

People’s Health Movement

*Background and Commentary on Items before
WHA77 May 2024*

This analysis and commentary on selected items coming before the World Health Assembly in May 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 WHA77](#) which provides direct links to Secretariat papers as well as PHM’s Item Commentaries.

This version of PHM’s commentary is published 22 May 2024. Updates will be published on the Tracker.

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

For ongoing access to WHO Watch alerts, updates and commentary, subscribe to the Tracker Alert (subscribe [here](#)).

Contents

11.1 UHC	3
11.2 Follow up political declaration of the third HLM of the UNGA on the prevention and control of non-communicable diseases	8
11.3 Infection prevention and control.....	15
9. Immunisation agenda 2030.....	20
10. End TB Strategy	23
11.6 Roadmap for NTDs, 2021-2030.....	26
11.7 Acceleration towards the Sustainable Development Goal targets for maternal health and child mortality.....	31
11.8 Antimicrobial resistance	35
12. Global technical strategy and targets for malaria 2016–2030.....	41
13.1 IOAC for WHE	45
13.2 Implementation of the IHRs	46
13.3 Working Group on Amendments to IHRs	49
13.4 Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response.....	50
14.1 WHO’s work in health emergencies.....	56
14.2 Implementation of Resolution WHA75.11 (Russia Ukraine war)	61
14.3 Global Health and Peace Initiative.....	63
14.4 Polio: Eradication, Transition planning, Post-certification	66

18 Smallpox eradication: destruction of variola virus stocks	69
15.1 Social determinants of health.....	72
15.2 Maternal, infant and young child nutrition.....	81
15.3 Well-being and health promotion	86
15.4 Climate change, pollution and health.....	93
15.5 Economics and HFA	100

11.1 UHC

In focus

Edited extract from DG's Consolidated Report ([A77/4](#)):

The Executive Board at its 154th session noted the report on universal health coverage ([EB154/6](#)). It adopted decision [EB154\(6\)](#) on development of a global strategy and action plan for integrated emergency, critical and operative care, 2026–2035, in which it recommended to the Health Assembly the development of such a strategy for consideration by the Seventy-ninth World Health Assembly, through the Executive Board at its 158th session.

A77/4 (para 22) invites the Assembly to adopt the decision recommended by the Executive Board in decision [EB154\(6\)](#).

The Board also considered the text of a draft resolution introduced by Member States on social participation for universal health coverage, health and well-being ([EB154/CONF./10](#)). The Board agreed that consultations on the draft resolution would continue during the intersessional period.

In the discussions (see [M5, page 2](#) and [M6, page 2](#)), Board members acknowledged the declaration of the United Nations General Assembly on universal health coverage and the central role of reorienting health systems towards a primary health care approach in achieving universal health coverage. They affirmed that universal health coverage and strong health systems should underpin the draft fourteenth general programme of work.

Background

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

PHM Comment

Secretariat report on UHC (EB154/6)

EB154, held in Jan 2024, noted the report on UHC ([EB154/6](#)). See [PHM Comment on EB154/6](#) (Jan 2024). We reiterate the following major comments on [EB154/6](#):

The discussion on UHC in WHA76, in the Political Declaration on UHC that was adopted in the High Level of the United Nations General Assembly, in October 2023 and in the report presented in the EB154/6, all point to the same problems and it is clear that member states are unable to force a debate on some critical issues. The world is NOT on track to achieve UHC with worsening on some parameters, especially on financial protection. The report does call for

1. an increase in health funding,
2. the efficient and equitable use of such funding,

3. the strengthening of the health and care workforce, and
4. the expansion of primary health services and the orientation of health systems towards a primary healthcare approach.

The continuing failure to achieve universal health coverage is not just a failure of implementation but a failure of strategy. 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 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 public 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. The system is delivering what it is designed to deliver. What we need is a change of strategy, not more of the same.

Some of the key strategic changes required are:

1. **Rolling Back Privatization:** Roll back efforts to privatize medical and professional health education, to introduce publicly funded health insurance programmes and other forms of contracting private care that use public finances to strengthen private profits and measures that limit public package of services- so as to push other healthcare needs to private sector.
2. **Strengthening and democratizing public health services:** Invest more in strengthening public services to provide comprehensive packages of primary secondary and tertiary care services and increasing the level of social participation and democratization so that it provides acceptable care of good quality and is responsive to peoples needs.
3. **Cautions with international finance:** Roll back the Health Impact Investment Platform and stop using loans from Development Banks as a means to finance primary health care. Instead go for debt swaps and debt write-offs, and better terms of trade that can ensure that countries are able to invest in health. Most countries are paying more for debt servicing than on welfare. In particular ensure that global financial institutions and trade treaties do not oblige governments to privatize healthcare or encourage an open door to foreign for-profit investment for primary healthcare or integrated health management organizations.
4. **Cautions with corporate consultancies:** Limit and caution against the role of international consultancy agencies, who are active promoters of some of these privatizing strategies and who have serious undeclared conflict of interests when

they advise governments on health policy. 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.

5. **Increasing access to essential technologies:** The UHC project must break its silence on access to essential medicines at affordable rates and call for policies and progress reports that will ensure this essential component of progress towards UHC. WHA76 adopted some far reaching decisions with regard to universal access to diagnostics but there is no report on the progress made with respect to this either. Increased access to both drugs and diagnostics, would necessarily require greater capacity in domestic manufacture, price controls, and public procurement. For example, in most LMICs, universal access to diabetes care will not be possible unless human insulin and insulin delivery systems and diabetic diagnostics become much more affordable. This also requires a different approach to product innovation, one that is less based on restrictive patent regimes and more dependent on public financing and cooperation between academia, industry and governments in the global South.
6. **Measuring Progress better:** The current metrics for coverage are inadequate and could even be misleading. This makes measurement of progress towards UHC unreliable and difficult to compare. The coverage indicators relate only to a very selective package of services, and even these readings are not from reliable and objective sources. The proposal to include the measurement of financial hardship, quality of care and care foregone (unmet need) as important indicators of progress towards UHC (para 35 in [A76/6](#)) must be followed up. We also call for disaggregated measurement and reporting of these indicators so that we can better measure and address healthcare inequities. All of this requires a parallel effort on the lines of the demographic and health surveys. There is a need to ensure robust timely measurement and release of mortality data and indicators in LMICs based on each country's civil registration and vital statistics (CRVS) systems which are reformed to be more transparent, and reliable. Current estimates of mortality and burden of disease for LMICs are often based only on modeling from very scarce or absent country data with only one or two global institutions empowered to make these calculations. This disempowers member states from measuring and planning for UHC.
7. **Reducing the role of separated vertical programs:** Many earlier vertical health programmes continued to be strengthened as vertical silos and new ones are introduced, and this fragments public health services. Much of this problem emerges from the WHO HQ itself where disease specific initiatives including on NCDs, are poorly integrated with the PHC and UHC and strengthening health services initiatives. Integration has to take place at the level of human resource planning and management, facility strengthening, supply chain management, financing, digitization, monitoring and governance and community engagement. This lack of integration is yet another barrier to achievement of PHC and UHC. Even between UHC as reported in agenda item 11.1 and the initiative on

strengthening primary health care which is presented in Item 28.3 (under the heading a report on implementation of the WHO Framework on Integrated People Centred Health Services (IPCHS) as set out in resolution WHA72.2).there seems to be little to no coordination. Agenda item 28.3 on PHC, under the name of IPCHS seems to be on a silo of its own.

Integrated emergency, critical and operative care for universal health coverage

In [EB154\(6\)](#) the Board recommended that WHA77 resolve to develop a global strategy and action plan for integrated emergency, critical and operative care, 2026–2035, for adoption in 2026.

This draft decision is directed to the implementation of [WHA76.2](#). PHM welcomes this development within the UHC agenda, but has the following cautions:

1. It should be part of an integrated strengthening of health systems and not a stand alone agenda
2. The big limitation in strengthening such hospital care is that human resource policies with regard to specialists especially for specialists working in increasing specialised high-technology domains are not fit-for-purpose. We need policies that generate and retain the required skilled professionals in public health services and in under-serviced areas. In the last two decades the high degree of privatization of all professional education and the huge costs of getting a professional certificate have made it impossible to get or retain the type of health professionals needed to close the gaps. The current draft does not include this problem within its scope.
3. Another big limitation is that much of these skills, though generated in LMICs are emigrating to high income countries (HIC) and the source countries are getting no compensation in return. This problem has aggravated after Covid 19. This issue too is not flagged in the WHA76.2 resolution.
4. A third major limitation is that a major proportion of the specialists and the provision of such care is available in corporate hospitals which operate in an unregulated environment and are now making super-profits. Many of these do not even consider coming under publicly financed insurance schemes unless a much higher reimbursement package is provided. These hospitals also set the standards and expectations of this sector. There is an urgent need to address regulation of this private sector, and this should be included in the scope of the draft resolution.
5. We note that while a national emergency response and patient transport ambulance services and pre-hospital care has been touched upon, it is under-stated. Much work would have to be done in this area.
6. One specific challenge is the tension between the lack of finances (and importance) for primary healthcare and the need of increased finances for secondary and tertiary care. The latter has to be fulfilled without compromising the former.
7. Finally we need to go beyond expanding availability of such services to making it available as part of the right to healthcare. While physical access is part of the requirements, it is

not all of it. A rights based approach would also address challenges related to equity, affordability and discrimination.

8. We hope that civil society participation and representation for weaker sections and the sensitized professionals is strong enough in the process to ensure that these concerns are addressed adequately.

Social participation for UHC, health and well-being

The Board also considered a draft decision ([EB154/CONF./10](#)) to recommend that the Assembly adopt a resolution on social participation for UHC, health and well-being. The Board did not find consensus on this proposed draft resolution and it was agreed that further intersessional discussions would proceed with a view to achieving consensus on a final draft to be brought to WHA77. No such draft has yet been published.

There are only a few bracketed references in the proposed resolution. One of these (PP6) reflects resistance to applying a gender sensitive or gender responsive perspective in the development of health related policies and plans. In two paragraphs (PP6 and OP1(2)) the choice of [persons/people/those] was the obstacle to consensus.

PHM strongly supports the purpose and direction of the proposed resolution. It is perplexing that some member states do not think that health related policies and programs should be responsive or sensitive to gender related differences in people's needs.

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

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
 - [Comment on EB154/7](#)
 - [Comment on draft resolution on transplantation](#)

In focus

Extract from DG's Consolidated Report ([A77/4](#)):

The Executive Board at its 154th session noted the report on the prevention and management of noncommunicable diseases, promotion of mental health and well-being, and treatment and care of mental health conditions ([EB154/7](#)). It adopted decision [EB154\(7\)](#) on increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs, in which it recommended to the Health Assembly, inter alia, the development of a global strategy on donation and transplantation for consideration by the Seventy-ninth World Health Assembly, through the Executive Board at its 158th session. A77/4 (para 22) invites the Assembly to adopt the resolution recommended by the Board in EB154(7)

The Board also considered the text of a draft resolution introduced by Member States on strengthening mental health and psychosocial support before, during and after armed conflicts, natural disasters and health and other emergencies ([EB154/CONF./11](#)). The Board agreed that consultations on the draft resolution would continue during the intersessional period. In the discussions, Board members highlighted the need to include noncommunicable diseases and mental health in primary health care and universal health coverage.

Board members welcomed the global oral health action plan 2023–2030 and the planned development of a global status report on cancer 2025 and called for regular information updates to support Member States in preparing for the fourth high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases.

Background

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

Record of debate at EB154: [M6, page 14](#) and [M7, page 2](#).

PHM Comment

PHM comment on Secretariat report EB154/7

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.

Draft Resolution ([EB154\(7\)](#)) on “increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs”

The PHM welcomes the draft resolution (transmitted in [EB154/7](#)) and urge that the Assembly adopt the resolution. WHO has been involved for some time in collecting global data as well as providing guidance to countries in this field through periodic guiding principles. However, we note that there exists a significant gap between the WHO’s guiding principles and the reality on the ground.

The field of cell, tissue and organ transplantation has seen major advances both in science as well as in clinical applications in the last few years. The main public health approach to the management of chronic disease leading to organ failures has to be a good quality and coverage of both primary and secondary prevention. However, given the size of the NCD epidemic, and the increasing effectiveness of transplants as compared to other costly maintenance therapies, transplantation is now an important part of the treatment of end stage organ failure. The field is both resource and cost intensive and the activity in the field is currently largely restricted to high income countries. Given the risks to the ‘living donor’, organs from ‘deceased donation’ need to be promoted as the primary source of organs. This has happened in some high-income countries.

There is an urgent need for countries in the Global South to have enabling legislation as well as facilities for their residents to benefit from these advances. All of the problems of inequity in

access occur in their most severe forms when we are considering access to transplantation. This is further aggravated in certain countries by the increasing involvement of the private sector, stimulated by much higher profit margins. In some countries the private sector has occupied space left vacant by the state health system. Given the high profit incentives in the private sector this has resulted in unethical and even criminal activities. This phenomenon has not been adequately addressed in the document.

We note with concern that in spite of legislation in several countries this field continues to suffer from widespread unethical and criminal activities including organ trafficking. Given the demand supply gap in the availability of organs and the vulnerability of certain sections of society both coercion and financial inducement of living donors is well known. Also since transplantation is available only in a few countries, there is large scale travel for medical reasons across borders. This includes both legitimate travel as well as travel for the purpose of paid organ donation (transplant tourism). In some parts of the world transplant tourism forms a significant part of the medical tourism industry. The document does not clearly point out the dangers of promoting travel for transplantation as a part of medical tourism which could be a cover for illegal transplantation.

While the draft resolution covers a fair amount of ground we would urge that it takes a clearer stand and provides recommendations on the following issues

1. The responsibility of governments to ensure the development of organ and tissue transplantation as an integral part of its healthcare system and discourage its movement to the private sector. This involves allocation of specific budgets as well as building capacity in the state sector.
2. The responsibility of governments to protect vulnerable groups within the country from being coerced or incentivised into donating organs for those higher in social hierarchy. In addition to the historical vulnerabilities of gender, class, caste, ethnicity, minorities and the politically persecuted there is recent evidence of migrants being lured for donation.
3. Whilst governments should promote both deceased as well as living donation they also need to ensure that the donated organs especially from deceased donors are allocated on transparent criteria rather than the ability of a recipient to pay for the transplant procedure. *In other words treat the donated organ as a public good which is distributed on the principle of equity and justice.*
4. The responsibility of governments to commit themselves to high levels of ethics and transparency both in their domestic transplant policy as well as for trans-border movement of patients and organs
5. The mandate for providing complete and reliable data to global databases. This includes data on travel for transplantation both out and into the country as this is crucial to curb movement of individuals for unethical transplantation.
6. The responsibility of UN arms like the UNODC and Interpol to provide assistance to local regulators and law enforcers to crackdown on organ trafficking especially that involving transborder movement.

Finally we note that though modern organ transplantation has provided a lease of life as well quality of life for those suffering from end stage organ failure given the enormity of the challenge the global community must continue to strive for prevention. Even as transplantation numbers may go up, there must be a clear measure of transplantation requirement rates per population and per chronic disease population going down.

We are also concerned that the increasing availability of deceased donors should not be due to failed preventive measures, of which perhaps the most important in LMICs is road safety, especially pedestrians and motorcyclists involved in road traffic accidents due to very poor road safety measures.

11.3 Infection prevention and control

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
 - [Global action plan](#)
 - [Draft resolution](#)

In focus

Extract from DG's Consolidated Report ([A77/4](#)):

The Executive Board at its 154th session noted the report concerning the draft global action plan for infection prevention and control ([EB154/8](#)). It adopted decision [EB154\(8\)](#) in which it recommended to the Health Assembly the adoption of the global action plan and monitoring framework on infection prevention and control, 2024–2030.

A77/4 (para 22) invites the Assembly to adopt the resolution recommended by the Board in EB154(8)

Background:

[Tracker links](#) to previous global GB discussions of IPC

[Global strategy on infection prevention and control](#) and Executive summary ([EB152/8](#)).

PHM Comment

This agenda item has assumed considerable urgency after the Covid 19 pandemic where hospitals were a major source of spread and because, due to this risk, routine services were disrupted. It is also a focus of attention because this is closely related to AMR agenda, which has emerged as a major global health crisis, and there is a UN High level Summit coming up in September this year.

Global action plan

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 WHA 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 from investing in raising public health standards and health facility strengthening.

The indicators specified in relation to IPC are needed for IPC but would also be more useful and actionable 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 the roadmap to 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.

PHM cautions and recommendations in resolution [EB154\(8\)](#)

PHM welcomes and appreciates the WHO initiative in this area. However it makes the following observations and cautions about the draft resolution as currently drafted:

- a) There is no link made between IPC in the community and in the facility, though in the real world this cannot be separated. Even the resolution on IMR addresses this together. Addressing it in the community needs public health standards that are legally enforceable. It also requires community engagement. We also note that this strategy as it stands could have been better named “IPC in the public hospital” which is only a sub-

set of “IPC in all hospitals” and which latter is only a sub-set of IPC on scale in the entire population.

- b) The whole strategy, even if limited to public health facilities, is far too much of a vertical silo approach, with very little integration despite having one of the 8 strategies named as Integration. It calls for IPC dedicated committees, workforces, data flows, professionals, investment plans, financing and so on. Every sub-component including something like hand hygiene is presented as a national vertical and there are many such sub-components. That is unlikely to happen or sustain. Each of these must be integrated into corresponding system components. Illustratively:
 - i) HR for IPC is part of facility HR planning
 - ii) Data for IPC/HAI/WASH is part of hospital information systems and this should feed into data surveillance systems
 - iii) HAI and AMR monitoring is part of microbiological/laboratory capacity in the facility
 - iv) Training and certification and audits should be a part of facility management and quality assurance programmes. IPC is one element of QA and cannot be sustained as a stand-alone outside other elements of QA.
 - v) Committees and workforces could be part of facility development and quality assurance committees and not stand-alone IPC committees and these should have informed and adequate social participation.
 - vi) Financing for IPC cannot and should not be distinct from financing for facility strengthening and quality assurance.
- c) There is no mention of how any of these will be achieved in the private sector. Private sector regulation has to incorporate this- but any form of quality, ethical or price regulation is not in place in many countries.

On the whole though it is a step in the right direction it is a very incomplete proposal with many cautions. The targets set are too modest and if it is well integrated there is little reason why more countries cannot undertake many of the strategies which are quite basic. But as stand-alone even these targets are unlikely to be met.

9. Immunisation agenda 2030

In focus

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the report on the Immunization Agenda 2030 ([EB154/9](#)). In the discussions, Board members voiced support for the shared action agenda and its six short-term priority areas, and especially the "Big Catch-Up" initiative. They expressed concern over the rising number of outbreaks, particularly measles, and underscored the need for recovery of coverage levels and catch-up of children missed during the COVID-19 pandemic.

Background

[IA2030 Global Report 2023](#)

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

PHM Comment

WHA 77 is invited to endorse the report on progress towards global immunization goals and implementation of the Immunization Agenda 2030. The report is the same as that made to the EB and therefore the PHM response remains the same. See [PHM Comment at EB154](#)

In brief the DGs 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. Challenges persist in eliminating polio and measles and there are outbreaks of a number of diseases especially measles and cholera. The report stressed 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) and a "Big Catch-Up" initiative aimed to bridge gaps caused by missed vaccinations during the pandemic years and restore immunization trajectories.

PHM makes the following observations with regard to the report and IA 2030:

1. For national immunization strategies, robust public primary healthcare, centered on communities and territories, is of 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. The current UHC strategy, as implemented de facto with its focus on strategic purchasing from private sector is not fit for this purpose. Its failure is particularly evident when it comes to reaching marginalised

communities or when the systems comes under stress like what happened during the pandemic.

2. 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. Immunization never succeeds in isolation from other public health interventions. Yet, the emphasis on immunizations more often than not substitutes for all the other public health interventions that are required. No mention is made of this concern in the report.
3. Immunization coverage is highly dependent on an adequate density of trained motivate health workers in the public health services with an optimal geographic distribution. The report's lack of emphasis on health workers and their role within the Immunization Agenda needs correction.
4. The challenges associated with lack of health workers and supply chains is worst 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.
5. The DG's report does not address issues concerning corporate power and vaccine affordability and availability. Vaccine production has increasingly fallen under the control of major pharmaceutical companies primarily based in Western Europe, the USA, Japan, and more recently, China and India. 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 made clear that vaccine innovation is heavily funded by public resources and yet the government does not have any rights over the intellectual property created. Measures such as TRIPs waivers, implementation of TRPs flexibilities such as compulsory licensing, transparency regarding innovation and manufacturing costs, technology transfer, including the sharing of biological material samples, are all 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. The DGs Report and IA 2030 do not address these issues adequately.
6. PHM calls for transparency on what part of the health budget and within that the primary healthcare budget is now going to vaccines and whether the WHO targets on introduction of more vaccines for both children and adults are cost-effective and scientifically prioritized within the current and projected budgets. There is a concern that with the currently constrained public health budgets, money spent on vaccines profits private pharmaceuticals while also displacing other essential clinical care into the private sector. The failure to introduce some of the vaccines approved and promoted by WHO may indeed be rational decisions for many countries, given the lack of financial support they have. In the above context it is important to ensure 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;

10. End TB Strategy

In focus

Extract from DG's consolidated report (A77/4):

The Executive Board at its 154th session noted the report on the End TB Strategy ([EB154/10](#)). In the discussions, Board members expressed strong support for WHO's leadership in the fight against tuberculosis. They highlighted the need for increased investment, multisectoral collaboration, equitable access to tuberculosis services, and research and innovation in order to achieve the goals and targets agreed in the End TB Strategy and the [2023 political declaration](#) of the high-level meeting of the General Assembly on the fight against tuberculosis.

Background

[End TB Strategy](#): Global strategy and targets for tuberculosis prevention, care and control after 2015.

[WHA67.1](#): adoption of End TB Strategy

[PHM Comment from EB154](#) (Jan 2024)

[PHM Comment](#) at 2023 UNGA HLM

PHM Comment

As if reaffirming the PHM comment in January 2024 for the EB154, despite the picking up of progress and recovery in 2022, indicators continue to be far behind from the target objectives, more so in the 30 countries with the highest tuberculosis burden. Incidence and mortality continue to be high, treatment coverage stagnates and preventive treatment rises too slowly.

All these are still related to the glaring problem pertaining to the lack of access to treatment, or poor facilitation especially in public institutions. Poor socioeconomic safety nets for possible financial burdens on patients and their families, especially in vulnerable populations and in high-TB burden countries, also remain to add to patient burden. A significant number of symptomatic cases are still missed, either due to the costs of care leading to catastrophic health expenditures, or that they simply do not seek out interventions due to fear of the expenses or do not have an adequately functional and acceptable primary care team which they can access. Another factor is the societal stigma that comes with TB, due to the poor engagement of the programme with local communities and considerable misinformation and fears about the disease.

The access to rapid diagnostic tests, still barely covers half of the 100% target due to a variety of supply side barriers, including difficulties in procurement of kits and reagents, supply chain management issues and capacity building for the tests. Meanwhile earlier forms of diagnosis fail

to achieve the necessary access and outreach that is required to pick up the high levels of latent disease in the population.

It is also uncertain of reaching targets for detection and treatment of latent infection, when reaching out to disease itself is such a problem.

The policy document does call for addressing social determinants such as nutrition and occupational health and over-crowding- but there are not issues programmes that can be addressed by TB divisions. These are structural determinants, that require changes in government policy and quite often a changed ideological approach to welfare and public goods.

Most of the high TB burden countries continue to be areas with poor primary health care. In the absence of universal access to free primary healthcare provided by public or not for profit providers, there is no progress on reduction of high out-of-pocket expenditure for the common patient despite government-run TB treatment programs and poor access to drugs and diagnostic modalities, which include newer drugs to combat multi drug-resistant TB remains a big issue. Poor public expenditure for facilities and health worker hiring for local health stations, especially far-flung areas contributes to the gaps in primary healthcare and access to drugs and diagnostics.

The End TB strategy was based on a prediction that a new menu of vaccines, diagnostics and medical regimes would become available by 2025. There has been limited progress on tuberculosis vaccines but these are far from proven and not as yet approved for scaling up. Progress on medicines and diagnostics are also limited. Part of the reasons for this is that the scale of investment in TB research and innovation has not been met. But equally responsive for the slow development of novel tuberculosis vaccines, diagnostics, medicines and other critical research projects is the current regime of innovation and development, and patent barriers. Even if they are developed in the coming few years, given the current IPR and manufacturing regimes it is uncertain whether these technologies can be available at affordable costs.

Countries face the above issues to different degrees. This requires that WHO should engage country governments to investigate concrete causes happening on the ground that affect health intervention delivery. This uniform policy with regard to the introduction of same new strategies and technologies across all countries with widely differing health systems capacities, social contexts and access to technologies is not working.

This is also particularly true when taken in conjunction with flawed or inadequate implementation of universal health coverage which seeks to purchase healthcare from private providers rather than provide through free or subsidized public providers. Universal Health care based around universal primary healthcare. are essential foundations for programs like TB interventions. Advancements in diagnostics and treatments may be developed, but these will all be useless if existing policies and institutionalized systems on the ground do not reach the target populations to stave off the effects of this disease. Catastrophic Health Expenditures, especially for multi-drug resistant TB, is still a major risk for patients. WHO should be concerned in interacting with countries for both increasing funds and for ensuring that these are prioritized for better integrated non-market based forms of primary healthcare.

Furthermore there is a lack of provisions and engagement with country governments in bolstering other social determinants that allow tuberculosis to become more rampant. Such issues include the poverty, under-nutrition, migration, displacement, war and conflict, unplanned distress urbanization etc experienced by vulnerable minority populations, especially in the Global South, due to the financial burdens exacerbated by the COVID-19 pandemic waves require to be addressed more comprehensively. To reiterate the previous PHM commentary on EB 154: *“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”*.

Without socioeconomic safety nets in place, sub-optimal health-seeking behaviors will be inevitable, especially in lower economic classes. Tuberculosis is seen as a disease of poverty affected by poor food security, poor housing, poor social services. Though this is the case, and curative aspects must be addressed, there should also be steps to engage governments to take the necessary precautions for prevention, especially for the 30 mentioned countries with the highest TB burden. There should also be corresponding approaches in the adjacent sectors that address these determinants that contribute to the spread of this disease, particularly in agriculture, appropriate and affordable housing, and grassroots social services.

We thus reiterate our calls laid out for EB 154: besides the targets of “increased investment, multisectoral collaboration, equitable access to tuberculosis services, and research and innovation”, we once again call on the WHO to bring more into focus multisectoral efforts to address social determinants that shape the conditions continuing the Tuberculosis epidemics.

To summarize, PHM calls upon the WHO to re-think the End TB Strategy by a much greater emphasis on the following components.

1. Primary health care must be strengthened, universalized and delivered as a free public service and the community-based, government-run TB intervention programs should be an integral part of this.
2. Insist on a whole of government approach in addressing social determinants affecting TB, through better food security, greater gender and income equity, , appropriate housing, sustaining affirmative action in migrant and displaced populations, and other social services for all.
3. In conjunction to #2, there is a need to identify and address country specific roadblocks that exist in real time, especially in the high-TB burden countries, and to engage country governments in formulating solutions using the appropriate mix of technologies and strategies. Also ensure more appropriate country-specific End TB Strategy milestones and deadlines, while taking into account their ground realities. Re-align global deadlines based on this, rather than proceed top-down, based on models that seem to be based on unrealistic assumptions.
4. Ensure that the global policies for access to TB vaccines, medicines and diagnostics are in line with what the majority of LMICs especially the group of African countries are demanding in the pandemic treaty negotiations – which includes waiver of TRIPs conditionalities, transfer of technologies for promoting domestic and regional manufacture, major reductions in the costs of these essential commodities and government pooled procurement as necessary.

11.6 Roadmap for NTDs, 2021-2030

In focus

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the report on the road map for neglected tropical diseases 2021–2030 ([EB154/11](#)). In the discussions, Board members acknowledged the protracted impact of the COVID-19 pandemic on the financing and performance of health programmes. They noted the need to sustain innovation for medicines, diagnostics and strategic approaches, notably to tackle threats such as climate change, which can have a major impact on the epidemiology of neglected tropical diseases, and acknowledged that challenges in accessing treatments persisted. Board members noted the progress made, including the acknowledgement by WHO of the 50th country to eliminate one neglected tropical disease, and the inclusion of noma in this group of conditions.

Background

[Global report on neglected tropical diseases 2024](#)

See also [Wallace Review of Global Report](#)

[PHM Comment](#) from EB154 (Jan 2024)

PHM Comment

The report on progress made on the roadmap for NTDs 2021-2023 was presented to EB 154 and has been elaborated in the <https://www.who.int/teams/control-of-neglected-tropical-diseases/global-report-on-neglected-tropical-diseases-2024>

Given the fact that NTDs is not one programme, but a bundle of 28 programmes each with its own respective dynamics, we share a [brief power-point presentation on the global report](#) prepared by a PHM WHO Watcher Aletha Wallance for ease of reference to the full report.

In summary, the report described how COVID-19 pandemic had adversely impacted the financing and performance of NTD programmes, the impacts of climate change on epidemiology of NTDs; the persisting access to barriers for treatments; and the continued need to sustain innovation for medicines, diagnostics and strategic intersectoral approaches. It emphasized that even as compared to other routine health services, NTD programmes suffered the greatest disruption, leading to putting the whole programme off track.

As a first general comment, it's important to reaffirm what [PHM already said during the EB154](#). It is impossible to imagine any significant progress without proper financing. One of the key fragilities of the current roadmap is made crystal clear by the Covid-19 pandemic: many

programs were disrupted, funding and workforce were reduced, priorities of donors and richer nations changed amidst growing geopolitical tensions, rise of militarism and war and uncertain economic scenarios further reduced an already inadequate level of funding. As PHM stated on that occasion, accepting any budget reduction to NTDs programmes means giving up on building solutions for preventable diseases that affect the most vulnerable, cause suffering and cost many lives around the Global South. And it is admitting that neglected diseases will continue to be neglected. Reliance on one-disease specific donors whose funding is unstable and unpredictable will also continue to halt the progress.

Lack of a financing plan: The current worrisome situation is that (Section 3.3.2 of the report-Costing the road map), even WHO does not have an estimation on the costs of implementing the roadmap and achieving the goal. While WHO faces major difficulties with the lack of economic data - the number of countries reporting on NTD expenditure is just six. In the face of the huge withdrawal of resources from the programmes, the fundraising and advocacy strategy is still focused on convincing the same past donors to keep their same inadequate funding mechanisms. This is too little for the challenges ahead and even for the limited approach proposed by the roadmap.

Financing NTDs is a part of increased public health expenditure: There is a need for the funding of NTDs programmes to be reviewed completely. First, it should rely much more on public spending, which in turn implies the need for tax justice, and debt relief for the countries in the Global South and the end of austerity measures that hinder the local capacities of funding and structuring integrated approaches for NTDs. This is also key to expanding health coverage and strengthening public health systems as a whole. This needs greater priority in WHO's advocacy effort. Even in cases when external aid and donations are necessary, the administration and allocation of resources should be done by the public health system and the local health authorities while integrated into comprehensive health, environmental and social policies.

Breaking with the vertical approach: But the problem goes beyond funding volume and mechanisms. A key problem in the conceptualization of the roadmap is insisting on the old formula of implementation of disease-specific programmes, based mainly on the introduction of biomedical technical solutions, vertically implemented, funded by private donors and rich nations with the aim of taking 'aid' to poor countries and to selectively control and eliminate diseases that limit economic productivity and supposedly cause poverty. Over the last 60 years this strategy and conception have been shown to be insufficient, inadequate and ineffective, accumulating much more failures than success - the history of malaria and tuberculosis programmes (and many others) are there to tell. This is for several reasons. If the vertical approach was a problem for malaria and TB, it is absurd to think of such an approach for others on the list like scabies, or helminthiasis, or snake envenomation or food borne diseases. It is neither possible nor desirable to build 28 demarcated vertical programmes except perhaps in the area of research. Yet each of these diseases have different proximate social determinants and are at very different stages of elimination.

Fragmentation: A closely related reason for the current roadmap being inadequate is that organizing vertical interventions based on specific diseases leads to huge fragmentation of healthcare and health systems, once each program tends to have its own structure, management, staff, information, funds and procedures while other important health needs are not covered. This approach is based on the wrong assumption that each disease can be best tackled individually and set apart from other health conditions, and as if the biomedical disease causes could be isolated and treated with targeted interventions and focussed management of proximate risk factors. This is especially promoted by external donors in low income countries with poor health systems. In the end, this model leaves for the ministries of health and national health systems to be the administrative managers of private projects conceived from abroad. Although new “pillars” such as the introduction of “cross-cutting approaches” and “change operating models and culture to facilitate country ownership” try to alleviate some of the consequences of the model, the essence of the roadmap is still the same.

NTDs, UHC and PHC - the strategy mismatch: The point is that any attempt of controlling NTD's will fail if it does not come together with the strengthening of public and universal health systems grounded in comprehensive primary healthcare and social participation. At minimum, any NTD strategy should be closely linked to broader health systems strategies. But this strategy is unable to integrate with the Universal Health Coverage (UHC) approach, where the UHC approach is focused on the promotion of segmented mixed insurance schemes. The limited nature and scope of UHC makes it hard to fit the NTDs programmes into it's framework. One example of why this fails is in the reports admission of a failure to reduce out of pocket expenditure on NTDs. This is very difficult to achieve on a disease by disease basis- especially since the therapeutic part for addressing severe disease is only a small part of the overall strategy. Neither the preventive measures, nor the mass chemotherapy and vaccination measures will fit into UHCs minimum essential packages approach.

It's not a coincidence that WHO is still struggling to get recognition and inclusion of NTD's intervention coverage as tracers for progress on UHC (see section “3.2.3 Mainstreaming within national health systems”). In other words, while those worried with NTDs point out that confronting those diseases is key to achieving UHC, the UHC strategy doesn't seem to be worried with many things beyond what they measure for coverage and financial protection. And in this matter, as the recent WHO assessment showed, that the world is far out track of achieving progress on the SDG goals related to the UHC. Additionally, the same session recognizes the importance of PHC for NTD's intervention's success, but the roadmap as whole doesn't point to any consistent action to address this need. At the same time, the UHC preference for private provided essential services hinders more comprehensive approaches of PHC which includes not just NTDs, but a much broader scope of health needs, with community engagement, social participation, cultural competence, and intersectoral action in the territories.

Social determinants of the NCDs: The NTD programme touches on some proximal social determinants like hand hygiene or sanitation addressed through WASH but it does not touch or consider the social determination of the production and reproduction of NTDs which are subsumed to other broader social, economical and political processes.

A good example of this limitation is the current dengue outbreak in Latin America. The incidence in 2024 is 243% bigger than in 2023 and 445% than the average of the last 5 years. In the past decades, Dengue has expanded to new countries and areas that weren't endemic before. The traditional approaches of vertical programmes and vector control have been failing dramatically while it concentrates on the *Aedes aegypti* elimination, including the questionable use of pesticides. The fact is that vector proliferation is boosted by structural processes and conditions such as the poor urban infrastructure, sanitation and living conditions in segregated big cities, the extractivist economic model that devastates ecosystems, rising of the average temperature and the intensification of extreme climate events such as floods, rain storms, droughts, heat waves and so on. While new patented dengue vaccines with poor local production start being sold as the new hope for mitigating dengue's impact and will pressure health budgets across the region, the WHO and MS should have a much better look if the current approach is not just wiping ice.

The determinants can also be very different. For example, addressing rabies requires an inter-sectoral action which is very different from one required for addressing filariasis and so on. Reading the report we get the impression that an excessive reliance on mass chemotherapy or vaccines seems to be diminishing the emphasis required on addressing the social determinants.

Access to Technologies: Third, even though the strategy of the roadmap relies a lot on innovations, medicines and diagnostics, the commercial determinants of the access to the products are still being neglected and solutions that go to the roots of the problems are ignored. And funding gaps for medicines and diagnostic tools continue to hamper progress. As PHM stated on the EB154, the WHO proposes 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.*

Conclusion

PHMs notes with concern that there is still slow progress made in achieving the targets and indicators set out in the Global NTD roadmap 2021 -2030 and on many of the NTDs most countries are off track. There are both problems of design and implementation that underlie this failure. Some of these are summarized below:

- The single most important reason for this failure is the lack of financing- both at the global and at the country level and PHM calls for an increased public health expenditure directed at strengthening public health services into which the NTD programme is integrated as the way to achieving this.

- While WHO's acknowledgement of neglect of these diseases and efforts drawing attention to them are welcome, the design suffers from an impractical and inefficient overly vertical approach for each NTD and for NTDs as a whole. The WHO target of each country having to eliminate one NTD at a time is axiomatic of this flaw in the strategy and must be reconsidered. Resources and efforts must be directed to diseases causing the greatest suffering for the most, and not an abstract goal of certifying elimination because it is a target. We caution that the pressures to declare and certify elimination can be associated with premature declarations and a number of other undesirable effects. For many diseases (scabies is a good example) the disease is an indicator of a set of social dysfunctions that must be addressed rather than something which can be eliminated without addressing the social dysfunctions.
- The programme for elimination of NTDs is not compatible with any interpretation of UHC that makes it more insurance and strategic purchasing based. It requires universal free primary health care by a network of public providers as a pre-condition for its success. Many specific NTD disease strategies are based on mass chemotherapy. Where universal primary healthcare is not in place, such mass chemotherapies draw away scarce primary healthcare resources, especially human resources from other activities which are of much greater priority. Evaluation of success of single NTD elimination must be set against deleterious effects it has on other NTD priorities- much like the emphasis on Covid 19 interventions set back all NTD programmes.
- In many NTDs there is need for more innovation to find better tools and in others there is a problem of access and affordability to required technologies which are already available. The current global innovation, manufacture and supply chain regimes are unable to meet these needs and must be reformed on the lines of what has been suggested by LMICs led by the group of African nations in the Pandemic treaty negotiations: TRIPs waivers, technology transfer, domestic manufacturing capacities and pooled resources to ensure that no country in need faces scarcity in supply.
- Calls to include NTD in the global health architecture of health emergencies and pandemic preparedness and as a priority action in the AMR Global Action Plan.
- Need for capacity strengthening across all sectors (health and non-health sector) focusing on agriculture including animal husbandry, natural resources management, urban planning, and industrial and trade policy and environment policy so as to adequately address the many social determinants of NTDs. We note that climate change is a phenomena that cuts across all sectors and its impact on NTDs and their prevention must also be factored in.
- Dynamic incidence and prevalence data relating to NTDs are challenging, in terms of both their completeness and their timeliness, and there are difficulties associated with collecting reliable data on several NTDs. This calls for measures to improve quality and quantity of information that must be well integrated with other health data sources whose functionalities are optimized, instead of opting for vertical reporting systems- digitized or otherwise for each NTD.

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

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
 - [Comment on EB154/12](#)
 - [Comment on draft resolution](#)

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).

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the report on acceleration towards the Sustainable Development Goal targets for maternal and child mortality ([EB154/12](#)). It considered the text of a draft resolution introduced by Member States on accelerating progress towards reducing maternal, newborn and child mortality in order to achieve Sustainable Development Goal targets 3.1 and 3.2 ([EB154/CONF./4](#)). The Board agreed that consultations on the draft resolution would continue during the intersessional period. In the discussions, Board members expressed concern that many countries were not on track to achieve the targets for reducing maternal and child mortality by the year 2030.

Background

WHO [Global Health Observatory / SDGs](#)

See earlier [PHM Comment on EB154/12 \(from EB154 in Jan 2024\)](#)

PHM Comment

EB154/12: Acceleration towards the Sustainable Development Goal targets for maternal and child mortality

[EB154/12](#) notes the 'critical importance of government leadership and a whole-of-government and whole-of-society approach in improving maternal, newborn and child health'. While this

observation is laudable, the corresponding recommendation point (OP 1.1) presents this as a “strong country leadership and management capacity”-an approach that tends to be technocratic and apolitical. Undemocratic forms of governments and increasing setbacks on SRHR globally must be underlined. Maternal mortality like other women’s health and gender health issues suffers from deprioritization by the policymakers and severe paucity of a comprehensive gender transformative approach to building an equitable, resilient and accountable health system nationally.

The EB 154/12 report highlights the preventable deaths due to inadequate maternal and neonatal healthcare globally, primarily in low and middle-income countries and low-resource health settings. The report emphasizes the impact of social determinants on maternal health, particularly affecting the poor and marginalized populations, leading to hindrances in socio-economic development and the achievement of Sustainable Development Goals (SDGs). Despite prior advancements, progress in addressing these issues has stalled in recent years.

The report underscores the need for government leadership and a comprehensive, inclusive approach to improving maternal, newborn, and child health. However, it must be pointed out that the corresponding recommendation point (OP 1.1) seemingly favors an approach that is technocratic and apolitical. The current emphasis on "strong country leadership and management capacity" may overlook the political and democratic aspects of governance, especially in the face of global setbacks on sexual and reproductive health and rights (SRHR). The report emphasizes the deprioritization of maternal mortality and other women's health issues by policymakers and the lack of a comprehensive gender-transformative approach to establishing equitable, resilient, and accountable national health systems.

Maternal, child health, and sexual and reproductive health rights: a reproductive and social justice issue

PHM welcomes the EB 154/12 focus on this agenda and strongly recommends that WHO urge the MS to adopt a comprehensive SRHR and reproductive justice framework to address the critical issues at hand.

The EB 154/12 agenda focuses on maternal and child health, which is influenced by socioeconomic, nutritional, and environmental factors. It is crucial to support local research in particular settings and for particular population groups regarding the social determinants of inequities in accessing safe childbirth, safe abortion, and comprehensive women's and adolescent healthcare, especially in low and middle-income countries.

In the pursuit of Universal Health Coverage (UHC), it is essential to emphasize strong primary healthcare settings to prevent the medicalization of women's bodies. This comprehensive approach should prioritize building low-cost primary care during pregnancy and promoting the role of midwives during delivery.

National policies should align with this holistic approach, considering social and geographical contexts. It is important to recognize and support community health workers, many of whom are

women from rural and marginalized areas. Strengthening this workforce is crucial for improving primary and routine healthcare for women and children.

Comprehensive maternal healthcare requires a robust health system at various levels, with appropriate linkages and referrals to diagnostics, treatment, and care facilities. Monitoring mechanisms are needed to ensure quality care and respectful treatment, addressing issues such as obstetric violence and discrimination based on race, ethnicity, caste, class, and other identities.

Health facility-based protocols for ensuring behavioral and systemic accountability are critical in addressing these issues.

Developing evidence-based interventions requires attention to new developments and existing policies that significantly impact access to care, mortality, and morbidity. Restrictive abortion laws and mandatory full-term pregnancies undermine women's consent and rights. The lack of childcare resources and austerity measures limiting maternity benefits and social security entitlements also hinder these goals.

Policies hostile or indifferent to reproductive justice disproportionately harm marginalized groups, including Black, Dalit, Tribal/Indigenous, and other marginalized women, as well as women with disabilities, immigrants, and undocumented individuals within their own political contexts.

Acknowledging structural inequalities as fundamental drivers of maternal and child health issues

The impact of poverty and the globalization of marketing and trade can significantly compromise the health of children and the overall population (for example-marketing and sale of sub-par quality baby food products in several countries-particularly global south). Health outcomes are heavily influenced by the social and economic environments in which they occur, and these factors can vary greatly from one context to another. As a result, it is crucial to gather evidence at all levels to understand and address these disparities. In particular, reproductive health inequities are directly worsened by social and economic injustices, including policies that limit women's ability to make decisions about their reproductive health and their rights to determine the course of their own lives and the lives of their children and families.

Similarly, it is not sufficient to recognize the need for maternal health policies within humanitarian settings. Such a demand must be complemented with the demands and accountability from MS to control and reduce the situations of wars, conflict and immigration. This only proves the point stated above how setting maternal health agendas in a way that no one is left behind is inextricably linked to the global policies at the broader level and must be recognized as such

Draft resolution

The draft resolution (in [EB154/CONF./4](#)), sponsored by Somalia with the support of Egypt, Ethiopia, Paraguay, South Africa and Tanzania, aims to accelerate progress towards reducing maternal, newborn and child mortality in order to achieve Sustainable Development Goal targets 3.1 and 3.2.

However, it was clear from the extensive bracketing in the draft that there was no consensus around the proposed resolution.

During the debate (see [M12, page 6](#)), Iran objected to ‘non-consensual language’ which appears to have included: ‘unsafe abortion’ (PP2 bis), ‘gender equality and empowerment of women and girls’ (PP3), ‘sexual and reproductive health and reproductive rights’, ‘girls to make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care’ (PP5), ‘child marriage’ (PP6), ‘early and forced marriage’ (PP6 ALT). Many clauses have been bracketed for reasons which are unclear.

PHM affirms that the Somalian draft resolution ([EB154/CONF./4](#)) offers a clear analysis and urges progress on several important fronts.

As noted earlier, progress to reduce the global maternal mortality ratio has stalled and 54 countries are off track to end preventable deaths of newborns and children under 5 years of age.

PHM deplores the assumptions about women, girls and sex which appear, from the extensive bracketing, to have led to the holdover of the draft resolution.

A revised version of this draft resolution has not been published at the time of writing.

11.8 Antimicrobial resistance

In focus

[A77/5](#): WHO strategic and operational priorities to address drug-resistant bacterial infections in the human health sector, 2025–2035.

The Executive Board at its 154th session in January 2024 noted an earlier version of this report ([EB154/13](#)) and considered the text of a draft decision introduced by Member States ([EB154/CONF.7](#)). The Board anticipated further informal consultations among Member States on the draft resolution during the intersessional period.

The present report (A77/5) incorporates feedback on the draft strategic and operational priorities from Member States and partners during the session and through the online consultation. A revised version of the draft resolution proposed in [EB154/CONF.7](#) is also anticipated.

In 2024 a high level meeting of the UN on the theme of AMR is scheduled. This current report ([A77/5](#)) is a part of the build up towards the UN Meeting on antimicrobial resistance scheduled for later this year.

Background

See also [PHM Comment on EB154/13](#) (Jan 2024).

See record of debate at EB154 [M12, page 24](#) and [M13, page 9](#)

PHM Comment

[A77/5](#), posted for this item is a revision of [EB154/13](#) considered by the EB in January. The revision is based on the intersessional discussions.

WHO strategic and operational priorities to address drug-resistant bacterial infections in the human health sector, 2025-2035

1. The first five paragraphs of A77/5 (DG report dated 11th April, 2024) 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 in paragraphs 6 to 10, the earlier efforts by WHO with regard to AMR and the creation of a quadripartite alliance to address it as part of a comprehensive One Health approach. The Quadripartite organizations consist of WHO, the Food and Agriculture Organization (FAO), the United Nations Environment Programme (UNEP) and the World Organisation for Animal Health (WOAH). All have endorsed the global action plan drawn up in 2015 (in [WHA68.7](#)), and agreed on multisectoral actions for its implementation. The other three have adopted sector-specific strategies against AMR, and this is the WHO's step to do the same in the human-health sector.

As of now 170 countries have made national plans, though only 27% report progress on effective implementation of these (para 7) and only 11% have provided a budget for this.

2. The strategic vision (para 11) and the four strategic priorities (paragraph 12) are most welcome. To quote “ The strategic vision underlying the development of the priorities is the control and reversal of the urgent public health and socioeconomic crisis due to drug-resistant infections in humans, as a crucial contribution to the global effort to build a healthier world for all”. PHM hopes and calls for an interpretation of a healthier world for all to include all the elements of nature in the Buen Vivir sense and not be limited to narrow reductionist anthropocentric interpretation of the same.

3. The recommendations proposed are cast as “four urgent strategic 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 termed strategic information, science and innovation and includes surveillance of both antimicrobial resistance and antimicrobial consumption/use as well as the development of new vaccines, diagnostics and antimicrobial agents; and measures to make these accessible and affordable; and the fourth is called governance and financing.

4. 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. Links to these reports have been provided. However a brief discussion of each of these showing the points of convergence is required.

5. Paragraph 20 which elaborates the first strategy of prevention of infection is a very brief statement of intent that flags some proximal determinants of infection. This is inadequate to guide action or measure progress. The structural determinants of the high rates of infection in the poor and marginalized as well as the proximate determinants of water, sanitation, adequate housing and clothing, decent working and living conditions require to be addressed by introducing and enforcing public health standards. Many countries do have such public health 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.

7. The second strategy (para 21), “Universal access to affordable, quality diagnosis and appropriate treatment of infections”, is most welcome. 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 in treatment of infections, inappropriate individual provider-patient transactions has an adverse 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. There is no mention of how we would achieve this strategy in the private sector, without strengthening the regulation of private clinical establishments.

11. The third strategy proposed in this report has now been termed strategic information, science and innovation. The emphasis of this strategy is on surveillance both of resistance and of antibiotic consumption and of resistance prevalence surveys. There is a line in para 22 that states: "Comprehensive measures to promote increased research and development for vaccines, diagnostics and antibiotics (and alternatives) targeted to greatest public health needs" but beyond that no mention is made of this in the tables or indicators. Even with regard to surveillance, a stand-alone surveillance for AMR will not work. AMR surveillance would be adequate only if it is part of strengthening health systems to deliver comprehensive health services, with better diagnostic capacity, and with better hospital information systems and with

an integrated disease surveillance system. There is also no mention of how these systems will extend into a private sector. A call for better regulation of the private sector is essential to achieve an impact at a population level.

12. 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. There is awareness of some of these problems, but the proposal to address them as stated in para 36 is disingenuous. WHO's role is portrayed and monitoring and promoting write choices in what industry and other partners would take up in research and development and some additional managerial measures that would have little impact without addressing the central questions.

13. In summary though there are many welcome measures in these strategies every single strategy is too incomplete to succeed. |

Draft resolution: Accelerating national and global responses and preparing for the UN High Level Meeting on AMR.

The draft resolution included in [EB154/CONF./7](#) makes frequent reference to the strategic and operational priorities for accelerating national and global responses. Since those priorities were still undergoing discussion the Board did not formally recommend the draft to the Assembly. However, the broad direction and framework of the draft resolution is clear and assuming the priorities included in A77/5 are now agreed, the resolution as amended will be presented to the Assembly. Even more important this resolution will also guide the discussions in the Special Session on AMR of the UN General Assembly later this year.

The PHM welcomes the three main strategies that constitute the Action Plan against the growing problems of AMR. These are – 1. prevention of infections; 2. universal access to affordable, quality diagnosis and appropriate treatment; and 3. strategic information, science and innovation. These three independent elements of a comprehensive public health approach for sustained impact in slowing the emergence and spread of drug-resistant bacterial infections and preserving effective antibiotics. The PHM also welcomes the call to strengthen governance and financing and to support country level plans as the operational elements to achieve progress towards these goals

While these are all essential, there are a number of other concerns that we call for inclusion in this resolution and in the in the political declaration of the scheduled United Nations High Level Meeting on Antimicrobial resistance:

1. A call to countries to enact and implement public health legislations that can enforce the rights of the residents on the state to ensure that access to safe water, sanitation, and hygiene measures is delivered as an entitlement through public services. This would need to go along with local-self-governments being provided with the financial powers, the transfers of technology and other capacities required to play their role. Also a call for countries to enact public health standards for quality assurance in all health care facilities. Taken together these are specific measures that would move us forward towards infection prevention and control and at least in part redress the inequities in current causes and consequences of high levels of infection in the poorer and more vulnerable sections.
2. Acknowledge the role that poorly regulated private markets in medical commodities and in healthcare provision has made to the spread of antibiotic resistance and call for strong regime of antibiotic marketing regulation, accompanied by provision of good quality information and proactive promotion of better antibiotic choices. This would have to be part of a better regulatory regime for private sector care in LMICs. Especially in primary health care, but in all levels of health care, one principle of organizing health services must be that clinical decision making is not subject to market pressures. This can be best assured by public provisioning of services and in designing contracts with private providers, which adhere to this principle.
3. Ensuring public provision of microbiological guidance including affordable rate - controlled or free testing services to all patients irrespective of choice of provider. It should also call for local availability and use of information from ongoing microbial surveillance to guide appropriate local guidance on antibiotic use.
4. Banning the use of antibiotics for preventive purposes and growth promotion in rearing animals for food, better microbial surveillance and feedbacks to farmers and veterinarians to guide antibiotic choice, and restriction of some antibiotics for use in some sectors.
5. Call for the UN high-level meeting and political declaration to become a convergent call of the quadripartite alliance and not only of the human health sector.
6. Expedite the development of better antibiotics with putting in place a more effective innovation regime for antibiotics which should 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, mandate a public

acquisition of IPRs and mandatory licensing of multiple generic manufacturers to undertake production including where possible public sector manufacture.

These demands are in addition to the many welcome measures that the resolution has itself proposed.

References:

1. Moss M. Charting the Course for the AMR Agenda in 2024. unfoundation.org. Published November 28, 2023. Accessed February 4, 2024. <https://unfoundation.org/what-we-do/issues/global-health/the-amr-agenda-in-2024/>
2. Ayukekbong JA, Ntemgwa M, Atabe AN. The threat of antimicrobial resistance in developing countries: causes and control strategies. *Antimicrob Resist Infect Control*. 2017;6(1):47. doi:10.1186/s13756-017-0208-x
3. Koya, S.F., Ganesh, S., Selvaraj, S. *et al*. Determinants of private-sector antibiotic consumption in India: findings from a quasi-experimental fixed-effects regression analysis using cross-sectional time-series data, 2011–2019. *Sci Rep* **14**, 5052 (2024). <https://doi.org/10.1038/s41598-024-54250-2>

12. Global technical strategy and targets for malaria 2016–2030

In focus

The Secretariat report ([A77/6](#)) reviews global trends, threats to malaria control, actions taken to counter threats, and opportunities to accelerate progress against malaria. In para 28. The Health Assembly is invited to note the report and to consider the following questions:

- Building on the momentum from the Malaria Ministerial Conference in Cameroon in March 2024 ([see Declaration](#)), how can increased political commitment in the highest burden countries be translated into domestic resources for primary health care and malaria control?
- In view of the stalled progress against malaria in moderate- and high-burden countries (see [World Malaria Report](#), 2023) what should Member States do to secure sufficient international investment that is aligned with national plans and priorities?
- What support (technical, financial) do Member States need to ramp up their responses to biological threats such as antimalarial drug resistance?
- How can Member States ensure the most efficient, equitable and sustainable responses to malaria?

It seems likely that a draft resolution based on the Ministerial Declaration from the Cameroon Conference will be tabled.

Background

Global Technical Strategy for Malaria 2016–2030 adopted in [WHA68.2](#) (2015) and updated version adopted in [WHA74.9](#) (2021).

[World malaria report 2023](#). Geneva: World Health Organization; 2023

See [Tracker links](#) to previous governing body discussions of Malaria

PHM Comment: Progress on the Global Malaria Strategy is seriously off track - and so are the WHO's strategies to correct it

The Report by the Director-General on the progress made with respect to the Global technical strategy and targets for malaria 2016–2030 is sobering. The strength of the report is its honesty. In para 5 it candidly states “Progress towards the strategy’s case incidence and mortality reduction targets is seriously off track. If the current trajectory persists, the 2030 target for reducing case incidence will be missed by 89%, while the target for reducing mortality rates will be missed by 88%.”

In the last two years (between 2019 and 2022) there has been a significant increase of cases from 233 million to 249 million and of these 16 million increases 15 million is from Africa alone, which now accounts for 94 percent of cases and 95 percent of deaths. There were approximately 608,000 recorded malaria deaths in 2022- which is also an increase from 576,000 recorded in 2018.

On the positive side the retention of elimination status in 102 countries and the near elimination status in 21 more is positive news. All of the latter are low burden countries. If retention strategies are well integrated with routine health systems functioning and not dependent on international debt financing and not taking away a disproportionate budget from the immediate challenges of saving lives then such news would even be even more welcome. There is considerable caution needed that the argument for maintaining elimination does not become an excuse for exhausting public expenditure on selective priority and leaving the rest of healthcare to the markets and then blaming the public sector for under-performing.

The DG's Report offers the following reasons for the global strategy, going off track (see para 7 to 15 of the Report):

1. Fragile health systems with weak supply chains, and shortage of skilled health professionals,
2. Weak surveillance, monitoring and evaluation - especially with an equity lens,
3. Inequity in access to essential health services,
4. Insufficient financing for malaria commodities,
5. Insufficient domestic and global financing for strengthening health services,
6. Humanitarian and health emergencies,
7. Drug resistance (especially to artemesin) and insecticide resistance (specially to pyrethroids),
8. The spread of Anopheles Stephansi- indicating the development of high levels of urban malaria in regions which did not have this before (we add: but where its coming could have been predicted from past patterns), and
9. Climate Change.

All the above factors are correctly identified. However in the recommendations most of these are inadequately addressed. The emphasis of the recommendations is on the biomedical factors- of addressing resistance with better medicines, better, more informed choice of medicines and improved bed-nets. These are necessary and welcome, but the main issues are well beyond the potential impact of these measures. There is also a huge expectation building up about the two new vaccines introduced. At least one of these is introduced only for children and as of yet shows a modest 13 percent drop in childhood deaths. Would certainly help, but expanding on this strategy could consume resources and one has to monitor carefully for expected outcomes. While being very welcome as an additional tool of implementation vaccines at this stage of development are unlikely to be the game changer.

On issues related to integration with health systems the report limits itself to noting that :

To accelerate progress towards the goal of universal health coverage, WHO is working with countries to reorient health systems towards primary health care – an approach that

can help deliver 90% of essential health services, including those for malaria, and save 60 million lives by 2030. Primary health care uses a whole-of-society approach to effectively organize and strengthen national health systems to bring services for health and well-being closer to communities.

This is just an acknowledgement of WHO's UHC strategy. We know that this UHC strategy is not doing very well and one of the reasons is lack of integration. Even in the agenda items in WHA 77 on UHC (11.1) and PHC (28.2- as IPCHS) scant mention is made of malaria. We also know that on the ground donors and national malaria programme leaders insist on retaining a vertical silo for malaria control- justifying it by weak health systems. This vicious cycle between weak health systems and lack of integration is at its worst in those countries and areas (like urban health care) where primary healthcare is very weak.

The failure of the global malaria strategy to understand and factor in primary health care beyond a nominal acknowledgement of the same, is most apparent from how completely the agenda of **decentralization, community engagement/community participation** is missing from the recommendations. There is some reference to this with respect to urban malaria, where traditionally the malaria programme has had no staff or outreach, but even that level of recognition is not there for in the rest of the strategy. The remote hard to reach settlements in malaria endemic regions pose problems of perennial malaria transmission bcz in these areas prevalence asymptomatic malaria cases is very high. These hidden infections are not detected and treated by the routine malaria programmes. Thus these infections act as malaria transmission reservoirs. Again due to inherent communication difficulty and weakness of health system these hotspots remain away from the vigilance of the National malaria programmes. Hence special strategy is needed to halt malaria transmission from these areas and eliminate reservoirs.

The case for informed decentralized action: Though the epidemiological and social determinants of prevalence, the systems determinants of success, and the menu of technical options to address the disease are well known, the exact combination of these three elements vary widely across provinces and districts and even within districts. In the malariologists lore- "malaria is a very local and focal disease." It therefore requires considerable effort at decentralized planning with the community at the centre to be able to have an impact. Surveillance and the use of data is most effective if it is used to guide local action. Local action is most effective if the community participates with a well informed understanding of the choices they have and the choices too are acceptable for the community. We would contend that wherever there has been success in control, it has always followed that logic.

The remote hard to reach settlements in malaria endemic regions pose problems of perennial malaria transmission both because of high prevalence of asymptomatic malaria. These latent infections are not detected by the routine malaria programmes, which anyway are weaker in such areas and such areas become malaria transmission reservoirs. Hence special strategies specific to these settlements are required to interrupt malaria transmission and eliminate reservoirs. This again emphasizes the need to make informed decentralized action plans based

on local epidemiology, local health systems maturity, and appropriate technical choice with the last including not only technical efficacy but also community acceptability.

Community at the Centre; Market Mechanisms do not work: UHC as purchase of care from private providers using market mechanisms as signals has nothing positive to offer for malaria control. For markets the community is a consumer, and not a co-producer. Yet if malaria elimination is the goal the community must be active participant and all of malaria elimination including the access to skilled professional care for curative care must be a public good. And that public health services are democratized and decentralized in parallel with empowering communities and bodies of local self-governance with the necessary knowledge and tools to make the right choices.

Role of Community Health Workers: Another very important dimension of the malaria control programme that its technocratic bias seems to have missed completely in this report is the tremendous role that community health workers are playing at the front-line of malaria control. Treating the CHW as an ad hoc fixture and withdrawing CHWs prematurely (or diverting them to non-healthcare roles) as soon as malaria incidence starts going down has been a major contributor to the repeated resurgence of malaria.

Public Health Standards and Social Determinants: The failure to recommend for and implement public health standards that duly empowered and resourced local governance bodies are accountable for, and that the residents are aware of, is another missing dimension of the global strategy. The Global Strategy needs to factor in the social and environmental determinants of malaria control more rigorously if it needs to make progress.

Vector dynamics as part of OneHealth: Finally, we also point out that malaria is one mosquito borne and vector borne disease among many and, especially in Africa, there is a close relationship between the control of malaria and others. In some areas malaria control is closely followed by dengue resurgence. In other areas multiple diseases are transmitted by same vector. There is also a relationship between vectors in animal husbandry and in the non-domesticated animal species. Professional research must address vector dynamics in an integrated manner and note their relationship to human action and environment change. Such an understanding must inform health systems interventions and community engagement in malaria control.

13.1 IOAC for WHE

In focus

Twelfth report: [A7717](#)

Background

[IOAC webpage](#)

[Terms of reference](#)

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

PHM Comment

Salient issues from IOAC report:

- Condemns attacks on healthcare (par 7). 620 deaths in Palestinian OTs in 2023;
- Global shortage of cholera vaccine, need to boost manufacturing capacity;
- Impact of climate change on dengue risk;
- Disaster in Sudan: 6.6m internally displaced; 1.8m across borders;
- Humanitarian crises: “more than 300 million people in 72 countries will require humanitarian assistance in 2024 and WHO is facing multiple challenges, including limited humanitarian access and decreasing funding for humanitarian crises”;
- IOAC highlights need for standardised reporting and independent monitoring of country preparedness and readiness; see para 38 regarding disbursements from Pandemic Fund including for supporting the upgrading of core capacities;
- “Committee reaffirms that equity and solidarity are not only moral principles but a prerequisite for preventing, and effectively responding to, pandemics. Disparate and inequitable response facilities spread disease.” [...] “the agreement must be based on equity and solidarity”. Cast as advice to INB but no operational suggestions;
- Call for strengthening of member state accountability in relation to sexual exploitation, abuse and harassment in humanitarian emergencies, with more support from regional office and WHO country representatives;
- Need for closer alignment between WHE headquarters and relevant departments in regional offices; eg closer ‘whole of organisation’ cooperation in various review exercises;
- More attention needed to recruitment and retentions; vacancies 425 out of 2290 positions;
- Need for substantial increase in WHE funding; IOAC deeply concerned about chronic shortage of flexible and sustainable financing.

PHM appreciates the work of the IOAC.

13.2 Implementation of the IHRs

Contents

- [In focus](#)
- [Background](#)
- [Overview of issues under consideration](#)
- [PHM Comment](#)
- [Notes of discussion](#)

In focus

“28. The Health Assembly is invited to note this report ([A77/8](#)), to consider the standing recommendations for COVID-19 and mpox contained in documents [A77/8 Add.2](#) and [A77/8 Add.4](#), in accordance with Article 53(g) of the Regulations and to provide guidance on the following question:

- How can WHO Member States continue to strengthen implementation of the Regulations, including pending the entry into force of any amendments to the Regulations that may be adopted by this Health Assembly?”

[A77/8](#): Secretariat report

[A77/8 Add.1](#): Report of the Review Committee regarding standing recommendations for COVID-19 (see [original version of this report](#))

[A77/8 Add.2](#): Standing Recommendations For COVID-19 issued by the Director-General, corresponding to the termination of the declared PHEIC due to Covid

[A77/8 Add.3](#): Report of the Review Committee regarding standing recommendations for mpox (see [original version of this report](#))

[A77/8 Add.4](#): Standing Recommendations for monkeypox/mpox, issued by the Director-General, corresponding to the termination of the declared PHEIC due to mpox.

Background

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

Overview of issues under consideration

IHRs

[A77/8](#) reports on the ongoing operations of the IHRs (focal points, events and information, emergency and review committees, support provided to countries for core capacities, points of entry, and additional measures). Polio remains a PHEIC. Covid and mpox no longer so.

Results data for core capacity self-assessments, joint external evaluations and national action plans for health security are provided through the [IHRs Monitoring and Evaluation Framework](#). For country profiles see Strategic Partnership for Health Security and Emergency Preparedness Portal - [SPH Portal](#).

Covid: current situation

[A77/8 Add.1](#) provides a useful overview of the current situation globally with respect to Covid. Salient issues covered include:

- current patterns of transmission, declining notifications, declining deaths reported;
- weekly reported deaths (late 2023) around 3000pw;
- significant variations in primary vaccinations; booster vaccinations inadequate and inequitable;
- surveillance and reporting inadequate in many countries, including reduction in number of sequences contributed;

Covid: standing recommendations

In accordance with Article 16 of the IHRs (non-binding), in [A77/8 Add.2](#) countries are recommended to:

- revise and implement revised national plans aligned with [WHO's current Covid Preparedness and Response Plan](#);
- sustain collaborative Covid surveillance;
- continue reporting Covid data (morbidity, mortality, sequences, vaccine coverage and efficacy);
- achieve vaccination coverage as recommended;
- undertake research;
- deliver optimal clinical care;
- continue to work towards ensuring equitable access to safe, effective and quality-assured medical countermeasures.

Mpox: current situation

The report of the Mpox review committee (in [A77/8 Add.3](#)) highlights:

- clinical severity less than previously described but worrying for people living with HIV who are immunosuppressed; case fatality in West and Central Africa worse than elsewhere;
- uncertainties about animal reservoirs but susceptible species include various species of squirrels, rats, mice and monkeys;
- people at higher risk include men who have sex with men and sex workers; modes of transmission in African context uncertain, other modes of transmission likely;
- transmission in Europe and North America declining; continues in Nigeria and DRC and elsewhere in Africa;
- WHO's Draft Global Strategic Framework outlined (from page 17)

Mpox: standing recommendations

The review committee deliberated on the need for standing recommendations but concluded (although not unanimously) that they are necessary and appropriate.

In [A77/8 Add.4](#) countries are recommended to:

- develop and implement national mpox plans; including
 - including mpox as a notifiable disease;
 - strengthen diagnostic capabilities;
 - ensure timely reporting to WHO;
 - ensure that genetic sequencing is accessible and share sequence data;
 - notify WHO regarding relevant events;
- build capacity for community engagement ... continuing to strive for equity and build trust with communities;
- undertake appropriate research;
- apply measures in relation to international travel;
- provide guidance for clinical care
- work towards ensuring equitable access to safe, effective and quality-assured countermeasures.

PHM notes that while the recommendations include the sharing of genetic sequence data there is no mention of benefit sharing (still subject to debate in the negotiations around a pandemic treaty).

PHM Comment

PHM appreciates the work of the IHR review committees and the Secretariat advisors and recognises the rationale and evidence base of the standing recommendations.

13.3 Working Group on Amendments to IHRs

In focus

[A77/9](#) (NYP)

[Bureau text for WGIHR Meeting 8, 22-26 April](#)

Report of Review Committee on amendments to the IHRs ([A/WGIHR/2/5](#))

Background

[Working group website](#)

See [Tracker links](#) to previous governing body discussions of the IHRs

See [Tracker links](#) to recent published reports regarding the WGIHRs

PHM Comment

What is (likely to be) new in the revised IHRs and what is still open?

- Art 3 highlights equity and solidarity among states parties (will this survive?); no mention of equity and solidarity within countries;
- New provisions regarding 'health products' (includes a definition, reference to a dossier, requirement for WHO to facilitate access (Art 13, still open), to be included in recommendations (Art 15, 16 & 17), concern for supply chains (Art 18), additional health measures, collaboration and assistance, 'access' a core capacity; still debate over 'voluntary' vs mandatory nature of various provisions;
- New gradings of emergencies (provision for early action alert (Arts 11 & 12) and for including declaration of pandemic including more detailed definition and decision tree);
- New provision for a National IHR authority as well as the existing IHR focal points;
- New provisions regarding communication, consultation, verification
- Creation of a new Implementation and Compliance Committee (Art 54 bis)
- More explicit obligations regarding financial assistance (Art 44), including for core capacities, possibility raised of a 'dedicated' financing mechanism, finance included as a responsibility of new Implementation and Compliance Committee.

Further comment pending finalisation of the WG's work and publication of A77/9.

13.4 Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response

In focus

[A77/10](#) (NYP)

The Assembly will have before it a report from the INB. This may include an INB recommended constitution for the proposed pandemic treaty or agreement with a draft resolution proposing a plan of action from here on (likely to include one or three intergovernmental working groups to work on the issues which the INB could not resolve).

Alternatively the report may include a draft resolution authorising the INB to continue beyond WHA77 trying to find consensus around the outstanding issues for the proposed treaty/agreement.

Background

See [INB website](#). See in particular draft text in [A/INB/9/3 Rev.1](#) (22 April 2024). See revised A/INB/9/3 Rev.1: [WHO Pandemic Agreement Text reflecting onscreen versions up to FRIDAY 10 May](#) at 12:30 CEST

See [Tracker links](#) to previous governing body discussions of the proposed pandemic accord

See [Tracker links](#) to recent published reports regarding the proposed pandemic accord

Recent reports

[KEI \(0517\)](#): KEI comments on May 10 draft

[HPW \(0515\)](#): Latest draft shows progress but a long way to go

[HPW \(0509\)](#): Consensus by deadline looks impossible; what are the options

[GHF \(0503\)](#): levels of surveillance and accountability for; new set of One Health provisions (but what about the other three partners); pathogen access and benefit sharing

[TWN \(0502\)](#): WG1 Arts 4 (surveillance) & 5(One Health); WG2 Arts 10(local production and tech transfer) & 11 (tech transfer); WG3 Arts 14(nat procurement) & 15(reg strengthening)
See report on Arts 4 (surveillance), 10 (local production), 14 (reg systems strengthening), 17 (whole of govt/socy)

[HPW \(0502\)](#): some detail re debate over PABS

[TWN \(0430\)](#): discussion of Arts 4 & 5; UK raising questions about incl of One Health; discussion of linking fin and tech assistance for surveillance (Art4); more about OneHealth (Art5)

[GHF \(0430\)](#): role of Africa Group re equity; PABS versus OneHealth (fin implications); conflicted position of Africa CDC; tensions between a WHO pandemic fund, the WB pandemic fund, and the Global Fund; final statement of Africa meeting (reject Pand Fund, PABS, PPPR includes IP waiver); incremental cap bldg; tech transfer); useful analysis of PABS vs OH; see also disc of process issues (text vs parallel WGs); useful diagram; bare min agrt or defer finalisation

[PHD \(0429\)](#): “ imbalance between the requirement for developing countries to share pathogen samples and the lack of mandatory provisions for equitable distribution of benefits such as vaccines, diagnostics, and therapeutics”

[TWN \(0429\)](#): commentary on process; useful analysis of core contradictions; need to continue after WHA77

[CSO \(0427\)](#): excellent agenda (qv)

[Fems4PV \(0426\)](#): process criticism;

[MLP \(0426\)](#): binding provisions vs voluntary; undisclosed knowledge; TRIPS waiver; ‘peace clause’ (no challenge); adapting IP laws for pandemic; transparency needs protection

[SouthCentre \(0425\)](#): useful background to the INB process; extended criticism of the process adopted; reference to proposed WHA77 draft resolution (3 wgs or one); recommendations re process and content; consider postponing finalisation; specific recommendations qv; cut back commitments under OneHealth; strengthened accountability; equitable access to gov funded R&D products; tech transfer and knowhow; temp susp of IP rights; pabs; closer specification of supply chain and logistics framework; nat procurement; sustainable financing

[KEI \(0419\)](#): need for mandatory exceptions to IP obligations; provisions re tech transfer; EU CL annex

[GHF \(0419\)](#): refers to **draft resolution** being discussed (qv) and the proposed IGWGs; changes from last version;

[GHF \(0416\)](#): useful overview of key issues

[TWN \(0409\)](#): Focus on Viroj presentation, PABS in particular

[Nikkei \(0406\)](#): tensions over tech transfer

[Gostin&Watal \(0403\)](#): focus on PABS; need for mandatory benefit sharing

[KEI \(0403\)](#): useful about the ‘peace clause’

[SouthCentre \(0315\)](#): calling for unity in Global South and the poss of vote on floor; useful recapitulation of background (esp hoarding of vaccines); useful overview of key provisions and debates

[Lancet \(0302\)](#): shameful and unjust

[Gopa-GHF \(0227\)](#): useful overview of key issues

[Kavanagh-FP \(0205\)](#): WTO failed in Covid; cannot leave IP to them

[Politico \(0129\)](#): Biden has pharma's back

PHM Comment

The 'core capacities' campaign

In the years leading up to the Covid pandemic, there was increasing pressure on developing countries, especially low and lower-middle income countries, for full implementation of the 'core capacities' specified in the IHRs. This pressure was increased after the 2014 Ebola epidemic in West Africa with the move from self-assessment to 'peer review' and high profile campaigning.

In many respects this pressure was exerted in order to guarantee the 'health security' of the rich world in the face of disease threats seen as coming from the developing countries.

This pressure on lower income countries to comply with the 'core capacities' was quite problematic. The core capacities for pandemic prevention, surveillance, and response are integrally associated with the level of development of the health system more generally. For countries which are only spending \$40-50 per capita on health care, the additional expenditure needed to achieve the core capacities would be disproportionate in comparison to other claims on limited funds. The opportunity costs of such expenditures in terms of disease burden *not* reduced would be hard to justify in the context of national decision making.

However, the imposition of such obligations is fully consistent with the unequal power and unequal exchange relations of imperialism.

The priority being given to 'compliance' by the rich countries was also in some degree a maneuver in the propaganda war against China.

Reality check: the critical weakness during Covid - predictor of avoidable mortality - was the lack of solidarity, not the shortfalls in 'core capacities'

The core capacity most lacking across the globe was solidarity, epitomised by the inequities of the lock-downs and the hoarding of vaccines and other health products.

A range of reviews during and after the pandemic focused attention on vaccine hoarding; less so on the inequities of the lockdowns in some countries.

However, the tension between intellectual property rights and equitable access to various health products was brought into clearer focus by the conflict over whether or not to waive IP restrictions as provided for in the TRIPS agreement during the pandemic.

Commitment to develop a pandemic accord

The proposal to develop a pandemic accord under the treaty making powers of WHO was supported by many countries including from high, middle and lower income groups. It appears that the rich countries hoped to achieve their compliance objectives (strengthening surveillance capacities) and the poor countries hoped to gain concessions in the reduction of IP barriers to access and local production in the context of pandemics (and public health emergencies of international concern) including financial as well as technical transfers.

Barriers to agreement

After three years of negotiation there remain major barriers to agreement. Key issues in contention include:

- Pathogen access and benefit sharing (mandatory sharing of meaningful benefits);
- Mandatory waiver of IPRs during pandemics (or PHEICs), including the so-called 'peace clause' which would enable breaches of IPRs during a pandemic because of an agreement not to dispute such breaches;
- Support for tech transfer (including knowhow) to support local production;
- Tighter enforcement provisions regarding core capacities including health system strengthening;
- Arrangements for funds mobilisation, controlled by the parties to the agreement (instead of the World Bank); including support for surveillance and response;
- Provisions for One Health (notwithstanding the fact that the other relevant intergovernmental organisations (animals, plants, environment) are not parties to the proposed agreement).

Coming to agreement in the INB negotiations has been complicated by departures (by the INB Bureau) from standard treaty making norms with respect to the negotiating process.

In the face of continued disagreement during the early May negotiations delegates were contemplating either (i) a framework agreement with no binding provisions and the hard issues to be deferred to protocols for subsequent consideration; or (ii) authorising continued negotiation after WHA77 with a view to adoption at a special session later in the year; or (iii) more intensive negotiations between now and the closure of WHA77. The DG appears to be pushing for this third option.

But the lack of consensus also shows that the pre-existing balance of power has been contested. The European Council had been one of the strong proponents of a Pandemic Treaty, perhaps because it felt that it would be able to ensure better compliance with surveillance, notification and pathogen sharing while having to concede little on ensuring access to finances and technologies. Earlier it was only the big developing countries of Brazil, China, India, Russia which had to be brought on board and these countries already had domestic capacities. But in

the course of the negotiations the 54-member Africa Group and a host of other nations in Asia and Latin America have refused to be pushovers. Empowered by the high levels of discussions in civil society and political circles on the issues at stake, these countries have stood firm on their “technical” demands- and thereby altered the balance. This is a new situation that PHM has contributed to and it needs to be defended and built upon. The poorest countries have little to gain and a lot to lose if a pandemic treaty comes through which increases their obligations but brings them no benefits. The developing countries must stand firm on an understanding that an unequal agreement is worse than no agreement.

The current draft agreement and the debates in the INB do not touch upon the social and economic inequalities which have compromised solidarity in pandemic response within countries. At one stage the developing countries had pressed for a Common but Differentiated Response and Respective Capabilities Approach- similar to the climate change negotiations which are also stalled. High income countries not only pushed back but even contested the use of the word solidarity. But even on this developing countries should stand firm and interpret the consequences of these principles more widely.

Another area not touched upon, with reluctance to do so from both the developed and the developing countries is the prevention and remediation of human rights violations.

Strategic perspective

The pandemic agreement negotiations can be analysed at the word for word level or at the wider strategic level. Both are necessary but for activists who are unable (for lack of time or for lack of access to the negotiating process) it is particularly important to pull out the implications for public health, for geopolitics and for sustainable and equitable economic development (at a time of environmental crisis).

In terms of public health (pandemic prevention, preparation and response) there are some prospects for marginal improvements over the Covid experience. It was hoped that the rich countries are likely to accept reforms regarding IP barriers, support to local production and financial transfers which could avoid the worst features of the vaccine hoarding of Covid. However, present state of negotiations offer little hope of significant improvements in the pandemic prospects for poorer people in poorer countries.

In terms of geopolitics, one of the striking features of the negotiations has been the strength of the Africa bloc (including Egypt) in driving for a meaningful agreement, including pathogen access and benefit sharing, and the efforts being exerted to divide the Africa group, including through increased bilateral US funding for surveillance and response capacities.

In terms of the wider struggle for sustainable and equitable economic development (at a time of environmental crisis) the negotiations around the proposed pandemic agreement can be seen as a significant engagement, in particular, through the challenges being raised to the prevailing intellectual property regime and to the global configurations of research, development, and production of goods and services. This should be seen as an opportunity by progressive governments to push forward for alternatives to the current IPR and to forms of South-South

cooperation and collaboration, that would build regional and country level capabilities to better resist domination by the formal colonial powers.

In assessing the significance of the pandemic negotiations in relation to this wider set of struggles, the conditions for pandemic emergence and provisions for prevention and response need to be contextualised in relation to the political economy of deepening inequality, asymmetrical power relations and the perpetuation of unequal exchange, and the existential challenges of global warming.

PHM calls for a global mobilisation of civil society in support of the developing countries who are pushing for a meaningful agreement which will make the world safer in the face of future pandemics; which will strengthen the geopolitics of a multipolar world order; which will contribute to redressing the power relations of unequal exchange (and economic insecurity); and which will contribute to redressing the contemporary environmental crisis.

14.1 WHO's work in health emergencies

In focus

Edited extract from DG's consolidated report ([A77/4](#)):

Reports. The Executive Board at its 154th session noted the reports on public health emergencies: preparedness and response ([EB154/14](#), now revised and re-presented as [A77/11](#)); strengthening the global architecture for health emergency preparedness, prevention, and response and resilience ([EB154/15](#)); and health conditions in the occupied Palestinian territory, including east Jerusalem ([EB154/51](#), revised and re-presented as [A77/12](#), not yet posted).

The Assembly will review WHO's work in health emergencies ([A77/11](#)) and the report on health conditions in the occupied Palestinian territory, including east Jerusalem ([A77/12](#), NYP).

UHPR. (Informed by [EB154/15](#)), in [EB154\(9\)](#) the EB proposed a draft WHA decision on the universal health and preparedness review. [A77/4](#) (para 22) invites the Assembly to adopt the resolution recommended by the Board in EB154(9).

Laboratory risk management. In [EB154\(10\)](#) (sponsored by the EU and the USA) the EB proposed a draft WHA resolution for strengthening laboratory biological risk management. [A77/4](#) (para 22) invites the Assembly to adopt the resolution recommended by the Board in [EB154\(10\)](#).

Palestine. The Board also adopted resolution [EB154.R7](#) on health conditions in the occupied Palestine territory, which proposed that the Assembly adopt a resolution based on [EBSS7.R1](#) from EBSS7 with reporting times deferred by one year. [A77/4](#) (para 22) invites the Assembly to adopt the resolution recommended by the Board in [EB154.R7](#).

Natural hazards. The Board also considered the text of a draft resolution introduced by Member States on strengthening health emergency preparedness for disasters resulting from natural hazards ([EB154/CONF./2](#)). The Board agreed that consultations on the draft resolution would continue during the intersessional period. Presumably a revised version of this conf doc will be published in due course.

(It should be noted that this item is about WHO's work in emergencies so the focus of discussion regarding the conflict in the Occupied Palestinian Territories will be on WHO's role in providing humanitarian assistance. The focus of discussion under Item 20 will be the health conditions in the OPTs, more generally.)

Background

See [Tracker links](#) to previous reports on WHO's work in emergencies

See [Tracker links](#) to previous *governing body discussions* of health conditions in Occupied Palestinian Territories

See [Tracker links](#) to previous *reports* regarding Palestine

See also various investigations of WHO's emergency preparedness by the External ([A77/22](#)) and Internal Auditors ([A77/33](#)).

PHM Comment

See [PHM Comment](#) at EB154 (Jan 2024)

WHO's work in health emergencies

[A77/11](#) provides a summary of WHO's work:

- in all WHO Grade 3 emergencies,
- in UN coordinated humanitarian emergencies, and
- in public health emergencies of international concern.,

[A77/11](#) also:

- provides a summary of global trends and challenges with respect to health emergencies over the reporting period, as well as the short- and medium-term outlooks; and
- reports on the Surveillance System for Attacks on Health Care in complex humanitarian emergencies.

WHE is doing excellent work. Unfortunately it is grossly underfunded.

Universal health and preparedness review

In [EB154\(9\)](#) the EB proposes a draft WHA decision on the universal health and preparedness review. The decision would note the results of the pilots, request the DG to continue developing the voluntary pilot phase of the UHPR, and to report on lessons learned.

(For more about UHPR, see [2022 Concept Note in A75/21](#) and other docs linked from the [UHPR webpage](#).)

PHM Comment

A number of provisions of the revised [\(2005\) IHRs](#) require that state parties shall establish the capacities listed in Annex 1.

In resolution [WHA59.2](#) (2006), the Health Assembly requested the Director-General to undertake several activities "to support immediate compliance, on a voluntary basis, with provisions of the International Health Regulations (2005)".

The IHR Review Committee, established after the 2009 H1N1 pandemic, [concluded \(A64/10, para 23\)](#) that " many States Parties lack core capacities to detect, assess and report potential

health threats and are not on a path to complete their obligations for plans and infrastructure by the 2012 deadline specified in the IHR”.

The pressure on delinquent states parties increased after the West Africa Ebola outbreak of 2014.

PHM has repeatedly commented that the ‘opportunity costs’ for developing countries to invest in achievement of the Annex 1 core capacities are very different from the opportunity costs for rich countries. In a country facing under-fives stunting or high maternal mortality, the cost of diverting resources to achieving the core capacities, in part in order to protect the rich world from diseases seen to ‘emerge’ in the Global South, can be very high, if measured in terms of deferred action on under-fives stunting or maternal mortality.

The increasing pressure on delinquent states parties has been expressed in the pressure to participate in ‘joint external evaluations (JEE)’ and in 2019 the establishment of the [Global Preparedness Monitoring Board](#) with Gates Foundation and World Bank support.

The painful paradox of Covid was that the ‘core capacities’, which would have made a difference to the burden of morbidity and mortality - domestic and international solidarity - are not included in Annex 1 of the IHRs.

The UHPR initiative is a member state controlled peer review mechanism which assists countries to review their emergency preparedness, in the context of other demands on national resources. It should be supported.

However, national and international solidarity and equity, as key resources in the face of emergency events, remain on the ‘to do’ list.

Biological laboratory risk management

[EB154\(10\)](#) proposes that the Assembly resolve

- to urge member states to strengthen national protections regarding biological laboratory risk management and to “to augment and secure international cooperation, development of technical tools and sharing of information about laboratories and incidents”,

and to request the DG to:

- support member states in laboratory risk management;
- develop Secretariat capacity ... “including, but not limited to convening discussions for proposing consensus-based baselines for enabling objective assessment and incident reporting under the International Health Regulations (2005) of facilities working with microbiological agents through the identification and promotion of best practices ...”
- to monitor evidence and trends
- to promote international collaboration including with non-state actors (presumably philanthropies and private companies)
- to enable continued discussion among Member States and relevant international organizations or stakeholders for possible additional proposals to strengthen biological laboratory risk mitigation and management comprehensively

PHM Comment

[A74/18](#) (2021) provided a useful review of WHO's work in and around laboratory biosafety. It pointed out that there had been significant technical developments since Resolution [WHA58.29](#) (2005), which had provided a mandate for this work, had been adopted.

The proposed resolution, cosponsored by the EU and the USA, might be referred to as the 'Wuhan Resolution', in particular the reference in OP1(6) to information sharing, which might be directed to needling China around the lack of transparency regarding the origins of Covid-19 and the allegation that Covid arose from laboratory release.

Nonetheless the draft resolution is sensible and should be adopted.

Gaza disaster

In Resolution [EB154.R7](#) the EB proposes that the Assembly adopt a resolution based on the text of [EBSS7.R1](#) from [EBSS7](#), but with reporting times deferred by one year.

EBSS7 was called (in Dec 2023) to consider the humanitarian disaster unfolding in the Gaza Strip as a consequence of Israel's war on Hamas following the October 7 incursion. EBSS7 deliberations were informed by the [WHO Emergency Program Situation report](#) (most recently updated on 10 May 2024). See [full set of Emergency Situation Reports](#). The discussion at EB154 was informed by [EB154/51](#).

[EBSS7.R1](#) expresses grave concern about the dire situation in Gaza, describing the situation in some detail and appreciating the work of the WHE. The resolution calls for unimpeded passage of humanitarian relief and for all parties to comply with international law. The resolution asks the DG to report to the Assembly through the EB and the SCHEPPR; to coordinate with donors; assess needs and continue to provide technical and material assistance. It calls on the international community to secure adequate funding for immediate and future needs. The report requested of the DG in OP5(a) was to have been considered at this Assembly but EB154.R7 proposes that this be deferred to WHA78.

PHM Comment

It is not clear why the report requested in EBSS7.R1 has not been produced in accordance with the original time lines. It would be understandable if this were simply because the WHE has been too busy addressing the humanitarian disaster in Gaza.

However, the production of the requested report might have triggered a deepening of international urgency around the need for a permanent ceasefire, the upscaling of humanitarian response, and the mobilising of support for rebuilding infrastructure and services.

The situation described in EB154/51 (dating from January 2024) is truly dire. The updated Emergency Situation reports confirm that it has worsened since then.

PHM calls upon delegates to the World Health Assembly to familiarise themselves with the disaster documented in EB154/51 and in the subsequent reports, and to urge their health

ministers to engage with their foreign affairs colleagues in a strong intersectoral advocacy with a view to deploying all diplomatic levers towards a ceasefire, humanitarian access, and mobilising support for recovery and rebuilding. Such a diplomatic push should include the cessation of arms supplies and indicting the occupying power for genocide, ethnic cleansing and collective punishment.

‘Natural hazards’

EB154 considered a draft resolution introduced by a group of Member States on strengthening health emergency preparedness for disasters resulting from ‘natural hazards’ ([EB154/CONF./2](#)).

EB consideration was informed by [EB154/15](#) (“Strengthening the global architecture for health emergency preparedness, prevention, and response and resilience”). EB154/15 does not in fact mention disasters resulting from ‘natural hazards’ but in para 24 it discusses the need for flexibility in developing, adapting and aligning core capabilities to different kinds of threat and different settings.

Consensus was not achieved and the draft resolution was deferred pending further consultation. The debate appears to have centred around references to gender and age sensitivity in OP1(4), OP1(8) and OP2(4).

PHM Comment

The term ‘natural hazards’ is unfortunate in that it appears to discount the role of climate change in increasing the severity and frequency of extreme weather events. However, the draft makes it clear that extreme weather events associated with global warming are included in its scope.

Operative paragraph 1 urges member states to prepare appropriately for disasters of various kinds with a number of useful suggestions. OP2 requests the DG to provide support to member states and to strengthen Secretariat capacity (including the Contingency Fund) and to report to future meetings.

The draft proposes what would be a sensible resolution which might usefully strengthen preparedness and response to ‘natural hazards’. However, it might have been more useful for the sponsors of this resolution to engage more closely with the issue raised in EB154/15 para 24, namely, adapting and aligning core capabilities to different kinds of threat and different settings.

It is perplexing that some member states appear to believe that disaster response should not be gender and age sensitive.

14.2 Implementation of Resolution WHA75.11 (Russia Ukraine war)

Contents

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

In focus

[A77/13](#) (revision of [EB154/16](#))

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 transition to sustainable development remains a future prospect. 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.' [A77/13](#) 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, support to the national immunisation programme and training of primary

healthcare workers, 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. [A77/13](#) 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.

14.3 Global Health and Peace Initiative

In focus

Extract from DG's consolidated report (A77/4):

The Executive Board at its 154th session noted the report on the Global Health and Peace Initiative ([EB154/17](#)). It also adopted decision [EB154\(11\)](#), in which it recommended to the Health Assembly a draft resolution which, inter alia, continued support for evidence gathering, communication and dialogue as part of the consultative process of strengthening the Roadmap for the Global Health and Peace Initiative and submission of a status report on the Roadmap to the Health Assembly in 2029. In the discussions, Board members emphasized the importance of protecting health care infrastructure and workers in conflict-affected areas.

A77/4 (para 22) invites the Assembly to adopt the resolution recommended by the Board in EB154(11).

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, a background paper was announced (para 4), shared with NSAs in January 2024 and a Handbook (para 19) is awaited this 2024. However, for the background paper there is need for caution about context and risk analysis which include peace and conflict analysis to inform the right decisions.

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 GHPI.

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.

Draft resolution in EB154(11)

The draft resolution in [EB154\(11\)](#) recalls various important documents and reaffirms important principles. It then asks the DG to keep working on the Roadmap for the Global Health for Peace Initiative and to come back to the Assembly in five years time to report on the “on the status of the Roadmap in view of a possible, consensual strengthened Roadmap”.

The [record of debate at EB154](#) does not explain the five year delay nor the reference to “a possible, consensual” Roadmap. The only speaker at EB154 who expressed reservations about the Initiative was China.

PHM urges the Assembly to adopt the resolution.

14.4 Polio: Eradication, Transition planning, Post-certification

In focus

Extract from DG's Consolidated Report ([A77/4](#)):

Poliomyelitis eradication

The Executive Board at its 154th session noted the report on poliomyelitis eradication ([EB154/18](#)). In the discussions, Board members highlighted the need for robust surveillance and for targeted measures to reach all zero-dose children in critical areas.

Polio transition planning and polio post-certification

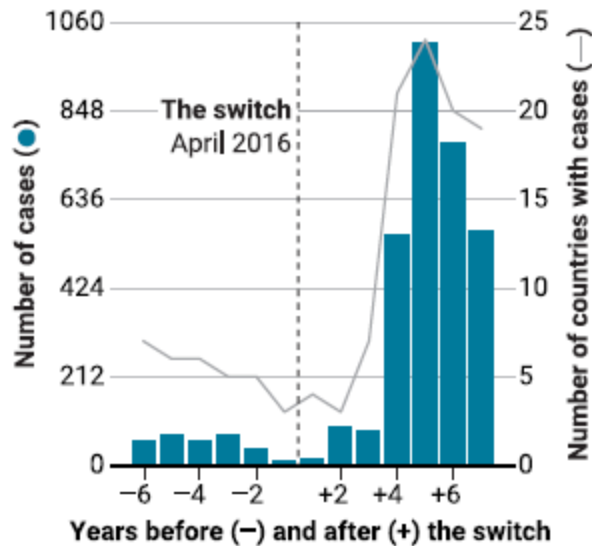
The Executive Board at its 154th session noted the report on polio transition planning and polio post-certification ([EB154/19](#)). In the discussions, Board members emphasized the importance of taking the steps necessary to prepare for a polio-free world, including strengthening immunization, surveillance, outbreak preparedness and response and poliovirus containment.

Background

[Tracker links](#) to previous discussions of polio. See summary of EB debate in [PSR10 from EB154](#).

See WHO Statement following the Thirty-eighth Meeting of the IHR Emergency Committee for Polio (8 April 2024) [here](#).

See also: [Roberts, L. \(2024\)](#). "'Unqualified failure' in polio vaccine policy left thousands of kids paralyzed." *Science* 384(6696): 609-610. The below graph from Roberts (2024) demonstrates the increase in the number of cases and countries affected by vaccine derived type 2 polio paralysis following the removal of Type 2 from the trivalent oral polio vaccine.



*Years range from 1 May to 30 April.

See also GPEI document, 'Circulating vaccine-derived polioviruses Global update A new approach to control cVDPV2', August 2020, [here](#).

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 polio 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 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.

For more extended analysis see [PHM comment on polio eradication at EB152 \(2023\)](#)

Polio transition and polio post certification

[EB154/19](#) summarises the post-2023 strategic framework for polio transition including continuing work on the polio post-certification strategy, including reporting and regulating containment and development of criteria for verifying elimination.

The post 2023 strategic framework for polio transition 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).

For more extended analysis see [PHM comment on polio transition at EB152 \(2023\)](#)

18 Smallpox eradication: destruction of variola virus stocks

In focus

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the report on smallpox eradication: destruction of variola virus stocks ([EB154/20](#)). In the discussions, Board members suggested that the Secretariat should continue to share information on the state of variola virus and ensure regular inspections of the WHO collaborating centre repository laboratories. They welcomed the information provided on the status of the continuing multicountry mpox outbreak for which smallpox countermeasures had been deployed in many countries. In advance of the Seventy-seventh World Health Assembly, Member States were invited to consider whether and how research on orthopoxviruses and smallpox should continue.

Background

[Tracker links](#) to previous discussions of smallpox and mpox.

See also [A77/8 Add.3: Report of the Review Committee regarding standing recommendations for mpox](#)

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 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.”

The emergency declaration was ended in May 2023 and a review committee was appointed under the IHRs which recommended that the DG issue a set of standing recommendations for mpox. See [A77/8 Add.3: Report of the Review Committee regarding standing recommendations for mpox](#)

15.1 Social determinants of health

In focus

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the report on progress of the World Report on Social Determinants of Health Equity ([EB154/21](#)). In the discussions, Board members drew attention to several promising initiatives to address social determinants of health, while expressing concerns about the slow progress in implementing the 2008 recommendations of the WHO Commission on Social Determinants of Health. They provided guidance for the finalization of the forthcoming world report.

Background

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

PHM urges that the Secretariat consider the usage of the term “social determination of health” instead of “social determinants of health”. The concept of ‘the social determination of health’ focuses our attention on the structures, forces, processes and dynamics which shape the conditions in which we grow, learn, play, work and grow old. This usage contrasts with the common use of ‘social determinants’ which focuses attention on the prevailing features of our social environment that shape people’s health without giving systematic attention to the social, political and economic processes which reproduce those features.

PHM Comment

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 drivers of health inequity be progressed and those 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 claims that, “progress has been made against all three targets, but the current rates of improvement are insufficient to meet the targets by 2040. Inequity persists between countries, and within countries, where data are available, the trends are often disconcerting. Disadvantaged population subgroups, such as those with lower socioeconomic status and education levels and those affected by racial discrimination, experience shorter and unhealthier lives”. 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 maximize 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 fierce opposition of corporations to regulation that would make their activities less damaging, by investing massive amounts of money into lobbying and influencing government agendas; influence through corporate philanthropy, corporate social responsibility strategies which can deflect attention from their negative health and social impacts, and from ideological domination and accumulating economic power;

- the economic, political and cultural impact of neo-colonial forces to former colonies or less powerful nations, through mechanisms such as economic dominance and debt dependence, trade imbalances and intellectual property laws, political influence in local governance, western cultural imperialism, data and technology control, and environmental exploitation;
- the perpetuation and climaxing of war and conflict due to the impact of economic and geopolitical interests, promoted as well by intergovernmental alliances;
- the ownership of new digital technologies and technological tools by few private companies, leading to monopolistic practices that prioritize profit over public interest, data privacy, security concerns and censorship issues; surveillance capitalism erodes personal autonomy, civil liberties and social progress, increasing influence exerted by the companies in public policy due to their substantial economic and information capital and digital imperialism;
- the impact of deepening economic inequality and the evaporation of decent employment on community depression and anger, sometimes manifest in neo-fascist movements;
- the historical and persisting link between exploitative economic systems and other systems of oppression, including patriarchy, white supremacy and ableism;
- the impact of the economic system on human culture and relationships through fostering individualism, mistrust, passivity and consumerism, the erosion of public spaces, and the commodification and fragmentation of time.

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, commercialisation and marketisation of human services including health care;
- the impact of money politics and the revolving door (between business and government) on policy formation, facilitating the shaping of public policy to serve private interest;
- 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.

The lack of an in-depth critical analysis of the current historical context can increase the risk of introducing biased recommendations for the promotion of health equity. A relevant example in EB154/21 is the recommendation of legislating and regulating commercial and private sector activities, which has repeatedly failed to produce sustainable outcomes towards global health equity.

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 and research; pro-equity civil society; health systems and 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.

However, it is also necessary to recognise how and why such endeavors have had limited results in the past. These reasons include:

- The overall commercialization and marketization of research, eroding academic freedom, ethics and values, undermining the quality of evidence produced over quantitative indicators of academic success, as well as deteriorating the working conditions of academics and researchers;
- Political and economic interests to which academic institutions and research are depended on and which may resist or undermine research efforts that highlight systemic inequities in health;
- The underfunding of critical health equity research compared to other areas of medical and public health research which may adopt a less critical perspective or may be more profitable, limiting the scope and scale of studies, as well as the ability to sustain long-term research initiatives;
- The exploitation of research labor by institutions and companies, creating precarious working conditions;

- Authorship issues in the global academic health equity research field, characterized by the over-representation of dominant social groups' gaze in academic journals, stemming from agents of western, colonial and patriarchal backgrounds.

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.

EB154/21 calls for universal health coverage through progressive financing and PHC approaches, by strengthening PHC orientation in health systems and increasing governments' share in health expenditure, especially for marginalized populations. Although progressive, this recommendation omits to further address major obstacles in healthcare systems' ability to cover the growing healthcare needs, including the multiple forms of privatizing the delivery of healthcare services which undermine equal access in quality, comprehensive, continuous and needs-based services.

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.

The [Call to Action](#) adopted by the fifth People's Health Assembly calls for a world free of corporate control, resisting corporatisation, marketisation and colonisation.

PHM urges public interest civil society organisations to go beyond the policy platform foreshadowed for the World Report and insist upon:

- Progressive taxation of income, wealth, inheritance and corporations imposed globally with all loop-holes closed;
- Binding regulation of global corporations and the introduction of antitrust legislation to break up their monopoly power;
- Elimination of intellectual property barriers that limit access to health technologies as public goods, removing them from TRIPS; make full, expeditious and broad use of the public health safeguards contained in international regulations;
- Transforming the current health technology R&D regime into one guided by public health needs;

- Regulation and legislation of unsafe employment practices and the promotion of employment that brings satisfaction and wellbeing;
- Ratification of the UN Guiding Principles on Business and Human Rights;
- Full support for the UN declaration on the rights of peasants and rural workers.

15.2 Maternal, infant and young child nutrition

In focus

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the biennial report on the comprehensive implementation plan on maternal, infant and young child nutrition ([EB154/22](#)), including the guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes ([here](#)). In the discussions, Board members called on the Secretariat to hold further consultations on the implementation of the guidance. They also requested the Secretariat to hold consultations on the options for extending global nutrition targets and the comprehensive implementation plan on maternal, infant and young child nutrition after 2025.

Background

[Guidance on regulatory measures](#) aimed at restricting digital marketing of breast-milk substitutes. Geneva: World Health Organization; 2023

[Tracker links](#) to previous discussions of maternal, infant and young child nutrition.

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 ($\geq 70\%$ 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 anemia 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 still born with low birth weight in 2020	There will be 14.4% of babies born low birth weight in 2025, completely missing the 30% reduction target	A 30% reduction of low birthweight incidence	Only 11 out of 157 countries with sufficient data available are on track to 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,	53.4% of infants will be exclusively breastfed in 2025, marginally surpassing the target	Increase exclusive breastfeeding in	Although the global progress is looking good, of the 106 countries with

	47.7% of infants under 6 months were exclusively breastfed in 2021		first 6 months to ≥50%	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\(21\)](#) 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 item at the EB in January IBFAN](#) 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.

PHM calls

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.

PHM joins with IBFAN in calling for a strong resolution demanding that member states fully implement the new 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.

15.3 Well-being and health promotion

In focus

Extract from DG's consolidated report (A77/4):

The Executive Board at its 154th session noted the report on well-being and health promotion ([EB154/23](#)). It also adopted decision [EB154\(13\)](#) on strengthening health and well-being through sport events. In the discussions, Board members welcomed the progress in implementing the global framework on well-being and health promotion, reiterated the need to integrate subjective and societal well-being into public health and highlighted the importance of social connection for the health and well-being of individuals.

A77/4 (para 22) invites the Assembly to adopt the resolution recommended by the Board EB154(13).

Background

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

Link to record of debate at EB154: [M14, page 8](#)

WHO [topic page](#) on health promotion

WHO [team page](#) on health promotion

PHM Comment

This commentary addresses first, the Global Framework described in [EB154/23](#) and second ([here](#)) the draft resolution on strengthening health and well-being through sport events

Global framework “for integrating well-being into public health utilizing a health promotion approach”

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.

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.

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.

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 determination* (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 overstating 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) of [WHA75.19](#) 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 II d) 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 workers in dangerous workplaces, increasing control and improving health, may involve joining a union and going on strike. 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 as an institutional sector 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

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

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.

Strengthening health and well-being through sport events ([EB154\(13\)](#))

The draft resolution in [EB154\(13\)](#) is sponsored by China, Egypt, the European Union, Iraq, Japan, Malaysia, Mexico, Morocco, Oman, Qatar, Serbia, Sri Lanka, Thailand, Türkiye, United Arab Emirates and Yemen, but its development appears to have been coordinated by Qatar.

The resolution is evidence-free, disregards core public health principles enshrined in previously adopted policies, and reeks of vested interests. PHM urges the Assembly to reject the resolution.

Equity, gender, disability, environments

To propose a policy regarding sport and physical activity which makes no reference to gender is extraordinary.

In all WHO regions, bar the Western Pacific Region, the prevalence of insufficient physical activity in women and girls is significantly greater than that for men and boys, dramatically so in the Americas, the Eastern Mediterranean and the South East Asian regions. (see Figs 2 & 3 in the [Global status report on physical activity 2022](#)).

Data available through the WHO Global Observatory shows dramatic gender differences in different countries. In Qatar, the organiser of this draft resolution, 49% of women have insufficient physical activity, compared with 33% of men. The figures for school children show 91% of girls and 86% of boys having insufficient physical activity.

[WHO's Global Action Plan on Physical Activity, 2018-2030](#) identifies **Equity across the life course** as one of seven principles underpinning the global action plan.

Disparities in physical activity participation by age, gender, disability, pregnancy, socioeconomic status, and geography reflect limitations and inequities in the socioeconomic determinants and opportunities for physical activity for different groups and different abilities. Implementation of this action plan should explicitly consider the needs at different stages of the life course (including childhood, adolescence, adulthood and older age), different levels of current activity and ability with a priority towards addressing disparities and reducing inequalities.

Not only is there no reference to gender in the draft resolution; there was no mention of gender in the EB154 debate ([PSR14](#)).

There is no reference to equity in the draft resolution and the only mention of equity in the debate was in the remarks of the representative of the European Regional Director, “concerning decline in people’s well-being globally, with stark inequities that were leaving more people behind, in spite of economic growth, and were negatively impacting societal cohesion.”

There is no reference to schools in the draft resolution notwithstanding the emphasis placed on physical activity in schools in the report of the [Commission on Ending Childhood Obesity](#), for example, in Rec 2.2 “Ensure that adequate facilities are available on school premises and in

public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate”.

The special needs of people with disabilities is mentioned in the preamble to the resolution but there is nothing in the operative paragraphs.

There is virtually nothing in this resolution about the environments which shape participation in sport and other forms of physical activity. WHO’s [Global status report on physical activity 2022](#) commented that:

The environments in which people live, work and spend their leisure time can either help or hinder their opportunities to be physically active. The built environment includes the design and location of homes, schools, retail and commercial centres, workplaces and transport networks, as well as all the spaces between them that make up neighbourhoods and cities. Well-designed urban environments can directly support people to be more physically active, and “nudge” less-active people to be more active by making it an easy choice. Conversely, poorly designed and poorly maintained environments can deter or restrict physical activity by, for example, the absence of necessary infrastructure or by a creating a real or perceived sense of insecurity.

There is nothing in the draft resolution which might draw the attention of governments (or of WHO) to the need to pay attention to disparities in people’s access to environments which are safe and support physical activity including sport.

Professional sport versus community sport

There appears to have been no consideration of the possibility that promoting professional sport as mass entertainment may contribute to the neglect of community sport where ordinary people may get their exercise.

OP1(5) recognises a need to ‘limit the marketing of unhealthy products’ and to ‘minimise the negative consequences of gambling to health and well-being’. These are very weak provisions. They appear to leave space for commercial sponsorship of sporting events, including limited advertising of unhealthy products and gambling where ‘positive consequences for health and well-being’ can be perceived.

The role of digital technologies

In OP1(2) the draft resolution urges member states to

to implement effective, evidence-based health promotion measures [...] including by utilizing innovative digital technologies [...] to improve the impact on population health through reducing risk factors of noncommunicable diseases and enhancing mental and social health, and well-being;

The preamble cites [WHA71.7](#) as the authority for this claim but that resolution makes no reference to physical activity or sport.

The draft resolution reaffirms “the resolutions adopted at previous sessions of the United Nations General Assembly and World Health Assembly that emphasize the significance of collaboration between public and private sectors aimed at promoting health integration within sport events”. No such resolutions are cited.

Is WHO contemplating seeking funding support from Apple and other manufacturers of smart phones, smart watches, and exercise monitoring apps?

Reject the draft resolution

The highpoint of the [debate at EB154](#) was the contribution of the International Federation of Medical Students whose representative said that

efforts should be focused on building healthy societies, rather than on healthy lifestyles. If action remained focused on individual lifestyles without systematically protecting people from social, economic, commercial and environmental determinants of health, it would not be possible to protect future generations. She urged the Secretariat and Member States to address the root causes of ill health and build societies and structures that promoted and enabled health and well-being.

This resolution falls short when measured against these standards.

PHM urges the Assembly to reject this draft resolution.

15.4 Climate change, pollution and health

In focus

Extract from DG's consolidated report ([A77/4](#)):

Impact of chemicals, waste and pollution on human health

The Executive Board at its 154th session noted the report on the impact of chemicals, waste and pollution on human health ([EB154/24](#)). In the discussions, Board members expressed support for the exploration of options described in the report for future involvement of WHO in the intergovernmental science-policy panel to contribute further to the sound management of chemicals, waste and prevent pollution being negotiated by the [ad hoc open-ended working group](#) convened by the United Nations Environment Programme. Board members also underscored the importance of including health aspects in negotiations for the new legally binding instrument to end plastic pollution.

Climate change and health

The Executive Board at its 154th session noted the report on climate change and health ([EB154/25](#)) and considered the text of a draft decision introduced by Member States on the same topic ([EB154/CONF./12](#)). In the discussions, Board members observed that the climate crisis was a health crisis and welcomed the Secretariat's efforts to improve Member States' capacities to respond to the impacts of climate change on health while promoting low carbon societies and health systems. The Board agreed that consultations on the draft resolution would continue during the intersessional period.

It appears that the late appearance of this item on the EB agenda may have been prompted by the WHO-led [Alliance for Transformative Action on Climate and Health](#). See also [WHO News Release of 2 December 2023](#), "GCF, UNDP and WHO join forces to ramp up climate health support for developing countries: New partnership to develop global Climate and Health Co-Investment Facility".

The core group of governments behind the draft resolution on Climate change and health comprised Peru, Netherlands, Kenya, Fiji, Barbados and the UK.

Background

Tracker links to previous discussions of [chemicals](#) and [pollution](#)

[Tracker links](#) to previous discussions of climate change

PHM Comment

Impact of chemicals, waste and pollution on human health

The Executive Board in January reviewed 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 Board noted [EB154/24](#) and Board members encouraged the Secretariat to proceed to explore options regarding the WHO participation in the science policy panel and in the negotiation of the plastics treaty.

It is not clear from the record of debate ([PSR15](#)) why the Russian Federation opposed deepening WHO engagement in the science policy panel, in the plastics negotiation, and in relation to global warming. Russia was the only participant to take this negative stance.

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.

PHM urges the Assembly to endorse WHO's participation in the panel in ways that encompass all of the six options listed in [EB154/24](#). PHM urges the Assembly to request regular reports to WHO's governing bodies regarding the work of the panel and WHO's contribution to the panel.

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.

Most members of the Executive Board (with the exception of the Russian Federation) endorsed such engagement.

PHM urges the Assembly 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.

Extractivism and pollution

[EB154/24](#) centers around pollution by lead, hazardous pesticides, and plastic. But, other forms of chemical waste pollution on health should be highlighted. For example in many low- and middle-income countries, multinationals in the extractive industries are drivers of environmental pollution with resulting health impact. There are many instances of chemicals and waste in the environment disrupting livelihoods, degrading biodiversity and causing untold health burdens. The consequences of chemicals and waste on environmental pollution and health are immense, sometimes underreported or not fully assessed. Given weak health systems, some cases remain undiagnosed. Strong country leadership and strengthening national environmental protection agencies should help curb this problem.

The Chevron Ecuador case highlights also the need for a binding international instrument to regulate the practices of transnational corporations.

Climate change and health

PHM welcomes the item and welcomes the report in [EB154/25](#). 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.

The majority of speakers at the Executive Board in January (EB154) supported boosting the Secretariat’s work on climate change and health ([EB154/PSR/15](#)).

Critique

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

However, while the rhetoric of 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 [EB154/25](#).

The report does note the differential impact of global warming with LMICs more affected, but it does not recognise 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 countries 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?

Primary health care and community engagement

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.

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 WHO 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.

Draft resolution on Climate change and health ([EB154/CONF./12](#))

The preambulatory paragraphs in the draft resolution articulate clearly the present reality and future threat of global warming, including for health; highlights the need to scale up financial transfers to support scaled up adaptation in the developing countries (including loss and damage funding); and recalls Article 2, paragraph 2, of the Paris Agreement, which provides that “the Agreement will be implemented to reflect equity and the principle of common but differentiated responsibilities and respective capabilities, in the light of different national circumstances”.

The operative paragraphs of the resolution urge a range of constructive initiatives on member states and for the Secretariat.

In view of the failures hitherto to curb global warming and the magnitude and urgency of the threats to health, PHM strongly urges the adoption of the draft resolution.

Bracketed sections reveal multiple obstacles to consensus

The version of the draft resolution published during EB154 ([EB154/CONF./12](#)) has many clauses fully or partially bracketed. The Board anticipated that further intersessional consultations would yield a consensual text. No such text has been published yet (20 May).

Many of the bracketed sections in the draft appear to reflect the culture wars around any mention of gender and ongoing resistance by the developed economies to any mention of common but differentiated responsibilities (CBDR). PP19 in the draft resolution is fully bracketed and several developing country speakers highlighted the importance of this principle in their contributions in the debate.

CBDR is mentioned in Articles 3(1) & 4(1) of the 1992 [UN Framework Convention on Climate Change](#).

Art 3(1): “The Parties should protect the climate system for the benefit of present and future generations of humankind, on the basis of equity and in accordance with their common but differentiated responsibilities and respective capabilities. Accordingly, the developed country Parties should take the lead in combating climate change and the adverse effects thereof.”

Priti Patnaik in [Geneva Health Files](#) (28 Jan 2024) suggests that the allergic response to terms such as ‘gender responsive’ or ‘CBDR’ reflects concerns regarding the inclusion of such ideas in the revised IHRs and the proposed pandemic treaty.

PHM urges member states to insist on acknowledging and addressing gender equity in responding to global warming and likewise the principle of CBDR in relation to the challenges of mitigation and the funding of adaptation.

15.5 Economics and HFA

In focus

Extract from DG's consolidated report ([A77/4](#)):

The Executive Board at its 154th session noted the report on economics and health for all ([EB154/26](#)) and considered the text of a draft resolution introduced by Member States on the same topic ([EB154/CONF./8](#)).

In the discussions, Board members recognized the close two-way relationship between economic development and health and emphasized the importance of a multisectoral Health in All Policies approach. They highlighted the need to maximize the public value of investments in health and to counterbalance commercial influence that is not aligned with health for all.

The Board agreed that consultations on the draft resolution would continue during the intersessional period.

Background

See [EB154/26](#) which summarises the final report of the Council on the Economics of Health for All and reviews related ongoing work within WHO

See ['Health for All: Transforming economies to deliver what matters', final report of the WHO Council on the Economics of Health for All](#)

See also [Bulletin of WHO, 24 May Issue](#) themed around building an economy for health for all. See in particular the editorials: the first, by the Prime Minister of Finland and DG Tedros and two from the Secretariat of the Council.

PHM Comment

The Council's report

The report of the WHO Council on the Economics of Health for All projects an admirable vision of a global economy in which the economy works to support Health for All.

However, it provides a very limited analysis of the underlying forces and dynamics operating across the global economy which reproduce the obstacles to Health for All.

It over-estimates the driving capacity of well-being metrics as alternatives to GDP as guide posts for a reoriented global economy.

It is based on a limited range of drivers of change needed to realise the vision; little beyond inspiration and exhortation.

Most of the speakers during the Executive Board [debate](#) were appreciative of the Council's report. Some CSOs were less enthusiastic. KEI expressed regret that "WHO's proposals to de-link biomedical research and development incentives from monopolies and high prices had not been mentioned" [in the Council's report]. PSI "urged Member States to address the structural and political impediments to implementing the Council's recommendations".

The proposed resolution from EB154

The proposed resolution ([EB154/CONF./8](#)):

- Starts with preambulatory paragraphs which recall relevant resolutions and reprise the core arguments of the Council;
- Then OP1 urges member states to take action to reorient their economies, strengthen their public capacities, recognise health development as an investment rather than a cost, amongst other changes;
- OP2 (1) seeks to promote dialogue between health sector and international financial institutions with a view to encouraging the consideration of health in their deliberations;
- OP2(2) urges various stakeholders to support knowledge and information exchange on fiscal policy;
- OP3 requests the DG to develop a strategy, to undertake capacity building within the secretariat, and to support capacity building at the national level.

This resolution was not adopted by the EB in January. According to [A77/4](#) this draft resolution has been subject to intersessional consultations since EB154 but no revised Conf doc has yet been published for WHA77.

There are several references to people living under foreign occupation, which have been bracketed. Also bracketed is a reference to gender equality (OP3(2)) which may have offended some countries.

In the debate at EB154 most speakers supported the draft resolution. However the [US expressed](#) concerns about some aspects of the Council's report and sought further intersessional discussion. (The US has repeatedly chastised WHO for allegedly straying beyond its domain of expertise, in particular, in relation to intellectual property and access to medicines.) The [UK insisted](#) that "intellectual property rights framework must not be undermined".

Strengthening the draft resolution

PHM urges the Assembly to strengthen the draft resolution by specifying 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, the crisis of global warming and environmental degradation;
- identifying and exploring the barriers to the implementation of the 13 recommendations; including 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;

- reviewing previous proposals developed through WHO to de-link biomedical research and development incentives from monopolies and high prices; and
- exploring further the scope for 'meaningful public engagement' and community - healthcare partnerships working towards intersectoral action towards health for all.