impact of the Russian Federation's aggression against Ukraine on the health of the population of Ukraine, as well as related regional and wider than regional health impacts including its adverse effect on the attainment of the objective and functions of WHO.

WHA75.11 requests to the DG included:

- support to the humanitarian and emergency response;
- prevention of and response to sexual exploitation, abuse and harassment;
- support to the health sector;
- procurement of essential medicines and supplies;
- monitoring attacks on health care
- addressing mental health and psychosocial needs
- resource allocation.

In EB154/16 the Secretariat provides an update on the impact of the war on health and reports on the implementation of the requests in WHA75.11.

The Board is invited to note the report (EB154/16) and provide further guidance in relation to the following questions.

- How can the Secretariat best strengthen the Organization's response and promote the transition to sustainable development in Ukraine and countries hosting refugees?
- How can lessons be learned from this experience to enhance knowledge and evidence for best practice?

Background

Tracker links to previous discussions of WHA75.11 (war in Ukraine)

PHM Comment

PHM welcomes the detailed information on Ukraine's health system collected by the Health Resources and Services Monitoring System (para 3), as a good basis for plans to support the health sector in the longer term. The fact that WHO has consistently worked closely with the Ukrainian Ministry of Health to support existing services also means they are in a good position to work together on a longer term plan and consider how the primary level healthcare in particular can be strengthened. The first question at the end of EB154/16 implies that there will be a clear transition to sustainable development, however sadly given the present situation this is unlikely. It will be necessary to build sustainable elements into the system as and when possible; for example while it is appropriate to supply generators in the shorter term health facilities (para 3) could be part of the national renewable energy plan in Ukraine.

In A76/12 it was mentioned that 'WHO is engaged in discussions with the Ukrainian Ministry of Health and National Health Service (the single-payer mechanism for health services) on revisions to the Program of Medical Guarantees, which specifies national packages of health services, to ensure that the packages are responsive and reflective of the current priority health needs within the emergency context and beyond.' EB154/16 does not report on how these discussions have progressed and whether high out-of-pocket payments are being reduced in practice.

Prior to the war Ukraine had one of the highest maternal mortality ratios in Europe, although it was declining (A75/47). The infant mortality rate was also relatively high in compared with other European countries (around six deaths per 1000 live births). Vaccination coverage did not meet WHO targets. While the conflict has challenged primary care, if WHO's attention to outbreak preparedness (para 7) support to the national immunisation programme (para 15) and training of primary healthcare workers (para 23), can be embedded in a system with a strong primary health component going forward this should help improve these figures.

In WHA75.11 the Assembly noted that the WHO Regional Committee for Europe, in its special session 10 May 2022, had adopted a resolution asking the WHO Regional Director for Europe to consider temporarily suspending 'regional meetings in the Russian Federation, including technical meetings and meetings of experts, as well as conferences and seminars'....'until peaceful resolution of the conflict between the Russian Federation and Ukraine is implemented'. This would be a retrograde step for the people living in those areas. EB154/16 does not report on the outcome of the Regional Director's consideration of this proposal.

Frustration was expressed at a recent Executive Board meeting, regarding the cost of hosting Ukrainian refugees. Calls for 'sharing the burden' in this case points to the wider challenges facing desperate people seeking refuge from conflict, poverty and drought.

See EB152/36 for more details. A report on the implementation of the newly extended Global Action Plan on Promoting the Health of Refugees and Migrants is expected in 2025.

Item 16

Global health and peace initiative

In focus

The Seventy-sixth World Health Assembly took note of the road map for the Global Health and Peace Initiative. Pursuant to decision WHA76(12) (2023), the Director-General will submit a report (EB154/17) through the Executive Board to the Seventy-seventh World Health Assembly on progress made on strengthening the road map. The report will outline the work that the Secretariat has undertaken towards that goal as well as the outcome of consultations that have taken place. The Board will be invited to note the report and provide further guidance, in particular in respect of the following questions.

- What priorities should the Secretariat follow in its implementation and strengthening of the workstreams of the Global Health and Peace Initiative?
- What national experiences and/or needs and opportunities should be borne in mind when linking heath and peace in the specific contexts of Member States?

Background

Current draft roadmap

WHO home page for Global health and peace initiative, including, GHPI - An innovative approach: The Health and Peace approach to programming.

Lancet Commission on peaceful societies through health equity and gender equality

Tracker links to previous governing body discussions of Health and Peace

PHM Comment

Overview

The Global Health and Peace Initiative (GHPI) is operationalised at the country level through two key principles which define the initiative. The two principles are: 'conflict sensitivity' (do no harm), and 'peace responsiveness' (contribute to strengthening the conditions for peace, in particular, social cohesion and trust). The Initiative will be advanced through six workstreams starting with 'Evidence generation through research

and analysis'. See Draft Roadmap for discussion of the two principles and the six workstreams.

As requested by the Health Assembly in May 2023 the Secretariat has undertaken extensive consultation since then. EB154/17 reports on the main messages from the various consultation meetings. It appears that the responses have varied from enthusiastic to cautious (if not sceptical). It seems likely that some of the issues raised in the consultations will reappear at the Executive Board in January.

Following the September 2023 Member State consultation there was talk of a background paper being prepared (para 4). However, it appears that the background paper has now been absorbed into the Handbook mentioned in para 19.

Further details regarding the GHPI are provided on the WHO website, including some useful examples which illustrate the two key principles in operation.

EB154/17 describes a range of activities implemented in recent months as part of the implementation of the GPHI.

Appreciation

PHM welcomes the Global Health for Peace initiative. It is blindingly obvious that where possible, WHO country level programs and services should be conflict sensitive and peace responsive (in accordance with the meanings explained in EB154/17). The work so far undertaken and foreshadowed through the six workstreams appear well directed to the development and implementation of the Initiative.

PHM appreciates the emphasis on evidence generation through research and analysis including case study analysis. Several case studies are to be found on the WHO website. The continuing analysis of cases will lead to clearer principles and guidelines. This research and analysis will also generate useful information about the drivers of conflict and of peace in different settings.

Unequitable access to basic facilities such as healthcare services, educational facilities, development efforts, economic opportunities, job opportunities, technology services, lack of potable water, electricity, drive people to anger and can lead to conflicts. Poverty, forced displacements, marginalization, stigmatization, exclusion, injustice, insecurity, trade issues, land disputes, ethnic, religious and cultural differences, gender stereotypes, colonial influence, privatization, political inequities, tension between armed community groups and community members, hate speech, mistrust, food insecurity, climate-related issues such as water shortage for farming also contribute to conflict in fragile and vulnerable settings.

While the Global Health and Peace Initiative appears to be directed primarily to inform WHO's work in conflict settings, the principles should be incorporated into the training of

health personnel generally. Even where there is no overt conflict there are divisions within communities where conflict sensitivity (do no harm) and peace responsiveness (building social cohesion and trust) may make a contribution to well-being and health.

PHM appreciates the para 31 of the roadmap:

> *As such, the Global Health and Peace Initiative focuses on fragile, conflict-affected and vulnerable settings but is also relevant in any setting where social cohesion, resilience, or trust need to be built, sustained, or strengthened upon the request and acceptance of Governments. As the COVID-19 pandemic demonstrated, poor social cohesion or low levels of trust can undermine positive health outcomes and universal health coverage.*

Much of WHO's work during the Covid pandemic incorporated the essence of 'peace responsiveness' although not labelled as such.

However, it is evident that there are limitations to what can be achieved through the GPHI as was evident during EBSS7 which explored the devastating situation in Gaza.

Risk of securitisation

While PHM very much welcomes this initiative care must be taken to ensure that a focus on peace does not become securitised in the interests of external players.

The concept of securitisation here can be illustrated by the rich country bullying of L&MICs around the IHR Core Capacities: insisting on the diversion of funds to meeting core capacity standards - as public goods - essentially in order to guarantee the security of the rich countries (who had the resources to achieve the core capacity standards). See PHM comment on Item 12.4 at WHA70 for more detail.

The focus of the Initiative at the national level will help to ensure national autonomy, and WHO representatives will be able to support national ministries of health, including against undue international influence and the possible securitisation of health in conflict settings.

However, peace programming should not be understood as contained within one country. The majority of conflicts involving WHO are international, and grievances related to exclusion or discrimination could clearly be related to international issues. The attention given to delivering services equitably as a means of promoting peace is welcome and should be applied internationally as well as nationally.

PHM urges member states to support the continuing development of this initiative.

Item 17

Polio

In focus

Poliomyelitis eradication

The Director-General will submit a report on the implementation of the Polio Eradication Strategy 2022–2026 (EB15418), including progress on interrupting transmission of both wild poliovirus and circulating vaccine-derived polioviruses, with an update on the financing situation at the end of 2023. The Board will be invited to note the report and to focus its discussions on concrete ways to ensure the full implementation and resourcing of the Polio Eradication Strategy 2022–2026. Specific questions suggested by the Secretariat for Board consideration:

- What measures should be adopted to ensure that all remaining zero-dose children in the most consequential geographies are reached with oral polio vaccine, amid broader humanitarian emergencies affecting these areas?
- What steps should be taken to ensure that the financial resources required to fully implement the Polio Eradication Strategy 2022–2026 are mobilized, including to rapidly operationalize pledges, and mobilize additional commitments through international and national resources?

Polio transition planning and polio post-certification

Pursuant to decision WHA70(9) (2017), the Director-General will provide a status update (EB154/19) on the implementation of WHO's Strategic Action Plan on Polio Transition (2018–2023), with a focus on lessons learned and the proposed strategic direction for the period beyond 2023. The Board will be invited to note the report and provide guidance on the post-2023 strategic direction. Specific questions suggested by the Secretariat for Board consideration:

- Does the proposed post-2023 strategic framework address the needs of Member States, within the overall framework of building strong, resilient and equitable health systems and sustaining the public health gains made through the eradication effort?
- What steps should be taken to ensure accountability and ownership for operationalizing the proposed post-2023 strategic framework at country, regional and global levels?

Background

Tracker links to previous governing body discussions of Polio and previous PHM commentaries on polio eradication and transition (see in particular PHM comment on Item 17.3 at WHA75 much of which remains pertinent).

WHO topic page on polio with links to various useful pages

PHM Comment

Polio eradication

The report in EB154/18 sets out the current situation and current responses at national and global levels. WHO and partners and polio staff at all levels are to be commended for good works.

The report describes the situation for wild policy transmission in the endemic countries and advises that the recommendations (from June 2023 meeting of the Technical Advisory Group for Pakistan and Afghanistan) directed to addressing subnational immunity and surveillance gaps are now being implemented. These include a focus on house to house visiting, catch up immunisation, It is perplexing that there is no mention of WHO's Global Health and Peace Initiative (conflict sensitivity and peace responsiveness) in EB154/18.

The report describes outbreaks in non-endemic regions including vaccine derived polio. It described the wider use of novel opv2 and the full licensing and prequalification of the vaccine and mitigation of production volume constraints.

Among other initiatives reported include gender specific capacity building and further work to integrate of polio vaccination within general immunisation campaigns.

The report is quite upbeat about the prospect of adequate funding forthcoming for the implementation of the Polio Eradication Strategy 2022-26.

Polio transition and polio post certification

EB154/18 summarises the post-2023 strategic framework for polio transition including continuing work on the polio post-certificatoin strategy, including reporting and regulating containment and development of criteria for verifying elimination.

EB154/19 reports on the post 2023 strategic framework for polio transition. This comprises a Global Vision (described in more detail in EB154/19), regional strategic plans and country action plans in Afro, SEARO and EMRO. Accountability and ownership are seen as critical for the realisation of the Vision.

The transition is underway. The costs of polio essential functions carried by WHO regional and country offices have been integrated into the base segment of the Program Budget 2022-23 and PB 2024-25. The transfer of resources from the polio program into the base segment of the PB has been accompanied by a progressive reduction in the staffing of the polio program (positions supported by the GPEI).

Item 18

Smallpox eradication: destruction of variola virus stocks

In focus

In resolution WHA60.1 (2007), the Health Assembly authorized retention of variola virus in two repositories for time-limited research and associated activities for development of diagnostics, antiviral agents and vaccines for smallpox, in order to reach global consensus on a date for destruction of remaining virus stocks. The Director-General will submit a report (EB154/20) that provides an overview of these activities in line with WHO's Thirteenth Global Programme of Work (2019–2025) to better protect people from health emergencies.

The Board is invited to note the report and provide further guidance around the following questions:

- which avenues of research, if any, should be prioritized for ongoing development of countermeasures for smallpox and other orthopoxviruses?
- which actions can Member States propose to advance preparedness for outbreaks due to orthopoxviruses (which include smallpox and mpox)? .

Background

Tracker links to previous governing body discussions about Smallpox

WHO topic page on Smallpox

PHM Comment

Overview

PHM has repeatedly called for the final destruction of the remaining stocks of variola virus but as recounted in para 1 of EB154/20 the Health Assembly has deferred such action and authorised continuing research subject to conditions outlined in para 2.

As recorded in A72/28 (4 April 2019) the Advisory Committee

- judges that no need exists to retain live variola virus for development of safer smallpox vaccines beyond those studies already approved

- is conflicted as to whether retention of live variola virus remained necessary for the development of diagnostic assays essential for public health; and
- judges that live variola virus was still needed for the further development of antiviral agents against smallpox.

See record of the debate at WHA72 (B7) for explication of country positions on destruction of remaining stocks of variola virus.

The present report (EB154/20):

- summarizes the conclusions and recommendations of the recent meetings of the Advisory Committee on Variola Virus Research; these touch upon diagnostics, vaccines and therapeutics;
- provides an update on biennial biosafety and biosecurity inspections of the two authorized variola virus repositories (in Russia and the USA);
- provides updates on WHO recommendations on smallpox immunization and on WHO's vaccine reserves;
- WHO's response to the multi-country outbreak of mpox since 2022.

Issues

Synthetic smallpox

The Advisory Committee has recommended that genome sequences be placed in the public domain. The Secretariat notes that "advances in synthetic biology and genome reconstruction technology may bring both benefits and risks for smallpox preparedness" and underlines the importance of member states implementing WHO recommended guidelines in national legislation.

(It is ironic that if the last stocks of the variola virus had been destroyed in 1996 as originally mandated the risk of synthesis would not arise because the virus had not been sequenced at that time.)

Safety at the two authorised repositories

The inspection teams continue to suggest ways of improving facilities, protocols and practices. These repositories are not free from risk and their risk management arrangements are open to continuing improvement.

Vaccine stocks and protocols

Vaccine reserves held by WHO and member states range from lymph derived vaccinia virus based vaccines to recently developed fourth generation vaccines based on vaccinia virus from which virulence genes have been deleted. It is not clear that, in the event of a smallpox outbreak, that vaccine stocks would be sufficient, would all be of

comparable efficacy and safety, would be equitably distributed, and would be delivered efficiently and appropriately.

Mpox

The development of, and response to, the mpox emergency are described; “the outlook remains concerning”.

WHO’s topic page on mpox advises:

> *After 1970, mpox occurred sporadically in Central and East Africa (clade I) and West Africa (clade II). In 2003 an outbreak in the United States of America was linked to imported wild animals (clade II). Since 2005, thousands of suspected cases are reported in the DRC every year. In 2017, mpox re-emerged in Nigeria and continues to spread between people across the country and in travellers to other destinations. Data on cases reported up to 2021 are available here.*
>
> *In May 2022, an outbreak of mpox appeared suddenly and rapidly spread across Europe, the Americas and then all six WHO regions, with 110 countries reporting about 87 thousand cases and 112 deaths. The global outbreak has affected primarily (but not only) gay, bisexual, and other men who have sex with men and has spread person-to-person through sexual networks. More information on the global outbreak is available here with detailed outbreak data here;*

Mpox has been endemic in DRC since 2005 and in Nigeria since 2017 but it was only one month after the global outbreak in May 2022 that it was declared a public health emergency of international concern (June 2022). The emergency declaration was ended in May 2023.

The Secretariat has expressed particular concern about the interactions between AIDS and mpox owing to the immunosuppressive effects of the former. In its fifth and final report the Emergency Committee said:

> *The Committee emphasised the necessity for long-term partnerships to mobilize the needed financial and technical support for sustaining surveillance, control measures and research for the long-term elimination of human-to-human transmission, as well as mitigation of zoonotic transmissions, where possible. Integration of mpox prevention, preparedness and response within national surveillance and control programmes, including for HIV and other sexually transmissible infections, was reiterated as an important element of this longer-term transition. In particular, the Committee noted that the gains in control of the multi-country outbreak of mpox have been achieved largely in the absence of outside funding support and that longer-term control and elimination are unlikely unless such support is provided.*

EB154/20 notes that “funding for mpox response remains extremely constrained.”

Item 19

Social determinants of health

In focus

The upcoming World Report on Social Determinants of Health Equity presents an update on the situation of health equity and its social determinants, progress made so far in addressing them and recommendations for further action. The report submitted for the consideration of the Executive Board (EB154/21) previews the World Report and notes the impacts of the pandemic of coronavirus disease (COVID-19) and other interlinked crises and social transitions impacting health equity and highlights the increased importance of addressing social determinants across sectors.

The Board is invited to note the report submitted by the Director-General and to provide further guidance on:

- how Member States should address the social determinants of health equity in order to moderate the impacts of the current interlinked crises and societal transitions on health and health equity; and
- on the proposed recommendations of the forthcoming WHO World Report on Social Determinants of Health Equity.

Background

Tracker links to previous discussions of SDH

Report of the Commission

WHO topic page on SDH

PHM Comment

Preliminary draft comment. Please email comments and suggestions to editor@phmovement.org.

Appreciation

PHM appreciates the commitment of Dr Tedros, the Secretariat staff (in Geneva and in regional and country offices), and the experts who have contributed to the development of the report over the last several years. It is now 15 years since the launch of the Report of the Commission on the Social Determinants of Health and there were times when it appeared that the whole project had been shelved.

PHM appreciates also the member states who have insisted that action around the determination of health inequity be progressed and who have contributed resources to support this work. PHM also appreciates the health activists (in academia and in social movements) who have refused to allow inequities in health outcomes to be neglected.

The data summarised in EB154/21 are confronting; both the levels of inequity and the slow progress in redressing health inequities since 2008. It is to be hoped that the more detailed outcomes and analysis will throw new light on the most pressing challenges, the causes and priorities.

EB154/21 reflects on the (lack of) progress since the 2008 Commission Report. It concludes that "there has been insufficient attention and action on key structural determinants such as inequitable economic systems, structural discrimination including intersecting racism and gender inequality, and weak societal infrastructure". It concludes that "efforts to reduce health inequities have often focused narrowly on the efforts necessary for fairer health service provision" but there has been less effort on intersectoral advocacy and collaboration.

EB154/21 points to the impact of multiple intersecting crises (climate, Covid, conflict, cost of living) and points to major social and technical transitions which look set to exacerbate health inequities.

EB154/21 foreshadows 14 specific recommendations addressing four overarching objectives. The goals of these recommendations are to:

- "address the health effects of hierarchies of power and resource distribution; addressing systems and policies driving structural discrimination, including intersecting racism and gender inequality; and rebuilding weak societal infrastructure to improve living and working conditions and strengthen social connection" and
- to provide entry points for "the health sector to act as an enabler and driver of action at the structural level".

What is the theory of change which informs these recommendations?

The critical questions to be asked in evaluating these recommendations concern the underlying theory of change which has informed their development.

- Who are the agents whose practice will be changed because of this report?
- What are the fundamental drivers of inequity, discrimination, austerity, and alienation and how do these recommendations engage with those fundamental drivers?
- Why would the recommendations facilitate the adoption of equity policies and the implementation of equity programs; what were the obstacles to such policies and programs in the past (including the Commission's 2008 report) and how will this Report contribute to overcoming those obstacles?

Strategy

There is a strategy evident in this paper, although not clearly articulated in EB154/21. This strategy involves a strengthening and alignment of various drivers of pro-equity policies and programs. These drivers include:

- the articulation of a range of pro-equity policies, with the imprimatur of WHO, which are relevant to international and domestic debates around social and economic policies and programs;
- the emphasis on community engagement and social participation in policy processes and creating conditions that maximize the capabilities of independent and inclusive civil society to address the social determinants of health equity; and
- strengthening the focus on social determinants in health systems and policy platforms; and developing human capacity in health, social protection, education, labour, local government and service organizations to enhance intersectoral efforts to address the social determinants of health equity
- the emphasis on measurement, research, and publication of the various indicators of health inequity, discrimination and weak human services;

World Report as an intervention in global policy formation

EB154/21 suggests that the World Report will take a progressive (pro-equity) position on a number of issues which are highly contested in global policy debate. This is direct intervention in global policy formation and, because it comes with WHO authority, it is a significant intervention.

The authoritative articulation of such policy positions provides leverage which can be exercised by advocates for health equity.

Instances such pro-equity policy positions include:

- Use of progressive taxation and income transfers to promote equity and expand domestic fiscal space for universal public services;
- Provision of adequate public funding for infrastructure and service delivery across health, education, transport, housing, water, sanitation, and food systems;
- Highlighting the concept of commercial determinants of health and the need for regulation to maximise the health-promoting capacity of the private sector; highlighting the role of public procurement in encouraging " sustainable, safe and healthy products and safe and fair labour standards";
- Strengthening health equity considerations in global and regional trade processes;
- Highlighting the importance of fiscal space for pro-equity public investment in fields such as debt relief, development financing, international cooperation on taxation;

- Achieve universal health coverage through progressive health financing and primary health care approaches; Minimize out-of-pocket expenditure, and finance health services from pooled government resources;
- Highlighting the need to address and protect the social determinants of health equity in emergencies, migration and conflict; ensure the rights of displaced people to access health and social services.

World Report as an intervention in domestic policy formation

Likewise, the report will take a progressive (pro-equity) position on a number of issues which are highly contested in domestic policy debate (in some cases issues which are contested internationally and domestically). This is direct intervention in national policy formation and significant because it deploys WHO authority. Instances of pro-equity policy positions include:

- Ensuring that urban, rural and territorial planning, transport and housing investments are underpinned by approaches that ensure that housing and built environments are healthy and accessible;
- Highlighting the importance of 'age-friendly communities' in combating social isolation and loneliness;
- Highlighting the importance of universal social protection;
- Extending basic employment entitlements to precariously employed and informal workers;
- Recognize and repair discrimination, including those pertaining to gender, race and disability, and addressing the impacts of colonization, and acknowledging Indigeneity as a determinant of health and health equity;
- Articulate the health equity benefits of action on climate change, biodiversity, and food security;
- Strengthen support for Indigenous communities in their stewardship of land and natural resources;
- Highlighting the importance of steering the digital transformation in favour of health equity and the public good;
- Achieve universal health coverage through progressive health financing and primary health care approaches; Minimize out-of-pocket expenditure, and finance health services from pooled government resources.

Inadequate documentation and analysis of the fundamental drivers of inequity, discrimination, austerity, and alienation

It appears from the summary in EB154/21 that, notwithstanding occasional references, the Report will not provide a full documentation and analysis of the fundamental drivers of inequity, discrimination, austerity, and alienation. These include:

- the evaporation of decent employment associated with trade liberalisation, technological development, and the emergence of large corporations, sitting

astride global value chains, with the power to extort various concessions from countries as a condition for foreign investment;
- the impact on small farmers of the protection and subsidisation of Northern agriculture and the power of giant agribusiness across global food value chains (including the distinction between food security and food sovereignty which has key implications for trade in agriculture);
- the impact of financial liberalisation on the ability of national governments to manage their own economies, including progressive taxation and adequate fiscal space for social development;
- the impact of deepening economic inequality and the evaporation of decent employment on community depression and anger, sometimes manifest in neo-fascist movements.

The failure to fully document and analyse such drivers weakens the policy platform being advanced through the World Report and diminishes the leverage available to the various constituencies advocating for policy reform across this space.

Inadequate documentation and analysis of the obstacles to the adoption of pro-equity policies

It appears from the summary in EB154/21 that, notwithstanding occasional references, the Report will not provide a full documentation and analysis of the obstacles to the adoption of pro-equity policies and the implementation of pro-equity programs. These include:

- the power of 'market sentiment' (the voice of international capital) over elected governments in relation to taxation, public expenditure, privatisation and marketisation of human services;
- the impact of money politics and the revolving door (between business and government) on policy formation;
- the role of the World Bank and similar agencies in promoting neoliberal economic policies (notwithstanding its glossy reports purporting to solve all possible social and economic challenges);
- the role of the IMF and the global private banks in imposing austerity while refusing to address the causes of unsustainable debt and currency vulnerabilities;
- the limitations on domestic policy formation which have been embedded in the global network of multilateral and plurilateral trade and investment agreements.

The failure to fully document and analyse the obstacles to pro-equity policy implementation weakens the policy leadership to be provided through the World Report and diminishes the leverage available to the various constituencies advocating for policy reform across this space.

Building the constituencies which can exercise political pressure on domestic policy formation and international policy debate

It appears from EB154/21 that the strategy underlying the World Report, in terms of driving change, will rely on three leading constituencies: measurement, research and publication; pro-equity civil society; health systems and health personnel.

The measurement, research and publication constituency

The measurement, research and publication constituency includes the health equity researchers (epidemiology, social science, policy studies, etc) and the program monitoring and statistical reporting agencies.

The World Report will underline the importance of continued monitoring of health equity and of continuing research into the trends and patterns in health equity (including drivers of inequity and the obstacles to policy action).

The history of debate around health equity suggests that measuring and publishing (from Virchow to Marmot) makes a difference.

Pro-equity civil society

It is evident from EB154/21 that the World Report sees civil society advocacy as an important driver of change, from local communities advocating to local government; to international NGOs active in health equity; to public interest social movements working with those communities who bear the brunt of inequity, discrimination, and lack of services.

It is evident that the pro-equity policy positions mentioned in EB154/21, and developed in the World Report, will provide leverage for such civil society advocacy.

However, it would be important not to understate the challenges facing such civil society advocacy, not least the legal obstacles imposed by many governments on popular mobilisation and democratic expression.

The basic building blocks of civil society advocacy are the organisations and networks which bring together the experiences and demands of those who bear the brunt of inequity. Building a coherent voice capable of impacting on domestic policy making involves a convergence of different communities reaching across boundaries, in the light of the shared structural drivers of their different disadvantage.

In terms of building a coherent civil society constituency capable of intervening strongly in international policy debate there are many issues which claim priority and there are boundaries of language, culture, and context to be breached. However, these NGOs and

international networks are strengthened when they have direct links with grass roots organisations.

If WHO were to pick up the challenge of working with civil society, there is much that it could do, from Geneva, and from regional and country offices. However, as a member state organisation, WHO has been very cautious about collaborating with civil society beyond the sclerosis of 'official relations'.

Health systems and personnel

EB154/21 foreshadows a major policy push to strengthen the focus on social determinants in health systems and policy platforms; to integrate the social determinants of health equity in all health strategies, policies, emergency preparedness and response plans, and public health laws; to develop human capacity in health, social protection, education, labour, local government and service organizations to enhance intersectoral efforts to address the social determinants of health equity.

This vision of health agencies and personnel as advocates for equity recalls the promise of the Alma-Ata Declaration of 1978 which projected a scenario of primary health care practitioners and their agencies working with their communities to address the social determinants of their health (Newell, 1975). After 30 years of trying to bury or reinterpret the Alma-Ata vision of primary health care it is encouraging to see this fundamental principle being recognised.

However, health system managers everywhere are facing needs which outstrip resources and their employment contracts give them powerful incentives to focus all their resources on those programmatic needs. Health systems financiers are likewise preoccupied with patient throughput and while health promotion units have been allowed to speak about health inequities (sometimes), they rarely have the resources to back up their rhetoric.

Addressing these conservative incentives will require an outside constituency, outside the health establishment, demanding a change in policy; demanding meaningful action towards health equity. This outside constituency can only come from the communities who have most to gain from pro-equity policies and programs. Facilitating such voices will be critical in "leveraging the health sector" for health equity action.

PHM urges EB members to endorse the positive pro-equity policies and strategies foreshadowed in EB154/21 and to strengthen those areas where the World Report is at risk of glossing over key issues

PHM urges public interest civil society organisations to take full advantage of the progressive policy platform foreshadowed for the World Report and build domestic and

international advocacy around the development and implementation of pro-equity policies and programs.

Item 20

Maternal, infant and young child nutrition

In focus

This biennial report (EB154/22) will update progress on the realization of the comprehensive implementation plan on maternal, infant and young child nutrition and on implementation of the International Code of Marketing of Breast-milk Substitutes.

The Board will be invited to note the report and provide further guidance. The Secretariat seeks guidance on the following questions:

- As the comprehensive implementation plan on maternal, infant and young child nutrition is coming to an end in 2025, what next steps should be taken by the Secretariat in preparation for this deadline and in support of achieving Sustainable Development Goal targets by 2030, considering both the implementation plan and the formulated targets?
- Regarding the guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes, how can uptake of the guidance be strengthened?

Background

Tracker links to previous discussions of Maternal, infant and young child nutrition.

The last time this item was discussed in global governing body meetings was at the 75th World Health Assembly in 2022 under item WHA75 18.1.

PHM Comment

Lack of progress on the Comprehensive Implementation Plan targets

The Sustainable Development Goal Target 2.2 says the following "By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons."

The WHO Comprehensive Implementation Plan for Maternal, Infant and Young Child nutrition includes these global targets but goes slightly beyond that to include anemia in reproductive age women, low birth weight, overweight in children, and exclusive breastfeeding in the first six months of life. In document EB154/22 they describe

whether they are on track to reach these targets in 2025 and 2030, summarised in the table below and colour coded for convenience.

To summarise, it is currently projected that global progress on maternal and infant nutrition will fall short of reaching stunting, anaemia, low birth weight, childhood overweight, and wasting targets set for 2025, and will marginally achieve the exclusive breastfeeding target. Stunting, low birth weight and wasting have only reduced by less than 2% since the 2012 baseline, and to make matters worse, anaemia in reproductive age women and childhood overweight has actually increased since the 2025 targets were set.

In 2018, UNICEF and WHO proposed new targets for 2030, projecting the 2025 targets of the Comprehensive Implementation plan to the 2030 deadline for the SDGs. These included more ambitious targets for exclusive breastfeeding (≥70% in the first 6 months of life) and wasting (<3%). However, at the current rate the world is not on track to meet these targets, as the state of maternal, infant and young child nutrition is getting *worse*, rather than better.

	Progress since 2012	On track to reach 2025 target?	Target 2025	Comment
Stunting	Decrease 1.7% per year, but in 2022 there were still 22.3% children stunted	Projected excess of 31.5 million stunted, 138.5 million in total	A reduction of 50% in number of stunted children under 5	Only European and Western Pacific regions on track
Anaemia	Increase of 1.4%, now 29.9% of reproductive age women anaemic	More women will be anaemic than in 2012 (31.1% vs 28.5%), missing 50% reduction target	A reduction of 50% of anaemia in women of reproductive age	Lack of progress in seen across all WHO regions alike
Low birth weight	Decreased by 0.3% since 2012, but 14.7% of children were	There will be 14.4% of babies born low birth weight in 2025, completely	A 30% reduction of low	Only 11 out of 157 countries with sufficient data available are on track to

	still born with low birth weight in 2020	missing the 30% reduction target	birthweight incidence	reach 2025 target
Overweight	Increased with 0.1% since 2012, 5.6% of children are overweight in 2022	Still 5.6% of children will be overweight in 2025, nearly double the target that was set	Reduce childhood overweight to <3%	Regional disparities in progress. Increases in the Americas and Western Pacific, decrease in the European region
Exclusive breastfeeding	Since 2012 there has been a >10% increase in exclusive breastfeeding, 47.7% of infants under 6 months were exclusively breastfed in 2021	53.4% of infants will be exclusively breastfed in 2025, marginally surpassing the target	Increase exclusive breastfeeding in first 6 months to ≥50%	Although the global progress is looking good, of the 106 countries with sufficient data, 90 countries are not projected to reach the target by 2025.
Wasting	Decreased 0.7% since 2012, still 6.8% of children are wasted in 2022	In 2025 6.6% of children under 5 will be wasted, missing the 5% target	Reduce and maintain childhood wasting to <5%	Of the 125 countries with enough data, 85 will reach the target by 2025

No analysis of the structural drivers of malnutrition

The Secretariat report (EB154/22) does not provide any analysis of the drivers of the crisis of malnutrition. It does not describe the root causes or the obstacles to effective

implementation of agreed actions. The section on the five actions simply lists various activities which have taken place in the last two years with no reflection on why the five actions have not impacted on the six targets.

For the Secretariat to ask the Board to consider what should replace the Comprehensive Implementation Plan from 2025 onwards without offering any analysis of the drivers of malnutrition or the obstacles to effective action, suggests deep cognitive dissonance. In contrast, see Lancet on the political economy of infant and young child nutrition.

Despite the attention of different UN agencies to issues of nutrition, there appears to have been little attention towards the political economy of food systems, and the role of big agriculture and big food in shaping food supply globally. Nutrition policy must engage with the origins of food, its interconnectedness with land ownership and use, its mediation through neoliberal globalisation and trade, and how our disconnect from the origins of food is also contributing to ecological crises including climate heating.

The report fails to acknowledge or report action on the regulation of foods high in fat salt and sugar (HFSS) or ultra processed foods (UPF).

Global leadership for effective regulation of sugary drinks and the marketing of unhealthy products to school-age children is needed to curb increases in childhood obesity across different WHO regions. This is important as the combination of undernutrition in early life and overnutrition due to an obesogenic environment in later life predisposes towards non-communicable diseases such as diabetes type 2, cardiovascular disease and other aspects of metabolic syndrome.

IBFAN/BMA has recently reported on the adoption by the Codex Alimentarius of a new standard on follow up formula for older infants and young children which 'greenlights' products which are sweetened, unnecessary, ultra-processed and flavoured.

Food security, dietary diversity, food sovereignty

The Secretariat report provides no analysis of food insecurity and the need for substantive food system reform that addresses structural inequities inherent in global food systems.

The report regrets that official development assistance for nutrition specific interventions is insufficient and PHM shares this regret. However, nutrition specific interventions do not address the distortions embedded in global food systems. Reaching the 2025 targets will require rethinking the claims that big corporate agri-business can provide solutions for global food security through its control of global supply chains and reliance on technofixes. Food sovereignty should be the basis of a new approach.

Putting healthy nutrition at the core of primary health care

The EB document mentions that nutrition services should be included in universal health coverage. Universal health coverage proposes a minimal set of benefit packages of services that are purchased from service providers, both public and private in a market-based health care system.

In contrast primary health care puts prevention and a healthy environment for children to grow and develop at its core. Community health workers can play an important role in child malnutrition and their contributions have been documented in countries such as India, Thailand and Bangladesh.

PHM rejects a model in which nutrition is seen as a "service" which can be commodified into a stripped-down market-based health system. Instead, adequate nutrition, especially in early life, must be seen as a fundamental human right and as the basis on which health is built. This includes attention for dietary diversity and food sovereignty as a part of a community participation approach to ending malnutrition.

There are very real nutrition needs which can be addressed through targeted and context specific nutrition services, for example, micronutrient deficiencies in adolescent girls and young women, and during gestation and lactation. However, such services must be shaped by context and embedded in comprehensive primary health care and integrated with community wide programs directed to dietary diversity and food sovereignty.

Breastfeeding

The most serious weakness of this report is the lack of emphasis on breastfeeding, which is the intervention that has the best cost-benefit for several outcomes, including infant mortality. The document talks about exclusive breastfeeding, but any breastfeeding is important. The document states that there was a significant increase in exclusive breastfeeding, but it also states that out of 106 countries with sufficient data, most (between 90 and 100 countries) have not and are not likely to achieve the 2025 target which is very concerning.

Since the International Code of Marketing of Breast-milk Substitutes came into action in 1981, only 32 countries have adopted legal measures to implement measures aligned with the Code. In 2022 the WHA adopted decision WHA75(71) which requested guidance for Member States on regulatory measures to restrict digital marketing of breast-milk substitutes, which has led to a new guidance of 11 recommendations for Member State action.

In a preliminary comment on this EB agenda item IBFAN has highlighted digital marketing, infant feeding in emergencies, messaging and global trade. PHM joins with IBFAN in:

- calling on WHO to adopt a strong resolution demanding that member states implement fully the new guidance;
- emphasising the importance of protecting and supporting women who want to breastfeed in humanitarian and emergency situations;
- calling for safeguards to prevent humanitarian programs from promoting ultra-processed fortified products as magic bullets with no mention of breastfeeding or the importance of bio-diverse foods;
- calling on UN and humanitarian agencies to challenge the corporate-led food system that has done so much harm to the ecosystem and bio-diverse sustainable foods.

Responding to the Secretariat's two questions

What next steps should be taken by the Secretariat?

PHM urges member states to request that the Secretariat undertake a comprehensive review of the economic and political circumstances which sustain the nutrition crisis (including global food systems) and the commercial and political barriers to the effective implementation of the five actions of the comprehensive implementation plan.

Strengthening the uptake of digital marketing guidance

PHM joins with IBFAN in calling for a strong resolution demanding that member states fully implement the guidance. This resolution should include strong accountability provisions based on peer review principles. It should also include provisions which will contribute to strong professional and community constituencies which will encourage governments to implement the guidance.

Item 21

Well-being and health promotion

In focus

The Director-General will submit a report (EB154/23) on the implementation of resolution WHA75.19 (2022), including on the development of a framework for achieving well-being. The Global Well-being Framework comprises six strategic directions to promote societal well-being based on key determinants of health (namely, environmental, social and economic), equitable universal health coverage, digital transformation and measurement of progress, tying them together with suggested effective policy orientations drawn from country-level experiences. The Framework lays the foundation for improved coherence and coordination of policies and programmes to create healthy and resilient societies.

The Board will be invited to note the report and provide further guidance. In its discussions, the Board may wish to focus on:

- How should the overall responsibility for the promotion of well-being societies be organized at the national level?
- What additional technical resources should be developed to support country implementation and monitoring?
- Given increasing calls for a shift in public health towards health promotion, what would be the best mechanisms for setting priorities to ensure well-being of societies?
- How to ensure/facilitate the commitment for cooperation for well-being and health promotion while maintaining clear responsibilities.

Background

Tracker links to previous discussions of health promotion

WHO topic page on health promotion

WHO team page on health promotion

PHM Comment

No explicit theory of change

The Global Framework articulates no explicit theory of change. The key elements of its implicit theory of change appears to be new metrics, inspirational case studies, capacity-building, and policy guidance for member states.

The Framework provides an accurate diagnosis (albeit at a high level of abstraction) of 'common contemporary underlying causes' (para 5 of EB154/23 and Part IIb of the Global Framework). However, there is no analysis of the forces, agents and dynamics associated with those underlying causes; and no analysis of the obstacles, previously encountered, to addressing those causes.

Despite the call in WHA75.19 for 'an implementation and monitoring plan' as part of the Global Framework, no such plan is included in the Global Framework.

The last para of the Framework suggests an unrealistic reliance on consensus and accountability:

> *This Framework requires a whole of government and societal transition. Key partners including nongovernmental and civic organizations, academia, business, governments, international organizations should engage in effective partnerships based on* consensus and accountability *for decisive implementation of strategies for health promotion and well-being.*

EB154/23 advises (para 12) that "The Secretariat is currently setting up a multidisciplinary Strategic Technical Advisory Group of Experts to provide advice and propose inputs into the monitoring and implementation frameworks." However, it is not clear that the mandate of the Group will encompass the Global Framework.

The discovery of buen vivir

The focus on well-being in both the Geneva Charter and WHO's Global Framework reflects the influence of the discourse of 'living well' or buen vivir which has been very influential in Latin American public health for some decades. However, the draft framework would benefit from two other innovations from the Latin American school of social medicine/collective health.

One of these is the insistence on distinguishing between *social determinants* (as factors which are shown to influence population health) and social *determinatio*n (which focuses on the forces and dynamics which reproduce those factors). There is very little in the draft framework which addresses the social and political *determination* of health except at a very general level.

The second innovation is the turn from *public health* to *collective health* in order to avoid over-stating the role of the government in shaping population health and to highlight the ways in which the health of populations is shaped by the forces, engagements and dynamics of communities and civil society more broadly.

Ambiguities in the conceptualisation of health promotion

Operative Para 2(1) asks the DG to identify the role that health promotion could play in achieving well-being. Presumably the purpose of this request is to clarify the role that health promotion could play in promoting well-being if the proposed framework were to be adopted and implemented by WHO.

However, the conceptualisation of 'health promotion' which is offered is ambiguous, variously encompassing health promotion as an institutional sector, comprising experts and organisations, versus health promotion as a body of principles and practices that health practitioners, agencies and administrations might apply in their work, versus health promotion as a social process, a way of speaking about population health improvement. To say that 'Health promotion seeks to influence policies and programs' (part IId of the Global Framework) suggests 'health promotion' as a singular entity with its own agency. Later the Framework describes health promotion as a 'driver' of public health.

The project of creating a well-being society (or civilisation) is informed in different sectors and communities by a very wide range of principles and paradigms of practice. Indeed the professional and civic practice of health practitioners is informed by a wide range of principles and paradigms of practice, including but extending way beyond 'health promotion' (whether understood as an institutional sector or a body of principles and practices or as a synonym for health improvement).

The draft framework (Part IId) advises that "*Health promotion is the process of enabling people to increase control over, and improve, their health*". But health promotion is clearly not the only "process of enabling people to increase control over, and improve, their health". For many people the use of traditional or complementary medicines is a process of increasing control over and improving their health. Health promotion is not the only body of principles and practices which support governments, communities and individuals "to cope with and address health and well-being challenges in order to advance healthier populations and environments" (page 6).

There are sections of this Framework which appear to be directed to promoting health promotion rather than explaining its role as requested in WHA75.19. Part V of the Framework declares that:

> *... health promotion provides the platform, approaches and the tools to enable this transformative cross-sectoral collaboration, collective action through community*

empowerment, and ultimately generate the good governance that is essential for societal well-being to be realized.

Breach of mandate

This Item began with the Geneva Charter for Well-being, the outcome statement of the 10th Global Conference on Health Promotion, hosted in Geneva, Switzerland, and virtually on 13–15 December 2021.

The venue then shifted to the Health Assembly with a draft resolution sponsored by Azerbaijan, Bahrain, Bosnia and Herzegovina, Botswana, Colombia, Iraq, Oman, Peru, Saudi Arabia, Thailand, the United Arab Emirates, the United States of America and Vanuatu which was adopted as WHA75.19.

WHA75.19 requests the DG

> *... to develop, within the mandate of WHO, a framework on achieving well-being, building on the 2030 Agenda for Sustainable Development with its 17 Sustainable Development Goals and identify the role that health promotion plays within this*

This request includes two separate tasks: first, develop a framework for well-being based on the SDGs; and second, explain the role that health promotion plays in that framework.

However, the Global Framework which was produced is named "Achieving well-being: A global framework for integrating well-being into public health *utilizing* a health promotion approach".

This is a very significant departure from the original mandate; from developing a framework and identifying the role of health promotion to developing a framework utilising a health promotion approach. It is not clear how this transformation of the mandate took place. Presumably it involved deliberate choices by Secretariat staff but may have been supported by sponsoring member states, donors and advisors.

The adoption of decision WHA76(22), through which the Assembly adopted the framework accepts and endorses the transformed mandate.

The provenance of governing body decisions and resolutions and the provenance of publications and initiatives implemented through the Secretariat are hidden from public view. Likewise the role of particular member states, donors, program managers within the Secretariat, professional advisors, and private sector entities.

This secrecy ("commercial-in-confidence") represents a major breach of accountability. The lack of transparency puts into question the integrity of the Organisation.

The disintegration of WHO: a market place for influence

It appears that the drive for a Global Framework on Well-being is (at least in part) directed to the promotion of Health Promotion. The survival of many units within the Secretariat (and the continued employment of their staff) depends on the continuing struggle for donor attention and donor funding.

Notwithstanding the talk of 'coordinated' resource mobilisation, there is a tension between different units for donor attention and with this comes the disintegration of coherent policy and program development.

These damaging dynamics are a direct consequence of the refusal of member states to fully fund the Organisation through assessed contributions or to untie tightly ear-marked voluntary contributions.

PHM Position

PHM calls for a radical strengthening of the accountability of the WHO Secretariat in terms of the behind-the-scenes relations between member states, special interests, donors and program managers within the Secretariat. PHM calls for WHO to name the funding agencies supporting each initiative coming before the governing bodies.

PHM calls for the ending of the marketisation of WHO decision making and resource production and for predictable, adequate, flexible funding of the Organisation through assessed contributions and untied voluntary contributions.

Item 22

Climate change, pollution and health

Contents

In focus

Impact of chemicals, waste and pollution on human health

In EB154/24 the Secretariat reports on the implementation of resolution WHA76.17 (2023). This resolution called upon Member States to support the Secretariat in engaging with two initiatives by the United Nations Environment Assembly: the establishment of a science-policy panel to contribute to the sound management of chemicals and waste and prevent pollution (UNEP_EA.5_RES.8); and the development of an internationally-binding instrument on ending plastic pollution (UNEA-5.2). The report presents options for WHO's involvement in both of these initiatives.

The Board is invited to note the report and provide further guidance and the proposed science-policy panel; and the instrument being developed on plastic pollution.

Climate change and health

The report EB154/25 describes the increasing health impacts of climate change, the opportunities to protect and enhance health through climate action, the necessary actions by the global health community, and the unique role of WHO in leading, informing, guiding and implementing the health response to climate change. The Board is invited to note the report and provide further guidance.

Background

Tracker links to previous discussions of the Environment and of Climate and SAICM

WHO topics page on Climate change and Environmental Health

PHM Comment

Impact of chemicals, waste and pollution on human health

The Board will consider WHO's involvement in two initiatives from the UN Environment Program (UNEP): the science-policy panel and the internationally binding instrument on ending plastic pollution.

The science-policy panel

The UNEP has resolved that "the panel should be an independent intergovernmental body with a programme of work approved by its member Governments to deliver policy-relevant scientific evidence without being policy prescriptive". The UNEP considers that the principal functions of the panel should include:

- Undertaking "horizon scanning" to identify issues of relevance to policymakers and, where possible, proposing evidence-based options to address them;
- Conducting assessments of current issues and identifying potential evidence-based options to address, where possible, those issues, in particular those relevant to developing countries;
- Providing up-to-date and relevant information, identifying key gaps in scientific research, encouraging and supporting communication between scientists and policymakers, explaining and disseminating findings for different audiences, and raising public awareness;
- Facilitating information-sharing with countries, in particular developing countries seeking relevant scientific information.

In WHA76.17 (para 4(8)) the Secretariat was mandated to actively contribute to the work of the Ad Hoc Open-Ended Working Group to establish the proposed science-policy panel.

Iin para 12 of EB154/24 the Secretariat sets out six options regarding WHO's relationship with the panel. These options are not mutually exclusive.

In para 7, EB154/24 notes that WHO's has strict and well-established processes for identifying and managing potential conflicts of interest of experts. Comparable processes will be needed for the science-policy panel. PHM notes that conflicts of interest have proved problematic in some of the organisations involved in the Strategic Approach to International Chemicals Management.

PHM urges the Board to recommend a resolution to the Health Assembly which endorses WHO's participation in the panel in ways that encompass all of the six options. Such a resolution should also:

- make provision for regular reports to WHO's governing bodies regarding the work of the panel and WHO's contribution to the panel;

- request the Secretariat, in preparing its report for WHA77, to include advice on the provisions being negotiated for the panel which (in accordance with para 6(c) of UNEP/EA.5/Res.8) ensure that the work of the panel will be transparent, impartial, and protected from distortions arising from conflicts of interest.

PHM affirms that, as described in paras 6 and 7 of EB154/24, participation in the science-policy panel lies entirely within WHO's existing mandate and budgetary constraints should not prevent or curtail WHO participation.

Ending plastic pollution

The UNEP has determined (in UNEP/EA.5/Res.14) that an international legally binding instrument on plastic pollution, including in the marine environment, is needed and has resolved to convene an intergovernmental negotiating committee for such an instrument, to begin its work during the second half of 2022, with the ambition of completing its work by the end of 2024.

In paras 16-18 of EB154/24 the Secretariat reviews a range of options regarding WHO's role in the intergovernmental negotiating committee and in the legally binding instrument under development. In para 22 the Secretariat advises that WHO will continue to engage in relation to draft provisions on health issues, and in relevant technical work between formal negotiations.

PHM urges the Board to endorse such engagement, encompassing all modes of involvement discussed in paras 16-18.

PHM urges the Board to request the Secretariat, in its engagement with the international negotiating committee, to give close attention to ensuring that the legally binding instrument includes robust provisions to ensure that its implementation is protected from distortions arising from conflicts of interest.

Climate change and health

Provenance

The draft provisional agenda for the current EB meeting, published in June 2023, did not include this item on climate change. On that draft provisional agenda Item 19 was "The impact of chemicals, waste and pollution on human health". By 16 November, when the provisional agenda was published, this had changed to "Climate change, pollution and health". This was two weeks before COP28 opened in Dubai.

There is nothing in EB154/25 which explains how, in the face of ongoing concern regarding agenda control, a major new item was accepted for the revised agenda. We speculate that, in the face of record global temperatures and continuing resistance to climate action in Dubai, the Secretary General of the UN may have urged his specialised

agencies to do more to promote effective action on global warming. Or perhaps one of WHO's big donors has indicated that funds might be available for a new climate and health initiative.

(PHM welcomes the item and welcomes the report in EB154/25 but regrets the lack of transparency regarding the provenance of this item and many others (items, resolutions and decisions) appearing on governing body agendas.)

Whatever the origin of this report, the underlying message is that WHO must contribute more to the drive for effective action on global warming.

Appreciation

This is an excellent initiative. In view of the continuing resistance to curbing fossil fuel use, evident in particular at COP28, WHO must do more to contribute to building the case for effective action for mitigation and adaptation.

The report (EB154/25) provides a good description of the problems. It brings in the equity dimension, by highlighting the health consequences of climate change faced by the low- and lower-middle-income countries (floods, drought, displacement, and conflict) and small island developing States, while recognising the least contribution made by these countries to historical global emissions.

EB154/25 also highlights the development pathways and economic choices that are driving the climate crisis, and that are the direct causes of large health impacts. The paper cites polluting energy systems, which cause millions of premature deaths from air pollution each year; environmentally destructive and unhealthy food systems that are contributing to noncommunicable diseases; and urban planning and transport systems that result in car-dependency, physical inactivity and road traffic injuries. These parallel impacts on global warming and directly on health are important because they underpin the logic of the 'co-benefit' argument.

The paper identifies several elements of a health system response to global warming:

1. being prepared (to respond to extreme heat, floods, and infectious disease);
2. being climate resilient (including water and sanitation, sustainable food systems);
3. reducing carbon emissions from the health sector; and
4. working towards the achievement of health "co-benefits" (e.g. lives saved through improved air quality) through health promoting climate change mitigation in other sectors, notably, energy, food, transport and urban systems;
5. encouraging 'health actors' to work across sectors to jointly safeguard key environmental determinants.

The paper then proposes a number of actions by the Secretariat which might contribute to boosting the health system response. These include scaling up its own existing work in:

- providing leadership and awareness raising,
- generating evidence, collecting data, monitoring trends and producing technical resources, and
- capacity building and country support.

Critique

The commitment to boosting the health system response is appreciated. The actions proposed are comprehensive and strategic.

However, while the rhetoric that climate change as "a fundamental threat to human health requires a strong response from the global health community to protect health from increasing climate hazards, ensure access to high quality, climate resilient, environmentally sustainable health services, and improve health, while limiting global warming to the agreed 1.5˚C limit. (para 7)" is welcome, the need for a *Common but differentiated responsibilities and respective capacities* is absent from the articulation.

The report does note the differential impact of global warming with LMICs more affected, but it does not note that most of the mitigation effort has to come from the past and present polluters, and while the LMICs require considerable support for adaptation, the contribution that they can make towards mitigation is less. The HICs must be committed to providing financial support as part of common funds.

The reference to low-income settings identifying and rolling out renewable energy access for healthcare facilities (para 9) is misleading and distracting, when the struggle in these countries is to establish the minimum required healthcare facilities with the minimum levels of assured energy access - of any sort. The argument for co-benefits from climate friendly technologies is important but needs to go along with free and facilitated technology transfers (the respective capacities argument). The entire report sidelines the climate justice perspectives of the developing countries and goes too much with "the world is one" romance. Whatever happened to imperialism?

PHM also urges the Secretariat to strengthen this paper, in relation to people power and the primary health care approach, before submitting it to the Health Assembly. The paper recognises clearly the importance of people power in overcoming fossil fuel resistance and in pushing for adequate and equitable funding for adaptation. It also recognises the potential power of the 'global health community' in curbing global warming. It also

However, it does not make the connection. The primary health care approach, elaborated at Alma-Ata, envisages a 'community health partnership' for health; healthcare personnel (at all levels) actively working with their communities to define the risks and to mobilise against underlying causes.

A substantial fraction of the population work in health care; these are overwhelmingly people who care about their community's well-being and health including the threat of global warming. There are already a myriad of organisations and networks arising within the health system advocating and mobilising around global warming.

PHM urges the Secretariat to explore further actions which might gain leverage from this community health partnerships in different districts, at different levels.

The physical dynamics underlying global warming are global but the specific risks are diverse and can be very localised. Within a state, different regions or districts can have different exposures; consequences also vary and vulnerabilities differ. The PHC model makes provision for local healthcare agencies to identify and advocate for localised adaptation and mitigation measures, in partnership with their communities, as well as advocating around universal policies and strategies.

The Secretariat mentions climate resilience as a central component of health development in the context of universal health coverage and primary health care. However, it fails to recognise the consequences of a marketised insurance-based approach to UHC with the encouragement of private hospital care and private practice. This scenario drives super-specialisation and overconsumption of healthcare and poses further threats to climate resilience.

Robust primary healthcare has shown its capacity to address preventable causes of mortality and morbidity. It also has the potential to address the diverse threats associated with global warming including the increasing burden of communicable diseases. The report fails to recognise the urgent need to strengthen primary health care with a view to ensuring universal access to health care and strengthening resilience to cope with health emergencies/shocks (due to increased frequency of extreme weather events, pandemics, etc)and action on the social determinants of health including global warming.

Recognising local needs does not mean ignoring the forces and processes operating globally. PHM urges WHO to actively encourage health care organisations (policymakers, practitioners and CSOs) to participate in the UNFCCC Subsidiary Body for Scientific and Technological Advice and the Subsidiary Body for Implementation meetings to ensure that the health perspectives are heard. Such participation can give global context to localised struggles.

Item 23

Economics and health for all

In focus

The Director-General will submit a report (EB154/26) that summarizes the activities and recommendations of the WHO Council on the Economics of Health for All. It will also provide information to support an approach for policy- and decision-making that enables a better balance between the economy and health and which recognizes that achieving health for all requires sustained economic and fiscal investments that are multisectoral and long-term.

The Board is invited to note the report and to provide guidance on:

- How best can action be advanced on establishing an economy for health for all, recognizing the links between the economy and health and the value of developing both in a balanced manner?
- How can the Secretariat best support Member States in advancing an economy for health for all, recognizing the value of multisectoral action and whole-of-government approaches?

Background

'Health for All: Transforming economies to deliver what matters', final report of the WHO Council on the Economics of Health for All

PHM Comment

Please write to the editor@phmovement.org to provide feedback on this commentary.

Need for a theory of change

The Secretariat report (EB154/26) describes the context of the Council's work as characterised by the "interlinked crises of health, inequality and climate, which [...] disrupt solidarity and stability". The need for change is illustrated by extensive references to the Covid pandemic.

The report recognises that health system development (access, quality, efficiency, etc) and the conditions which shape population health are complexly determined by economic activities and trends and by the pressures of economic actors.

There is a clear articulation in the Council report for the need for an alternate economics that changes the way value is conceived and the financing of health services operates. While alternate valuation is positively described as needing to include the role of health workers and health as an investment not a cost there is no further examination of how this could be achieved.

The Council report critiques the subordination of health expenditure to debt repayments. To address this, it recommends the exclusion of health investment from sovereign fiscal deficit. The report also calls for a suspension of debt repayments by lower income countries during health pandemics and other disasters.

At the country level, the Council report critiques austerity policies and favours generating public funding including taxes on wealth and on multinational entities. It also promotes regulation of private sector actors for the common good.

The 13 recommendations are all excellent ideas; a package of directions which if achieved would make a big difference. The recommendations all take the imperative mood - commanding that something happen - but the agents who will drive the required change and their whys and hows are not identified.

The recommendations of the Council articulate high level desiderata which are flouted, in many respects, in the ways national economies and the global economy operate. The Council does not analyse the barriers to the implementation of its recommendations nor does it explain how these barriers might be overcome.

There is no explicit analysis of the forces and dynamics which have led to the interlinked crises of health inequality and climate, and there is no explicit theory of change articulated in the Council's report. Without a credible theory of change and implementable actions which arise from that theory of change, much of this is fantasist.

There are two aspects of the Council's recommendations which might reflect some implicit theory of change.

The creation of the Council itself was strategic in the sense that putting new ideas into public discourse and giving them the imprimatur of WHO might in some degree change the discourse around policy formation at national and global levels and contribute to change in that way. The calls for reform of the intellectual property regulation in the Council's report illustrate the importance of authoritative statements as contributing to change But those new ideas need to find the constituencies whose action and advocacy can change political realities on the ground. There is little in this report which might link high level pronouncements about intellectual property policy reform to successful domestic pressure in a sufficient number of WTO member countries to effect change..

The proposal for a 'Dashboard for a healthy economy' may reflect the view that new information can contribute to social and economic change. However, as a theory of

change, new information must change the distribution of political forces; strengthen the agency of constituencies seeking to achieve social and economic change. There is no indication in the Council's report of such consideration.

There are further hints of an implicit theory of change in the discussion offered in EB154/26 about how WHO could advance the Council's agenda:

- WHO should expand its work in macroeconomics and health and ensure additional resources to enable comprehensive contributions by WHO in this area;
- WHO's efforts to address the social and commercial determinants of health should be further strengthened and could include advocating for the transition to clean energy, more sustainable food systems and cleaner transportation systems;
- WHO could promote capacity-strengthening [...] in order to better equip country offices and health ministries to engage in dialogues with economic and finance sectors and to enhance overall public capacity to shape economic and fiscal policies and drive public-private collaborations;
- The report suggests that deploying WHO's technical expertise in providing normative guidance and rigorous analysis on the economics of health for all could also contribute to the achievement of the Council's agenda.

However, there is no discussion (in the Council's report or that of the Secretariat) of the obstacles which have limited WHO's capacity to move in these directions, for example, the repeated (and bullying) denials by the USA of the mandate or competence of WHO in these fields and the deliberate policies of most of the high income countries to keep the Secretariat on a tight leash through restricting the growth of assessed contributions and insisting on tightly specifying voluntary contributions.

It is noteworthy that none of the Council's suggestions on debt relief and international finance find their place in the Secretariat note. In fact, the term 'debt' is entirely missing in this summary of the Council report. Instead, emphasis is placed on the investment platform and loans from the multilateral development banks. Without debt relief, these could be counter-productive, increasing the stress on the lower income countries and damaging their health finances.

Similarly, in relation to the private sector, the Secretariat note restricts itself to working *with* the private sector, and building collaboration, without any mention of the need for regulation of this sector for the larger interest.

While the Secretariat report continues the call for 'fundamental economic shifts' what this would constitute is entirely missing. The 13 recommendations then stand alone and do not require any reform or even substantive criticism of the existing economic order. The common good recommendations in the Council's report (albeit high level and without implementation drive) have been marginalised in the Secretariat report.

Financing health care

The section on 'Related work by WHO' in the Secretariat report appears to have been developed in the WHO Secretariat and appears to bear no relationship to the work of the Council.

The following passage in this section is quite misleading and a seriously distorted version of history.

> *However, in 2001 the WHO Commission on Macroeconomics and Health concluded that the level of spending on health in low-income countries was insufficient to address the health challenges they face, and that with significantly more finance, a high-potential return to health and the economy would follow. The recognition of the interconnection of economics and health has also served as a basis to help curb rising health costs and address inequities.*

In the same section the report refers to WHO "developing and evaluating wider fiscal policies related to financing universal health coverage". This is corporate speak. The reality is that WHO has been bullied by the WB, Rockefeller and the US to promote marketised health insurance to raise funds for mixed public-private health care which is a model which, all things being equal, makes it more difficult to promote quality, efficiency and the equitable distribution of health care resources. The Secretariat note offers nothing to reverse the pressures for a privatised and marketised health system.

The questions posed for the Board's attention

The Secretariat invites the Board to note the report and to provide guidance on the following questions.

How best can action be advanced on establishing an economy for health for all, recognizing the links between the economy and health and the value of developing both in a balanced manner?

PHM urges members of the Board to request further work by the Secretariat, directed to:

- analysing in more depth the genesis of the interlinked crises, in particular the crisis of inequality and alienation;
- identifying and exploring the barriers to the implementation of the 13 recommendations;
- building the required consensus to operationalize international debt relief to sustain health finances and ensure health services in developing countries during periods of crisis;
- reorienting economics towards prioritizing health as a public good and therefore to build international alliances around exchanging knowledge and technology not driven by corporate profit requirements; and

- developing further recommendations to inform WHO action towards an economy for health for all.

How can the Secretariat best support Member States in advancing an economy for health for all, recognizing the value of multisectoral action and whole-of-government approaches?

PHM urges the Board to:

- request the Secretariat to design and undertake a survey of WHO member states directed to identifying and analysing the barriers to the implementation of the Council's recommendations and identifying initiatives which have successfully overcome such barriers;
- request further work by the Secretariat directed to exploring the role of health systems such as healthcare facilities, public health units, and healthcare personnel in building political pressure for intersectoral action towards an economy for health for all;
- to request further work by the Secretariat to explore the scope for 'meaningful public engagement' and community - healthcare partnerships working towards intersectoral action towards health for all.

Item 24.1

Financing and implementation of the Programme budget 2022–2023 and outlook on financing of the Programme budget 2024–2025

In focus

The Director-General will submit a report (EB154/27) on the financing and implementation of the Programme budget 2022–2023 and provide an update on the financing of the Programme budget 2024–2025. The Board will be invited to note the report and provide further guidance.

Background

Tracker links to previous discussions of PB22-23 and PB23-24.

Programme budget web portal for 2022/23

PHM Comment

This document (EB154/27) provides an update on financing the 2022-23 programme budget, building on earlier updates from the January 2023 EB and the May 2023 WHA meetings (EB152/26 and A76/18).

As with previous updates, EB154/27 sounds a positive note with regard to the amount of funding available or projected for the Program budget. The Program budget of US$6726m for the 2022-23 biennium is projected to reach 138% (US$9,315m). The increase is because of additional funding for event-driven segments of the Program (Polio eradication funding was 246% of the approved budget while Emergency operations and appeals funding was 303%). The core work of WHO (i.e. its 'base' programs) is projected to receive 96% of its approved budget of US$4968m, and WHO's Special Programs is projected to receive 84% of its US$199m.

Table 2 provides a more granular breakdown of where funding for the base programs goes. As in previous reports, we continue to see that some priority areas receive more money than they need while others receive less. These have previously been referred to as ‘pockets of poverty'. To give an example, priority area 1.1 (improved access to quality

essential health services) receives 118% funding while 2.1 (countries prepared for health emergencies) receives 55%.

The report informs us that the base programs are funded by US$957m in assessed contributions (ACs) and US$4,012m in voluntary contributions (VCs) (i.e. 24% ACs; 76% VCs). Confusingly, the report also states that "Voluntary contributions (specified and thematic) represent 62.2% of total financing for base programmes, including projections). The apparent discrepancy between 76% and 62.2% could be because the 'core' VCs are not included in the total. These 'core' VCs were projected to be around $150m in WHO's 2022-23 Program Budget (p28), so this would account for the difference.

The bottom line is that the base programs of WHO (not the total Program budget, just the base segment - its core work) is funded primarily by specified and inflexible VCs. This is important because it illustrates the need to increase the amount of flexible funding going to the base segment. The "aspiration", approved by Member States at the WHA in 2022, is to increase the amount of ACs for the base segment to 50% of the 2022-2023 base budget by the biennium 2028-2029 (WG on Sustainable Financing).

With regards to the future and the 2024-25 budget, we already know from the draft 14th GPW that there isn't going to be an increase in the base segment: it's going to remain at US$4968. Table 4 of EB154/27 (reproduced below) gives us a sense of the funding gap.

Budget segment	Programme budget 2024–2025	AC	VC	Total	Gap (US$)	Gap (%)
Base	4 968	1 146	1 281	**2 427**	2 542	51%
Emergency response and appeals	1 000	0	402	**402**	598	60%
Polio eradication	694	0	657	**657**	38	5%
Special programmes	172	3	46	**49**	123	71%
Total Programme budget	**6 835**	**1 148**	**2 386**	**3 534**	**3 300**	**48%**

Table 4. Projected financing for the Programme budget 2024–2025 by segment as at 30 September 2023

The table shows the increase in ACs (US$1,146m) in accordance with the 'aspiration' noted above, and it also shows that some VCs are already being projected. The new Investment Round, set to launch in the final quarter of 2024, needs to ensure that the base segment is fully funded for the period of the 14th GPW (2025-28). In the short term, it at least has to secure commitment from donors sufficient to cover the 2024-25 biennium.

PHM urges the Board to confront the urgent need to increase the budget for 2024-25 for both the base segment and Emergency operations. The demand for these two categories in the coming biennium is going to be much higher in view of widening

conflict, deepening inequality, accelerating global heating, looming zoonotic outbreaks, and increasing numbers of refuge seekers.

Item 24.2

Draft fourteenth general programme of work

In focus

The Director-General will submit for the Board's consideration the draft fourteenth general programme of work (2025–2028) (EB154/28). Building on the Thirteenth General Programme of Work (2019–2025), WHO's Transformation Agenda and the WHO Results Framework and incorporating lessons learned, the draft fourteenth general programme of work sets a health and well-being agenda for all health players, with the overarching goal of promoting, providing and protecting health and well-being for all people, everywhere. The Board is invited to note the report and provide further guidance for finalizing the draft programme of work.

In a separate document (EB154/INF./1), the Evaluation Office will provide an evaluation of the implementation of the Thirteenth General Programme of Work for the Board's information.

Background

Tracker links to previous discussions of GPW13

WHO about page on WHO funding and About GPW13

PHM Comment

The draft GPW14 offers incremental adaptations (and perhaps improvements) over GPW13. It is logical and well presented and will provide a useful framework for program planning and budgeting.

Don't mention capitalism

The Section on 'a changing world' (paras 1-4 of Part 1) provides a useful overview of the challenges of the context to which the GPW is responding.

It is unfortunate that this account is silent regarding the dynamics of globalised capitalism which contribute to reproducing the challenges humanity faces. Of particular significance, in terms of these dynamics, are:

- the power and impunity of large transnational corporations whose profit seeking frequently runs counter to the conditions for achieving of Health for All; illustrated

by the role of the fossil fuel giants in driving global warming and preventing or delaying mitigation and adaptation;

- the power exercised by the owners of capital over governments and important intergovernmental agencies such as the WB and the IMF; illustrated by the role of Europe and North America in preventing the implementation of WHO's T-TAP proposal in the early months of Covid and their insistence on establishing the ACT Accelerator outside the WHO with the consequential inequalities in access to vaccines;
- the liberalisation of global trade and finance in order to support the profit making of the big corporations through their control of global supply chains with impacts on unemployment and economic inequality; illustrated by the impact on small farmers of cheap subsidised agricultural products with rapid urbanisation but without basic urban infrastructure or decent employment; and
- the fiscal austerity demanded of governments and the associated demands for the privatisation of healthcare and marketisation of healthcare financing.

The proposition that these dynamics are somehow not relevant to understanding the challenges to be confronted in GPW14 is ludicrous. Many of these structural dynamics are referred to (obliquely) in the report of WHO's Council on the Economics of Health for All but the present draft GPW has not drawn on the Council's report. However, failing to acknowledge these dynamics has the benefit of avoiding the hard work involved in working out how to confront them.

Unacceptable impact

The Section on the impact on population health of the contemporary context (paras 5-12 of Part 1) is depressing but important. This section should be shared widely, in particular among healthcare personnel and through them, with their communities.

Solidarity

The draft GPW14 includes no mention of solidarity which is surprising after the pandemic period in which WHO used the word freely to describe the approach the institution (and MS) should take in governing health. It is particularly ironic that this "lens" has fallen by the wayside, given the emphasis in the GPW14 on the multiple intersecting crises we are experiencing, and the likelihood that this will exacerbate its work in emergency/humanitarian settings. A lot of the financial and other support for that work is likely to require solidarity.

Overly positive account of 'global health ecosystem'

The section describing the promise and potential of an evolving global health ecosystem (paras 13-19 of Part 1) takes a 'glass half full' approach, highlighting: 'evolving rapidly', 'important shifts', 'renewed awareness', 'renewed commitments', 'growing recognition',

‘increasing number of actors’, and ‘ongoing advances’. This is far from being a balanced evidence-based assessment of the strengths and weaknesses of the ‘global health ecosystem’ which might take a more sombre view of:

- the dominance of global health funding by US philanthropies with their own preferences and projects including the technical fix outlook of Gates and the privatisation push of Rockefeller;
- the dominance of individual sick care in communications between health care agencies and practitioners and their communities in contrast to the ‘community involvement’ concept of primary health care with its potential for prevention, including action on the social determinants, health system accountability, and community resilience;
- the continuing insufficiency of community health workers who have a particular contribution to make in terms of supporting community involvement;

How fit for the future is WHO?

The section on a changing and fit-for-future WHO (paras 20-27 of Part 1) focuses on the three key objectives of the Transformation Agenda: impact at the country level; enabling the full potential of the Organisation; and fully engaging the ‘global community’.

The transformations envisaged are admirable. However, the analysis is resolutely ‘glass half full’ rather than balanced and evidence based. Confronting reality more honestly would have to acknowledge that:

- voluntary contributions remain tightly earmarked;
- competition between units for donor attention continues to fragment the Organisation;
- WHO functions continue to be transferred out into unaccountable multi-stakeholder public private partnerships, such as the ACT Accelerator; and
- WHO has limited capacity to communicate or work with the communities it purports to serve.

The shortfalls noted in the GPW13 evaluation (see paras 14-21 of EB154/INF./1) could have been acknowledged in these sections.

A ‘global health agenda’ for 2025-2028

Part 2 of the draft GPW sets out the six strategic objectives and the 15 outcomes which will guide planning and budgeting for 2025-28.

The high level results for the draft GPW14 (see table, see also paras 1-17 of Part 2) are sensible although at a high level of generality. The intended meaning of these generalities is elaborated in the text in terms of a series of commitments under each objective and outcome. These commitments are admirable and PHM would welcome their achievement.

The commitments under the six strategic objectives are cast as directions with no consideration of drivers. The final para of Part 2 (para 18) presents five themes which are presented as being central to the success of the common agenda and achievement of measurable impact. These themes provide further guidance as to how the six strategic objectives are to be addressed.

WHO's results framework is outlined in paras 12-17 of Part 2. The Framework provides a sensible way of approaching measurement and accountability. The distinction is made between (a) impact measurement, which assesses the joint results of Member States, partners and the Secretariat in respect of overall impact and outcomes; and (b) output measurement, which assesses and facilitates management of the contribution of the Secretariat.

Outcomes versus impact is a useful distinction but points to the lack of accountability of member states in terms of implementing the resolutions they pass and the guidance documents that they note. While governing body resolutions generally include recommendations for member states *and* requests to the Director General, the Secretariat reports on implementation generally shy away from offering substantive analyses of member state implementation. An exception to this lack of accountability was the Commission for Information and Accountability for Women's Health which included a strong peer review element in its accountability framework.

Promises are conditional

Whether the commitments under the six key objectives are credible or not depends on the associated theory of change which is presented in paras 10-16 of Part 3 and summarised in the infographic on page 38. Achieving the commitments hinges on the joint action of member states, partners and key constituencies in four major areas:

- commitments to health and well-being and internationally agreed targets need to be reaffirmed and monitored;
- the priority health interventions and actions identified in the global health agenda need to be reflected in country, regional and global strategies, budgets, action plans, monitoring and evaluation frameworks and, when appropriate, legislation,
- domestic and partner resources for health need to be increased; and
- overall intersectoral, partner and community engagement for health and well-being needs to be expanded, particularly with key health "contributing" sectors (e.g. the food, agriculture, environment, finance, social and education sectors) and across public and private actors.

The articulation of an explicit theory of change is appreciated. The GPW13 evaluation comments that this was not part of GPW13.

The theory of change includes the key enablers, assumptions and risks that are critical for realizing the change and impact that the draft GPW 14 aims to achieve (summarised in para 16 of Part 3).

The key enablers reflect the conditions needed within the Secretariat to ensure its capacity to deliver on its draft GPW 14 contributions and commitments. This includes strengthening WHO country and regional office capacities and capabilities; a sustainably and flexibly financed WHO; a motivated and fit-for-purpose workforce; and a more effective, efficient and accountable WHO.

The assumptions and risks highlighted in the theory of change primarily relate to the external factors that could influence the degree of political support for, engagement in and financing of the draft GPW 14 and global health. More detail on risks is promised in the next version of this paper.

In effect the promises of the global health agenda set out in Part 2 are conditional and the conditions for their achievement are summarised in the commentary on key enablers and assumptions and risks. The findings of the GPW13 evaluation underline the importance of this recognition of enablers and obstacles.

WHO's role and capacity

Part 3 of the paper is focused on WHO's role and capacity in relation to the proposed 'global health agenda'. The draft proposes that WHO's vital contribution to the achievement of the global health agenda will be based on its:

1. health leadership and partnership role (convening, advocating, championing);
2. core normative and technical work; producing global public goods for health; and
3. differentiated country support and technical cooperation.

'Optimising' WHO's performance (discussed in Part 4) will involve new approaches to change management, an ambitious people strategy and expanding WHO's existing collaborations and partnerships. It will also involve:

- strengthening the core capacities of country and regional offices to drive impact;
- strengthening WHO governance, accountability and administrative functions; and
- sustainable financing.

Whether WHO will be *enabled* to develop its capacities in these ways is uncertain.

In sum

The draft GPW14 is not a radical departure from GPW13 but offers incremental adaptations to a changing environment. It is logical and well presented and will provide a useful framework for program planning and budgeting.

However, there are some critical gaps (don't mention capitalism) and several sections which reflect wishful thinking rather than a balanced and evidence based approach.

However, the promises of this draft GPW are not absolute. Embedded in the text are a number of warnings about the conditions which will need to be met for the achievement of the proposed 'global health agenda'.

PHM urges member states to confront the gaps in this GPW and to take a more balanced approach to the assessment of the global health ecosystem and the abilities and disabilities of WHO.

GPW13 evaluation

EB154/INF./1 provides a summary of the Evaluation of GPW13 undertaken between November and December 2023. The evaluation is presented as an input to the development of GPW14 but it seems likely that the results of the evaluation came fairly late in the process which commenced in August 2023.

Nevertheless there are some useful findings and conclusions in the Evaluation, several of which appear to have been addressed in the current draft GPW14.

Item 24.3

Sustainable financing: WHO investment round

In focus

In response to the request in decision WHA76(19) (2023), the Director-General will provide a full plan, with modalities and expected costs and efficiencies, for the WHO investment round (EB154/29 Rev.1). The plan has been developed through multiple consultations with Member States and includes proposed next steps. The Board is invited to consider the report and provide further guidance

Background

Tracker links to previous discussions of WHO financing

A health return: investment case for a sustainably financed WHO

GHF (10/1/24) "WHO Seeks to Raise US$7 Billion in First Ever Investment Round in 2024, Executive Board to Consider Proposal This Month"

PHM Comment

Purpose and vision for success

Under the heading 'Purpose and vision for success' the report tells us that the "WHO investment round aims to safeguard the global political momentum for health in order to rally stakeholders behind the General Program of Work 14 and move the Organization's finances towards more predictability and flexibility". Typically, the base segment gets fully financed, eventually. So, it's never really been a problem to 'rally' 'stakeholders' behind the GPW. It could now become a problem, depending on whether the IR is a success or not. But the sums of money involved are tiny, so it's unlikely to deter funders. The returns in fully funding the base segment are, of course, very significant.

"The success of the WHO investment round will not be measured solely by the funding raised but will also consider predictability, flexibility, broadening of the donor base and increased efficiency" (para 8).

"With regard to predictability, important markers will be the funding that is available through voluntary contributions at the beginning of the four-year period of the GPW 14

(baseline for the period 2020–2023: 17%) and the number of contributors pledging for the full four-year period (baseline for 2020–2023: seven)" (para 9).

The amount of funding raised by IR is crucial, so it feels as though the Secretariat is covering its bases here. If the IR does less well in raising money than the current arrangement, then it should be judged a failure regardless of whether the funding is more predictable, flexible, or has a broader donor base. The likelihood of the IR securing more flexible funding is quite low, and the flexibility will mostly be achieved by the increase in ACs. Nevertheless, it remains the aim (despite US efforts to wriggle out of its commitments) for the base segment to be fully flexible, so it's important that the quality of VCs shifts to being more flexible.

Markers/indicators of success

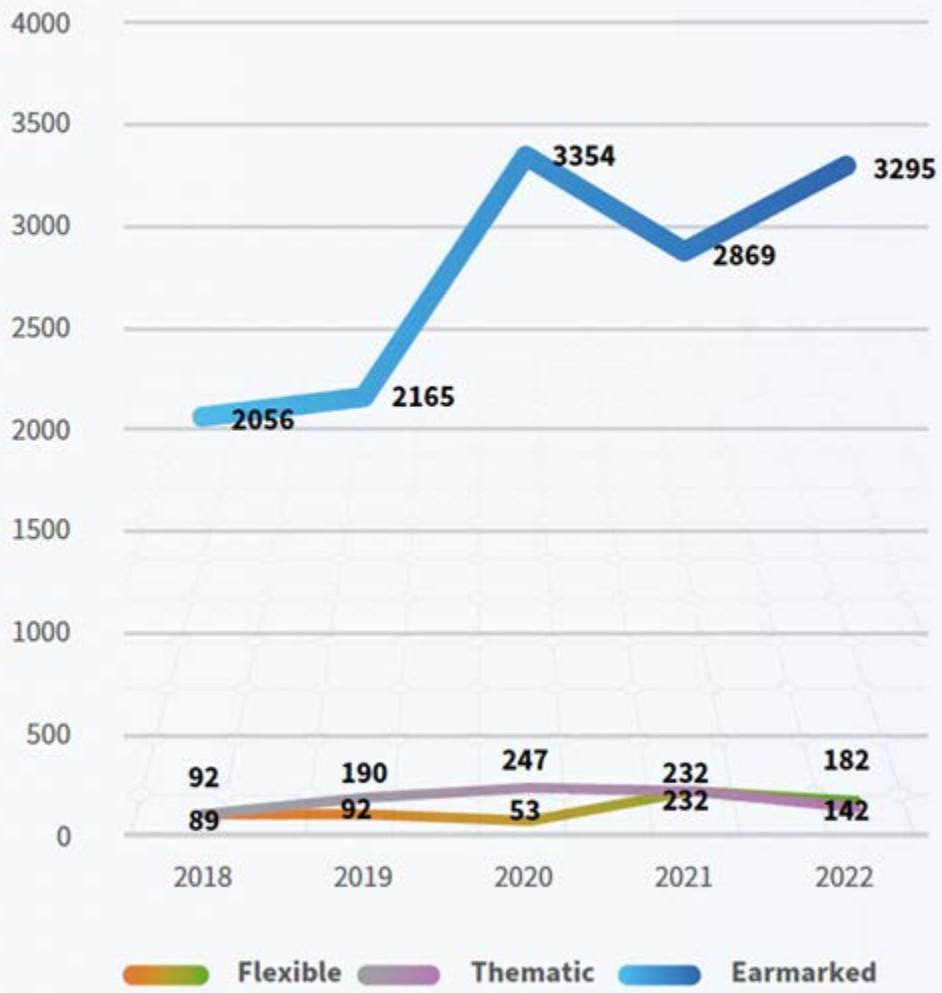
The first marker -17% of the total VCs at the beginning of the period. We know from the draft GPW 14 that the "indicative financial envelope" is around US$11.13bn for the period 2025-2028 of which US$7.14bn in VCs will have to be raised through the IR. 17% would = US$1.21bn. We know from EB154/27 Table 4 that the projected VCs for 2024-25 are US$1.28bn, so achieving an extra US$70m doesn't seem too much of a stretch!

The second marker, seven contributors, also seems on the face of it relatively easy to secure. Multi-year commitments of VCs to the Program budget from donors are actually on the increase - rising from US$818m in 2022 to US$964m in 2023 (A76/17, p10). Figure 5 of the report lists the top ten contributors to the base segment. It will be very interesting to see who of these will pledge for the duration of the GPW. Given the amount of money each of the top five contributes, not getting their commitment will mean that the amount of money secured for the period will be relatively low, undermining the potential utility of predictable funds.

The third marker: "With regard to flexibility, the indicator will be the percentage of available voluntary flexible funding for the base budget for the four-year period (baseline for 2020–2023: 16%)". Again, unless you're familiar with the different kinds of VCs, this might be confusing. The least flexible VCs are 'specified' or 'earmarked' VCs, which contribute most of the VCs to the base segment. There are also 'thematic' and 'core' VCs. Core VCs are the most flexible and are often referred to as 'flexible' VCs for that reason.

To get a sense of the relative weighting of these VCs see the figure below from A76/17. The 16% marker is quite a challenge. As A76/17 points out: "The proportion of flexible and thematic funding decreased by US$ 140 million from US$ 464 million in 2021 to US$ 324 million in 2022, which represents just 9% of total voluntary contributions". This is part of the reason why the IR has been set up. It will struggle to meet this target.

Fig. 6. Voluntary contribution revenue (Programme budget) for 2018–2022 (US$ millions).



The fourth marker or indicator of success: broadening the donor base. Here's the text: "Finally, the number of contributors that increase the amount of their contributions will demonstrate not only the broadening of the donor base but also the commitment of existing donors". On face value, 'broadening the donor base' does not necessarily mean increasing the number of donors. Rather, the 'broadening' condition is satisfied if more existing donors increase their contributions. That might demonstrate an increase in commitment, but it does not demonstrate a broadening of the donor base.

Modalities

The report gives us some more information about how the IR will proceed. Here's the description: "The event, which will provide an opportunity for all Member States and other contributors to participate, virtually or in person, and to make financial pledges to the GPW 14 base budget".

Tedros introduced 'investment cases' when he took the helm as DG as a way to secure donor support. He launched the first investment case in 2018 and clearly articulated the economic case in the 2022 report A Healthy return. A new investment case is being developed for the IR building on previous cases. It's hard to see why this is necessary. There is little need for the DG to provide another 'investment case' to donors. The WHO is a global public good and is necessary for international health cooperation. The 'case' for WHO is self-evident.

Resource mobilisation

We know how much money the IR will have to secure (recall that the IR is only concerned with funding the base segment of the budget). Of the total US$11.13bn for 2025-28, US$7.13bn will need to come from VCs. Ensuring the IR delivers will depend on the reach and intensity of advocacy. It will be enabled by broadening the definition of 'thematic' funding to include greater programmatic and geographical flexibility; a review of the Resource Allocation Committee's operations; and the rollout of a standardised report template.

Costs and benefits of the IR

A CBA was conducted (but does not appear to have been published). Because "WHO's resource mobilization capacities are already lean" there won't be much additional cost but "the potential for organizational efficiencies and increased effectiveness is significant". In monetary terms, the overall cost of the IR will be in the range of US$ 3.25-5.55m. Efficiency savings, on the other hand, will be in the range of US$15-40m plus the unquantified benefits of staff retention from more predictable funding.

Risks

The three risks with the greatest impact and probability are: (a) the financial risk of not meeting the target; (b) the reputational risk of the investment round being portrayed as a failure; and (c) the structural risk of WHO's resource mobilization approach not being optimized for an investment round.

These are serious risks - existential even. The mitigation strategy is not particularly convincing: "having a clear set of indicators for success beyond simply the total amount raised; leveraging the unique strength of WHO's resource mobilization approach; and

having a strong results framework and investment case with a clear communication plan". The indicators are deliberately not dependent on total moneys raised (even though this is really important).

Item 25.3

Matters emanating from the Agile Member States Task Group on Strengthening WHO's Budgetary, Programmatic and Financing Governance

In focus

The Director-General will submit a set of reports, covering some of the mandates given and requests made by the governing bodies in response to the work of the Agile Member State Task Group and the Secretariat's implementation plan for reform. He will also transmit two reports from the former co-facilitators of the Task Group The Board will be invited to note the reports, provide further guidance and consider the relevant draft decision (in EB154/34).

EB154/32: Secretariat implementation plan on reform

EB154/33: Strengthening WHO's budgetary, programmatic and financing governance: follow-up to the implementation of decision EB152(15) (2023)

EB154/33 Add.1: Proposals for improving the effectiveness of the WHO governing bodies

EB154/33 Add.2: Project plan: implementation of digital solutions for interactions between the Secretariat and Member States on matters related to the governing bodies

EB154/33 Add.3: Cost recovery mechanisms for voluntary contributions – an update

EB154/34 Report of the former co-facilitators of the Agile Member States Task Group

EB154/34 Add.1 Follow-up to decision WHA69(8) (2016), operative paragraph (10): Improving transparency of the process for the selection of Assistant Directors-General

EB154/35 Process of handling and investigating potential allegations against WHO Directors-General

Background

EB152/33 which conveys the report of the Agile MS Task Group explains the background:

> *The Agile Member States Task Group on strengthening WHO's budgetary, programmatic and financing governance held three hybrid meetings between July and November 2022, under the co-facilitation of Mr José Acacio of Australia and Ms Philomena Bawelile Simelane of Eswatini. In furtherance of the mandate of the Task Group, the co-facilitators also convened an information session and a deep dive on issues related to the work of the Task Group.*
>
> *The Executive Board at its 151st session in May 2022 decided, through decision EB151(1) (2022), and taking into consideration the outcome of the Seventy-fifth World Health Assembly, in particular the adoption of the recommendations of the Working Group on Sustainable Financing through decision WHA75(8) (2022) and noting paragraph 40 of those recommendations, to establish the Agile Member States Task Group on strengthening WHO's budgetary, programmatic and financing governance.*
>
> *The mandate of the Task Group was to: (a) focus on strengthening WHO's budgetary, programmatic and financing governance; (b) analyse the challenges in governance for transparency, accountability, compliance and efficiency; and (c) develop recommendations aimed at long-term improvements, building upon the recommendations of the Working Group on Sustainable Financing, as adopted by the Seventy-fifth World Health Assembly in decision WHA75(8) (2022).*

PHM Comment

Paragraph 38(e) of the Working Group on Sustainable Financing (WGSF) recommendations, which were approved by Member States at the 75th WHA, May 2022 (WHA75(8)), stressed that

> *any increase in Member States' assessed contributions needs to be accompanied by appropriate governance reforms, to be agreed by Member States, together with the further strengthening of transparency, efficiency, accountability and compliance within the Organization"*

The WGSF recommended the establishment of an "agile Member States task group" to provide recommendations that would assist in the implementation of these reforms by WHO's Secretariat (para 39(e)(i) and para 40).

The Agile Member States Task Group on Strengthening WHO's Budgetary, Programmatic and Financing Governance (henceforth referred to as the Task Group) was duly established at the May 2022 Executive Board (see decision EB151(1)). The Task Group's

1st report (which proposed 11 recommendations and 27 sub-actions to enhance the performance of the Secretariat and strengthen its budgetary, programmatic, finance and governance processes, and its accountability) was presented, discussed and endorsed at the January 2023 Executive Board (EB152/33; EB152/34; EB152(16)), the PBAC and also the WHA in May 2023 (A76/31).

Implementation of the Secretariat Implementation Plan on Reform

The Secretariat is required to provide progress reports on its implementation of its Implementation Plan on Reforms. The plan (see EB152/34) contains 98 actions across the seven thematic categories (accountability function and systems; country-level impact; financing; governance; human resources; programme budget; resource mobilisation). (See PHM comment on the Implementation Plan under Item 23.1 at EB152.)

Document EB154/32 provides an update on progress with the implementation plan, including progress towards completing those remaining actions. 38 actions had been implemented by the end of 2022 and the remaining 60 actions were progressing in 2023. "Between January and November 2023, the number of implemented actions progressively increased from 38 in January 2023 to 42 in March 2023. Since March of this year, the Secretariat has implemented an additional 25 actions" (para 10).

Paragraphs 5-7 give an insight into the demands placed on the Secretariat and an acknowledgement of risks associated with such demands. For example, the Secretariat has to ensure that a total of 269 separate actions from its own implementation plan, the Task Group, the transformation initiative and the ARG action plan 'fit together'. Risks associated with these demands are driven by "no specific allocation of funds to carry out the implementation plan, and an unprecedented increase in governing body negotiations, intergovernmental body meetings, and Member States consultations and information briefings" (p2).

The document lists eight highlights (program budget, transparency, PRSEAH, financing, accountability, resource mobilisation, country level impact and governance). The Secretariat has established a Member States Portal which includes a dedicated dashboard for monitoring the implementation plan and the transparent communication of progress, and also various digital platforms to monitor the program budget and access relevant budget-related documents. This is a significant effort on the part of the Secretariat and a really useful resource.

The report notes the importance for country level impact of the "selection and placement of heads of country offices and revised delegations of authority to country offices". It is important for WHO to reflect on the controversy surrounding the recent election of the SEARO RO Director, and whether that might affect the country level.

Progress on Secretariat actions in support of specific Task Group recommendations, as outlined in decision EB152(15) (2023)

EB154/33: Strengthening WHO's budgetary, programmatic and financing governance

Reviews progress on:

- Costing advice to Member States on draft resolutions and decisions;
- Secretariat organigram,
- Analysis of voluntary contribution earmarking,
- Strengthening the role of the Board and its Programme, Budget and Administration Committee;
- Production of reports for governing body meetings
- Preparation of draft resolutions and decisions

In January 2023, the EB reviewed the Task Group's 1st report and, based on the report, made some specific requests of the Secretariat (EB152(15)). EB154/33 is an update on progress towards meeting those requests. The Secretariat has now provided an organigram of the Organization and contact details of all its senior staff.

The report notes that "an analysis of voluntary contribution earmarking flexibility and limitations" was conducted in the summer of 2023 (no details provided) which found that "entities with substantially higher amounts of flexible and unearmarked voluntary contributions tend to use a "replenishment' model" for resource mobilization, for which unearmarked funding is a key parameter (eg. The Global Fund to Fight AIDS, Tuberculosis and Malaria; and Gavi, the Vaccine Alliance)".

This is not persuasive: both of these 'entities' have quite specific mandates (unlike WHO) and they have 'business models' (unlike WHO). They were also both funded - and continue to be funded - by the Gates Foundation, which would have significantly influenced their business models to include many (if not all) of the "incentives" described in para 32. The document notes: "The Secretariat has observed the best practices of other entities, adapting lessons learnt to WHO's context in planning for the Investment Round" (p10).

See PHM comment on Item 24.3 (Investment Round) at this EB

EB145/33Add1: Proposals for improving the effectiveness of the WHO governing bodies (a 'technical committee'?)

The Secretariat's implementation plan for reform (EB152/34) included a request for the Secretariat to provide proposals for reform of WHO's governing bodies. EB154/33Add1 sets out 10 problems with the operations of the governing bodies (para 2) and sets out seven proposals to address them:

A. Establishment of a new committee of the Executive Board on technical matters
B. New disciplines for the development of governing body agendas
C. By transferring item discussions to Board committees free up the Board for more strategic discussion
D. Focus WHA on outcomes of EB rather than considering all technical items
E. New disciplines regarding the preparation and submission of documents to the Board
F. New disciplines on member state speaking times
G. Improved support for participation by member states in governing body processes and meetings

Recommendation A (and related recommendations D and D) are controversial.

It's not clear how creating a new Committee is going to address the unmanageability of governing body documentation. Changing the venue for consideration of the documents will not reduce the document burden for the Secretariat.

The EB currently allows civil society organizations in official relations with WHO to provide statements. Will this opportunity continue through the new committee? PBAC does not permit this level of interaction, so there's real concern that Recommendation A will limit CSO participation to a discussion of the new committees report with no opportunity to 're-discuss' each agenda item separately (para 17).

The Secretariat is all set to start drafting the TOR for this new Committee. The Secretariat should clarify the situation for civil society before proceeding further with this recommendation. The irony is that Recommendation G in the document is titled: Effective participation in governing body processes and meetings. 'Effective participation', however, is about IT rather than encouraging and facilitating a diverse range of views.

PHM urges member states to reject the proposed technical committee

EB145/33 Add.2: Implementation of digital solutions for interactions between the Secretariat and Member States on matters related to the governing bodies

The Secretariat proposes four priority initiatives under this heading:
1. Searchable online database of WHO resolutions and decisions,
2. Contact management system and guidelines,
3. Official correspondence tool
4. Member State community portal.

EB154/33 Add.3: Cost recovery mechanisms for voluntary contributions

Earmarked VCs add to the administrative costs (stewardship, governance, infrastructure) borne by the Secretariat but existing cost recovery mechanisms do not cover these costs.

Sensible recommendations.

EB154/34: Report of the former co-facilitators of the Agile Member States Task Group on Strengthening WHO's Budgetary, Programmatic and Financing Governance (and draft decision)

An inclusive informal model for discussions on ongoing Member State-led reform, open to all Member States is proposed.

Proposals for improving transparency in the creation and filling of senior-level positions at WHO are presented

Proposals for strengthening member states consultations on the prioritization of the programme budget, resource allocation are presented

EB154/34 Add.1 Follow-up to decision WHA69(8) (2016), operative paragraph (10): Improving the transparency of the process for the selection of Assistant Directors-General

EB154/35 Process of handling and investigating potential allegations against WHO Directors-General

For backgrounds see Annual Report of IEOAC May 2023 in EBPBAC38/2

Item 25.4

Engagement with non-State actors

In focus

Report on the implementation of the Framework of Engagement with Non-State Actors

In accordance with resolution WHA69.10 (2016) and the Framework of Engagement with Non-State Actors (subparagraph 68(a)), the Director-General will submit the eighth annual report on WHO's implementation of the Framework (EB154/36), illustrating engagements with entities and reporting on the different aspects of the implementation of the Framework at the three levels of the Organization. The Board will be invited to note the report.

Non-State actors in official relations with WHO

In line with the provisions of the Framework of Engagement with Non-State Actors, the Executive Board is mandated, through its Programme, Budget and Administration Committee, to consider applications for admittance of non-State actors into official relations and to review collaboration with one third of the non-State actors in official relations in order to decide whether to maintain, defer the review or discontinue their official relations. The Board will be invited to note the report (EB154/37) and to consider a draft decision (EB154/37 Add.1).

Background

FENSA (Annex 5, WHA69/2016/REC/1 and WHA69.10, May 2016))

Tracker links to previous discussions of NSAs and FENSA

PHM Comment

This comment addresses the report on the implementation of the FENSA (EB154/36).

Time for deep evaluation

It is time the FENSA was evaluated. What is it contributing to public health globally and how efficiently? Para 2 of the FENSA states that "WHO engages with non-State actors in

view of their significant role in global health for the advancement and promotion of public health and to encourage non-State actors to use their own activities to protect and promote public health".

How strategically does WHO manage its engagement with NSAs in terms of optimising those engagements for public health outcomes?

EB154/36 promises (in para 3) to report on 'key achievements' during 2023 but what it describes is a series of activities in the regional offices and in Geneva which have been carried out under the mandate of the FENSA.

The FENSA was evaluated in 2019 (EB146/38 Add.2) but that evaluation was solely focused on the implementation of the Framework, not whether it was leveraging its relationship with NSAs in the most efficient and effective way in terms of protecting and promoting public health.

Reporting by regions rather than by categories and types of interaction

EB154/36 reports on activities under the FENSA umbrella in the regions and in Geneva. However, a key feature of the FENSA design was the identification of four separate categories of NSA and six types of engagement which characterise WHO's relationship with each of the four separate categories.

The four categories are: nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions. The five kinds of interaction are: participation, resources, evidence, advocacy, and technical collaboration.

Reporting on FENSA activities by region and head office collapses the four different categories and their interactions into one undifferentiated whole which prevents any focus on the benefits and risks associated with the different kinds of interactions with the different kinds of non-sttae actors.

Risk management

It appears that the main burden of the work of the 'specialised unit' involves assessing new relationships and new activities. It is not clear that the opportunities for maximising public health outcomes and minimising risks are being prioritised.

Risk (to integrity and reputation) associated with competitive resource mobilisation

One of the most salient risks to WHO's integrity and reputation arises from the competition between organisational units, particularly at head office, for donor attention. In view of the continuing inadequacy of assessed contributions and the tightly

earmarked nature of voluntary contributions, successful deals can make the difference between survival or closure for the unit and employment or retrenchment for its staff.

At most WHAs there are initiatives canvassed which have been generated by program managers, negotiating with donors, often with the facilitation of interested NSAs and member states. At best, such initiatives enable new ideas and approaches to be explored. At worst they breach the conflict of interest provisions of FENSA, fragment the work of WHO, and waste the time of member states in governing body meetings. There is no transparency about these relationships and negotiations and the 'specialised unit' does not seem able to notice them taking place.

PHM has drawn attention to a previous instance involving psoriasis and has expressed concern about the provenance of the item on Well-being and Health Promotion (Item 21) at this EB meeting (here). The chocolate case involved a member state arguing for 'stakeholders' (in this case a private sector entity) being involved in the setting of WHO guidelines.

Conflicts of interest associated with multi-stakeholder public private partnerships

There is a contradiction between focusing on the integrity of 'official relations' while transferring global health functions out of WHO to various multistakeholder partnerships (such as the ACT Accelerator) where philanthropic foundations (Gates, Wellcome) and business associations (IFPMA) play governing roles and where regulatory frameworks such as FENSA do not exist.

The ACT Accelerator was forced on WHO by powerful member states seeking to manage Covid while protecting their own corporations. The scandalous misallocation of vaccines and other medical resources during Covid had a massive impact in terms of avoidable Covid mortality and was in part a consequence of the deliberate side-lining of WHO.

The focus on conflict of interest under FENSA appears somewhat hollow beside the emergence of the new multi-stakeholderism.

Benefits

WHO's relationships with NSAs are of critical importance for its work. Examples involving all of the modalities of engagement for each of the four types of NSA. However, there has been little focus, in terms of the administration of FENSA, on maximising the benefits from such relationships.

The community health partnership

The Alma-Ata Declaration of 1978 projected a vision of primary health care agencies and personnel working with their communities to improve their healthcare and engage

intersectorally for improved population health. The PHC/community partnership is one of the most powerful drivers of Health for All. Aside from the case studies of Ken Newell's Health by the People (1975), the fields of occupational health, women's health, indigenous health, and environment and health all illustrate the power of partnerships between healthcare practitioners and their communities to achieve change.

The community health partnership retains a presence in WHO rhetoric but is virtually absent from WHO programming. Certainly there is little emphasis in WHO's strategic thinking about how to build engagements which might help to build a social movement for health equity.

PHM welcomes the new stakeholder initiatives referred to in para 22 of EB154/36 and recognises the difference between these initiatives and the multi-stakeholder public private partnerships created outside the WHO, referred to above. However, these initiatives are not designed to build the kind of community partnership of which Ken Newell spoke.

PHM calls for

- the adoption of a framework for reporting on the implementation of FENSA which pays attention to the forms of interaction associated with the different categories of NSA;
- an evaluation of FENSA which is focused on the efficiency and effectiveness with which the Secretariat leverages its relationships with NSAs towards the achievement of public health outcomes;
- full transparency regarding the provenance of items and initiatives appearing before the governing bodies;
- the development of a new framework for WHO's engagement with multi-stakeholder public private partnerships established outside WHO;
- a new focus on the strategic power for global health of the 'community health partnership' envisaged in the Alma-Ata Declaration.