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People's Health Movement

People's Health Movement

Background and Commentary on Items before EB156 February 2025

This analysis and commentary on selected items coming before the WHO Executive Board in February 2025 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 page for EB156 which provides direct links to Secretariat papers as well as PHM's Item Commentaries.

This integrated version of PHM's commentary is published 30 January 2025. For some agenda items there is no PHM Comment yet; in some cases because the papers were late; in other cases because our teams are still working on them. Users are invited to check on the EB156 Tracker page for PHM commentaries not included in this resource. They will be published on the Tracker as they are finalised.

Your comment and feedback would be most welcome. Write to editor@phmovement.org.

PHM thanks our team of analysts and our wider network of consultants.

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Item 6 UHC

In focus

The Director-General's report (EB156/6) summarizes progress towards universal health coverage in 2023–2024, including primary healthcare and integrated people-centred health services in response to resolutions WHA72.2 (2019) and WHA76.4 (2023) and decision WHA77(16) (2024).

The report highlights achievements and major challenges in expanding quality service coverage and strengthening financial protection. The Board will be invited to note the report and identify priorities in preparation for the next high-level meeting on universal health coverage in 2027.

Background

Tracker links to previous EB and WHA discussions of UHC and/or PHC

PHM Comment

The WHO Report EB156/6 for this agenda item is forthright in its acceptance that progress with respect to access to care and financial protection are off track globally. Over 4.5 billion people were not covered by essential health services in 2021.

And financial hardship has worsened since 2000, with 2 billion people experiencing catastrophic or impoverishing health spending due to out-of-pocket health costs in 2019. Improvement in global UHC service coverage index has stalled, and even the coverage this indicator projects given how it is measured and what is measured, is in the view of PHM an overestimate. The Report also projects the huge levels of preventable mortality and impoverishment that this has contributed to.

We also note, that unlike the reports under almost all other agenda items, the activity with regard to primary healthcare has been mainly in the regional offices and areas. Further the activities reported are mainly in terms of some governance and guidance creation processes. There is little in the report in terms of measured increase in services delivery, financial protection or outcomes. The contrast between the structure of this report on PHC and UHC and the reports on disease specific NCDs (in Item 7) and specific communicable diseases (Item 9) is instructive. In the latter there is no mention of primary healthcare, or UHC or the need to integrate those verticals with rest of health systems, much less with the thrust of PHC and UHC, or about what regional offices are doing. Every activity is Geneva based. In this agenda Item 6, there is little about integration of disease specific verticals, and about the contribution at the global levels.

PHM has consistently and clearly articulated earlier that we attribute the UHC progress being off track as a result of wrong choice of strategies and not poor implementation alone. This is reflected in para 10 where most of the examples are of shifting to insurance as equal to UHC. We highlight that publicly funded health insurance as rolled out in LMICs is significantly different from the social health insurance in some of the high income countries and these are failing to deliver financial protection or improvements in public services. We note that some examples of strengthening public services are mentioned with respect to Chile, Guyana, Belize and Timor leste, and Faafu atoll of Maldives, but these seem small and exceptional rather than the rule.

The regional initiatives are most welcome. These include the pooled procurement in the Eastern Mediterranean region and measures to strengthen capacity in the Americas, and the Regional Primary

Health Care Platforms for learning and dissemination in SEAR; all innovative and need to be sustained and scaled up.

On the health workforce, the report flags the huge shortages and the problems of migration but has little to offer for a way forward. Similarly the Report correctly identifies high inequality in health spending across countries as a problem and the contribution that the debt burden makes to reducing health expenditure where it most needs to increase expenditure- but again there are no concrete proposals.

We are most concerned with para 20 which talks of the Secretariat "resetting the UHC Partnership, through which WHO provides tailored three-level support on UHC in 125 Member States for 2025–2027." and of a "Health Impact Investment Platform with regional development banks to catalyse US$ 1.5 billion in investments in primary healthcare" and of a "Multi-Partner Trust Fund" with ILO and OECD to tackle the 11.1million health worker shortfall." We caution that any form of private investment, or even public investment which is loans based (debt-instrument) is likely to over-burden any country which already has a debt problem. We note that all these strategies must be reconsidered after the US withdrawal, and investments from corporate agencies, directly or indirectly, should be viewed with great caution.

The withdrawal of the USA from WHO is an opportunity to weaken the grip of corporate control over global institutions as USA has been the main champion of such institutions and policies and the main impediment to policies favouring health equity and efforts to limit the role of profiteering in health.

We also note that the worsening situation in financial protection is also a direct result in the increasing privatization of healthcare. In most LMICs as investment in public health facilities stagnates or are even de-funded,access and quality in public health care decreases and people are forced to seek alternatives in private health. Many countries see the resultant growth of what is now termed as " healthcare industry" as a desirable since this pushes up overall economic growth rate and provides higher return on investments for private capital.

It is also important to understand and fix accountability of global health and financial institutions, especially those like the IFC in promoting profiteering in the private sector and the failure to achieve financial protection and the role of WHOs vertical health programmes in undermining the primary health care approach.

PHM urges the Executive Board to provide direction regarding key themes for the third high-level meeting of the United Nations General Assembly on UHC in 2027 including:

- expanding the fiscal envelope through equitable tax reform (including international tax rules) and action to reduce the present debt crisis;
- a sober review of the costs and putative benefits of encouraging private sector healthcare delivery supported by health insurance as compared with publicly funded public sector delivery;
- economic relations and public policies which have the effect of deepening economic inequality (and cost barriers to access and/or medical impoverishment);
- the development of new health policy tools which can assist countries to develop practical health system development plans structured around their own realities which will guide the development of primary health care systems and health care financing arrangements among other aspects.

Item 7 Follow up of 3rd HLM at UNGA on NCDs

In focus

EB156/7 provides brief progress reports on the implementation of the following resolutions and decisions:

- Resolution WHA74.4 (2021) on reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes
- Resolution WHA74.5 (2021) on oral health
- Resolution WHA73.2 (2020) on the global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030
- Resolution WHA66.8 (2013) on the comprehensive mental health action plan 2013–2020
- Decision WHA72(11) (2019) on the follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases
- Decision WHA74(11) (2021) on the role of the global coordination mechanism on the prevention and control of noncommunicable diseases in WHO's work on multistakeholder engagement for the prevention and control of noncommunicable diseases
- Decision WHA75(11) (2022) on the follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

In para 41 the Board is invited to note the report and provide guidance in respect of the questions below:

- How can the Secretariat support Member States as they prepare for the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases? What additional technical discussions, dialogues, briefings and information sessions do Member States require?
- How could the outcome of the fourth high-level meeting best be utilized to further drive global progress on NCDs and mental health?
- How can the Secretariat further support Member States in their efforts to align with the strategies and plans covered in this report?

Background

Tracker links to previous EB and or WHA discussions of NCDs

PHM Comment

The report for this agenda item comprises a situation review regarding progress on NCDs and mental health and a number of very brief reports on the work of the Secretariat progress in relation to specific NCDs. The situation review provides grim reading with shortfalls against global targets in almost all areas.

Most of the reports include references to UHC, PHC, and multisectoral, whole of government, and whole of society responses. And yet, because these 'horizontal' dimensions are only included as brief references, the overall thrust of these policies emphasises vertical disease-specific initiatives. The consequence of this is that the horizontal challenges and the integration challenges are marginalised and remain at a level of theory and generality.

Consider:

- health system strengthening, focusing on public sector delivery with systematic links across levels,
- models for delivering primary health care (including the PHC contribution to all of the vertical NCD program objectives),
- prices, supply chain strengthening and local production of medicines, vaccines, diagnostics and other health care products,
- workforce development (mental health, dental workforce, imaging, surgery, etc)
- laboratory services,
- data systems,
- fiscal resources for health system development (including equitable taxation and international action on the debt burden),
- action on the social determination of health needs and risks (including poverty, inequality, alienation, unemployment),
- intersectoral action for health and well-being including housing, transport, water and sanitation, school health, occupational safety,
- many more.

Many of these issues are explored in EB156/6 (Item 6, UHC/PHC, on this agenda) but more needs to be done to integrate the disease-specific approach within a comprehensive health system strengthening approach.

PHM urges the Executive Board to ensure that the fourth high level meeting of the UNGA on NCDs is used to provide practical leadership in the development of integrated comprehensive health system responses to NCDs including practical solutions to the cross-cutting issues listed above.

Item 8: Mental health and social connection

In focus

The Director-General's report for this item (EB156/8) underscores the importance of combating social isolation and loneliness to improve mental and social health, outlining WHO's commitments and proposing actions to advance social connection as a global public health priority.

In para 23 the Secretariat invites the Executive Board to note the report and to provide further guidance.

Background

In November 2023 the DG established the WHO Commission on Social Connection; a report is expected in May 2025. It is not clear which donors are paying for the work of the Commission but we do know:

1. That there are three people from the US on the Commission including one of the two co-chairs;
2. That the US made an intervention in the EB154 discussion of Well-being and Health Promotion on behalf of the Commission, emphasising the importance of social connection for human health, asserting it had been overlooked and promising effective solutions;
3. WHO published an 'advocacy brief on social isolation and loneliness among older people' in 2021 in association with the United Nations Department of Economic and Social Affairs and the International Telecommunication Union (a body which includes in its membership over 1000 global companies, many directly involved in IT);
4. The Commission hosted 'a multistakeholder event' at the World Health Summit in Berlin in October 2024, at which a keynote speaker was Google's chief health officer;
5. This item on Mental health and social connection was included on the EB156 agenda at the request of two member states (para 1 of EB156/8); presumably a resolution is being prepared for WHA78.

PHM Comment

The report starts with the definition that "Social health refers to the adequate quantity and quality of relationships in a particular context to meet an individual's need for meaningful human connection….". This then leads to the concept of social connection as being synonymous to social health and then to social isolation and loneliness as the main form of social disconnection and proceeds to propose a programme to address this. This is a huge reduction of the concept of social health. Social isolation is only one aspect. Social health is affected in conditions of conflict, in conditions of poor personal physical security, or precarious employment, or overcrowding and lack of privacy, or where there is stigmatization and isolation of communities by majoritarian forces and so on.

Reducing social health to a concern with social isolation is to render it toothless. In fact social health is affected by the alienation that people experience through their roles in both production and consumption in ways that affects their mental health. Employment practices are exploitation in many cases and becoming more so with precarious work in high income countries and exploitative informal work on low- and middle-income countries which creates many mental health issues. In terms of

consumption a massive advertising industry sows disaffection to create demand and in doing so creates multiple stresses. Increasingly people must deal with corporate bureaucracies which are dehumanised and rely on understaffing to maximise profits which means “customers” are left feeling disempowered and frustrated. This often has negative effects on their mental health.

PHM considers that the missing concept in this paper is social cohesion. Connection is a static phenomenon – a link or an association that is there (or not), unable to deliver improvements in and of itself. In contrast, cohesion is a dynamic process: the action of forming a united whole. Cohesion is the social glue that joins people together as collectives around common interests (e.g. trade unions). Research has demonstrated that it is the foundation people need to act together to improve the conditions in which they live and work. Simple connections do not have the power to do this. Reducing social isolation with individual and/or IT solutions will not necessarily increase social cohesion and will not drive the community action for health improvements that WHO and member states desire. PHM urges member states to consider the crucial difference between focussing on connection as opposed to cohesion.

Social isolation is of course a problem but the proposal to address it is quite inadequate. There is no evidence cited or referred to in this report regarding the prevalence of social isolation, the societal context of social isolation or the relationships between social connection and health. There is reference to the quality as well as quantity of social relationships but no analysis of what quality might mean. The references in the report to ‘evidence’ make no distinction between causal associations and ecological associations.

The 2008 WHO Commission on the Social Determinants of Health found that:

> …avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.

The current report shows no inclination to explore social isolation in terms of the circumstances in which people grow, live, work, and age or the political, social, and economic forces which shape those circumstances (work and employment, urban design, transport, housing, culture, sport, racism, casteism, sexism, violence, etc).

In sharp contrast to the lack of evidence regarding prevalence, the societal context of social isolation or ramifying casualties, the Secretariat has focused on ‘technical interventions’ to address loneliness, building on earlier work on social isolation and ageing (supported by the ITU among others). There is only a passing mention of the word community in the line on the effects of mental health but never in context of social health. There is no mention of community engagement or community action in addressing social isolation. There are excellent examples of community based approaches from many LMICs to address these problems in different settings, but not recognised in this paper.

There is no trace of sociology or political economy in the EB document or in the Commission’s webpage. As unionised manufacturing is taken over by robots and young people are forced to find work in the precariat, is the number of relationships the only or critical factor in their well-being? The Marxist notion of alienation points to increasing levels of mental distress when people work under oppressive conditions which isolate them from one another in settings which privilege profits over workers’ health and wellbeing. The crackdown on trade unions in many countries is

likely to have an adverse impact on people's mental health by reducing opportunities for acts of worker solidarity.

In para 12 the report advises that promising solutions range from national policies and measures to improve social infrastructure to targeted interventions, such as social prescribing, cognitive behavioral therapy and psychoeducation. It advises that WHO has begun to map this evidence, but the focus of this mapping is very much on the individual. The Commission on the Social Determinants of Health included "structural determinants" in their conceptual map. There is no consideration in this report of how these structural determinants (including growing economic inequities) affect population mental health. These determinants will be covered in the forthcoming World Report on the Social Determinants of Health Inequities and it is surprising that this report does not refer to this forthcoming report.

Two sets of interventions are reviewed, 'in person interventions' and 'digital interventions'. While there are references to community level *outcomes*, the interventions are all individually focused. Surprisingly the WHO Department of Digital Health and Innovation does not seem to have been involved in the selection of digital innovations.

The lack of transparency regarding the funding of this project is regrettable. The references to the ITU as a partner and the presence of Google in the World Health Summit presentation suggest that the prominence given to digital interventions is not entirely the outcome of soberly considered evidence. Certainly there is no reference to any negative consequences of the rise of social media of which there are many. Australia has led the way by banning social media for those under 16 because of concerns about young people's mental health. The negative effects of 'digital interventions' needs to be recognised.

The 2008 Commission on SoDH identified social inclusion as one of the social determinants of health. It is not clear why, at a time when a new World Report on Social Determinants of Health Equity is being prepared (about to be launched), the WHO Department of Social Determinants of Health should have embarked on a new project which is completely at odds with the recommendations of the 2008 SDoH report. While WHO remains coy about the influence of donors on its agenda, it is hard not to entertain the possibility that the IT industry is involved.

The Commission (here) is top heavy with US representatives; three including the US Co-Chair. It is not clear what the impact of Trump's withdrawal from WHO will be or whether the putative support from the IT companies for this project will continue.

Bottom line

PHM urges member states to:

1. insist on transparency in terms of the role of donors in shaping programmatic priorities and the involvement of corporate players in health forums and their likely conflicts of interest;
2. express regret regarding the poor quality of science reflected in the current report;
3. ensure that the causes of social isolation that stem from structural determinants of health are fully explored including the increasing alienation produced by processes of production and consumption

4. seek Secretariat explanation of the divergence between the social determinants agenda and the social connection agenda and ensure that the emphasis on structural determinants in the World Report on Social Determinants of Health Equity is reflected in the social connection agenda;
1. be very wary about adopting a draft resolution endorsing this project for consideration at WHA78.

Item 9(i): Communicable diseases: meningitis

In focus

Global road map on defeating meningitis by 2030

In resolution WHA73.9 (2020) the Assembly approved the draft Road Map on defeating meningitis by 2030.

The Roadmap has three 'visionary goals' and five pillars and each pillar has a number of strategic goals each with their own activities and milestones.

In decision EB152(8) (2023), the Director-General was asked to submit a report to EB156 and then to WHA78 on progress in implementing resolution WHA73.9 (2020). This report is presented in EB156/10.

The Board is invited to note the report and is invited to provide further guidance in particular in relation to the two questions:

- What opportunities have countries identified and what barriers do they face when implementing the road map's five pillars?
- How can the Secretariat further help Member States accelerate the road map's implementation in terms of meningitis prevention, control and management, awareness raising and advocacy?

Background

See Tracker links to previous EB and or WHA discussions of meningitis

See also the 2024 report on investing in defeating meningitis, and the report on Developing national meningitis plans: an operational manual. See also the African Region report on the implementation of the Road Map (AFR/RC71/8).

PHM Comment

Meningitis is a life threatening and potentially disabling group of diseases which are common, particularly in the 'African meningitis belt'. The road map is a good initiative in terms of promoting an evidence approach to vaccine development and delivery.

However, the road map is too narrow and its focus on vaccination has led to the obscuring of several key issues where WHO has important policies.

The road map mentions a wide range of other WHO policies and programs and advises that the Technical Taskforce "is working to identify potentially complementary initiatives and will establish and maintain linkages with these initiatives to ensure alignment of goals and integrated approaches, wherever possible".

However this list of 'other global initiatives' is also quite narrow and does not appear to have been updated since its adoption in 2020.

The road map appears to focus on vaccine access and price but there are no references (in the road map, the investment case, the operational guidelines or the African Region report) to more recent work on regionally based research and production capabilities.

Health systems strengthening, including primary health care, is central to surveillance, immunisation, diagnosis, care, and rehabilitation. However, no useful guidance is provided in either the Operational Manual or the African Region report, as to how vaccine specific actions are to be integrated into health system development.

The reference to universal health coverage is not useful, particularly since WHO remains torn as to the role of private sector delivery under UHC.

Climate change and dust storms

The seasonal relations of meningitis incidence in the African meningitis belt is well known (much more common in the drier January to June period) but there does not seem to be any urgency to explore the implications of this for prevention or to explore the implications of global warming on this link.

Li et al (2025) note the increasing frequency of dust storms over the last decade in West Africa and East Asia which they associate with global warming. They note the association of meningitis outbreaks with the drier and dustier part of the year in West Africa and suggest that with climate change the risk of meningitis may escalate. It is surprising that it is ignored in this report.

The neglect of the social determinants of meningitis morbidity

The Road Map, the Operational Manual, and the African Region report all fail to address the social determinants of meningitis and how vaccine specific initiatives can be integrated with policies and programs directed towards literacy, displacement, indoor air pollution, tobacco use, sanitation, and malnutrition.

Pinilla-Monsalve and colleagues (2023) find:

“The post hoc analysis demonstrated that countries within the AMB significantly differed ($p < 0.050$) from both non-AMB African countries and non-African countries in geo-environmental aspects (temperature, humidity, and air pollution), demographic characteristics (age dependency ratio), socioeconomic conditions (literacy and social conflicts generating displacement), consumption habits (tobacco smoking rate in men), unmet basic needs (access/use to clean cooking facilities and sanitation), and additional comorbidities (anemia, vitamin A deficiency, malaria, hepatitis B, and anxiety).”

They comment that

“Our results support previous findings from studies at the individual and subnational levels, as similar variables were significant from the ecological scope. Population research conducted in specific AMB countries has shown 2.1 times higher incidence in areas with high population density, 34.8 times in those with very high levels of absolute poverty, and 41.6 times where the inhabitants exhibit low literacy rates (57). It has also been proposed that the use of closed kitchens with wood ovens, unhealthy housing, and low household income increase the likelihood of BM (27).”

Potential conflicts of interest

There has been no transparency regarding the funding of the Road Map. The report before the Board suggests that Gates and Gavi are quite central but there is no clarity about the role of the vaccine manufacturers.

Bottom line

PHM urges Board members to call for renewed effort to integrate vaccine specific goals and actions with other synergistic policy areas:

- Health systems strengthening
- Implications of climate change
- Social determinants which shape exposure, vulnerability, delays in diagnosis, and care

References

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Li, T., A. J. Cohen, M. Krzyzanowski, C. Zhang, S. Gumy, P. Mudu, P. Pant, Q. Liu, H. Kan, S. Tong, S. Chen, U. Kang, S. Basart, N. D. E. Touré, A. Al-Hemoud, Y. Rudich, A. Tobias, X. Querol, K. Khomsi, F. Samara, M. Hashizume, M. Stafoggia, M. Malkawi, S. Wang, M. Zhou, X. Shi, G. Jiang and H. Shen (2025). "Sand and dust storms: a growing global health threat calls for international health studies to support policy action." The Lancet Planetary Health 9(1): e34-e40, DOI: 10.1016/S2542-5196(24)00308-5, Accessed 2025/01/22.

Item 9(ii): Communicable disease: leptospirosis and skin infections

In focus

The Director-General's report (EB156/9) on leptospirosis and skin diseases outlines progress and gaps in surveillance, diagnosis and control of leptospirosis and integrated approaches to skin diseases and related conditions, including neglected tropical diseases, sexually transmitted infections and mpox. It describes the Secretariat's actions to provide support to Member States to address these challenges.

PHM Comment:

WHO engaging with both these communicable disease challenges is most welcome. We note however that there is little reason to bring in sexually transmitted diseases into this, because earlier resolutions on HIV, Hepatitis and sexually transmitted diseases have adequately addressed this issue. (Resolution WHA75.20 (2022): The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030).

Perhaps the fact that dermatologists in many countries are also STD specialists may be one reason, but public health of communicable disease is better organized on the lines of disease transmission rather than specialist boundaries. By itself, the discussion on sexually transmitted diseases in this resolution is very incomplete and misses to address both social determinants or the organization of care. However it does provide a cross reference to the main resolution.

On mpox too there is a more substantial strategic framework that this resolution refers to, namely the Strategic framework for enhancing prevention and control of mpox 2024–2027, which has been cross-referenced and is the main document in this area.

There is also a cross reference to "WHO road map for neglected tropical diseases 2021–2030" which sets global targets for the control, elimination or eradication of such diseases and the related document "strategic framework for integrated control and management of skin-related neglected tropical diseases" which was published in 2022. The main disease in this category is leprosy, which is a major problem, which has been prematurely declared as eliminated in many countries, and which remains a major public health challenge. There is a need for much more serious engagement with leprosy and indeed with all the neglected tropical disease and the current policies on this are failing. Or we can say, Neglected Tropical Diseases remains neglected. What this resolution also does is to flag the issue and give a cross-reference.

We understand that sexually transmitted diseases, mpox, and NTDs are included here as a way of showing the linkage, and drawing attention to this agenda being dealt elsewhere; this resolution does not include sufficient information on progress or guidance to member states on these three topics.

On leptospirosis, the resolution is comprehensive and most welcome. It is clear that a lot more knowledge, both with regard to epidemiology and social determinants is required and also that much more technological innovation is required before WHO has an adequate strategy to address this emerging challenge. However it is to be appreciated that WHO has acknowledged this as a serious public health challenge, has a good understanding of what more is required and is moving in this direction. We fully agree with its conclusions in para 8 that "Sustained financing is critical to advancing leptospirosis control efforts and improving the associated surveillance, diagnostic tools, vaccination

research, and environmental and community-based interventions. Given the potential increase in the public health impact of leptospirosis as a result of climate change, a multisectoral response embracing a One Health approach should be prioritized." We also appreciate and endorse its well drafted call for action (in paragraph 7) on the social and environmental determinants of the spread of this disease and vulnerability to its effect. This is indeed where member states should prioritize their actions against this challenge.

On skin diseases it appears that the WHO understanding is that it may be adequate to address this problem through the strategic frameworks, NTDs and Mpox. Its actions by the EB says as much. But this is quite inadequate. What it should have said is that addressing skin diseases must be a necessary part of the primary health care package, and should always be a part of UHC road-map. The marginal costs of adding this are minimal, the justification for leaving it out are even less. Most skin infections are fungal or bacterial and lend themselves to primary level care, and the chronic illnesses like psoriasis are best seen as part of a primary health care approach. The development of apps is not the priority. The priority is inclusion in the assured set of services available from the network of primary care providers. The priority is also addressing the social determinants of the common skin ailments especially the lack of availability of clean water, space and habitats required for personal hygiene. Neither of these important measures are mentioned in the way forward.

There is a need to call for continuation of the efforts to address leprosy as a major public health problem and well integrated with good diagnosis and care for all skin lesions. The disease is far from eliminated.

The report does mention stigma and violence, but it need not be so discreet and could call out, name and shame the stigma against albinism and vitiligo that takes on a violent and dangerous form in some societies, as also call out the persistent stigma against leprosy as a barrier to addressing this disease.

In summary on the skin diseases agenda, PHM's asks are:

a) Include assured services against skin diseases in the primary health care and UHC packages
b) Act on the social determinants of the most common and frequent skin infections which are related mostly to working and living conditions- especially the ability to maintain personal hygiene.
c) Tackle stigma against albinism, vitiligo, leprosy, psoriasis and all chronic skin ailments.
d) Note that leprosy remains a public health problem, which is far from eliminated and take measures well integrated with primary healthcare to address this problem.

Item 10 Substandard and falsified medicines

In focus

Pursuant to resolution WHA65.19 (2012), the Director-General has circulated a report (EB156/11) on the outcomes of the twelfth and thirteenth plenary meetings of the Member State mechanism on substandard and falsified medical products. The report includes a review of the progress made in implementing 10 activities prioritized for the period 2024–2025 that align with WHO's strategy to prevent, detect and respond to substandard and falsified medical products.

Also submitted is a report (EB156/12) on the outcomes of the independent evaluation of the mechanism. It also includes recommendations for restructuring the Mechanism. The Board is invited to note the report and to provide comments and guidance on follow-up actions to the independent evaluation, including a question on "What measures can be taken to increase Member States' participation in the mechanism and its work?"

The Board is invited to note both reports; to provide guidance on follow-up actions to the independent evaluation (in particular, increasing MS participation) and to (decide to) request the Director-General to submit the report of the fourteenth meeting of the Member State Mechanism to the Seventy-ninth World Health Assembly through the Executive Board at its 158th session.

Background

Tracker links to previous WHA &/or EB discussions of SFC

Homepage for MSM on SFC

Resolution WHA65.19 (2012) established the Member State Mechanism on Substandard and Falsified Medicines to improve collaboration among Member States and WHO to prevent and control substandard and falsified medical products from a public health perspective, excluding considerations of trade and intellectual property. It is the primary intergovernmental mechanism for MS to convene, make policy recommendations, exchange knowledge, support mutual efforts and coordinate actions to address the challenge of substandard and falsified medical products.

See Legge 2013 for the pre-history of the MSM (2013-2013). See also K.M. Gopakumar's contribution to a G2H2 webinar focused on this agenda item, for further background on the genesis of the mechanism, and on the evolution of the terminology WHO has used over the years to describe non-originator drugs.

See also the debate at WHA70 (Item 13.6) which led to WHA70(21) through which the Assembly decided to replace the term "substandard/spurious/ falsely-labelled/falsified/counterfeit medical products" with "substandard and falsified medical products" as the term to be used in the name of the Member State mechanism and in all future documentation on the subject of medical products of this type.

US withdrawal from WHO

Upon entering office, US Pres. Trump issued an executive order announcing the USA's intention to withdraw from the WHO.

Since the closure of the 12th meeting of the Mechanism, the USA and Brazil are representing the Americas on the Steering Committee of the mechanism. The USA chairs the working groups on:

- Activity H: Develop strategies for national regulatory authorities to mitigate public health risks posed by the distribution of substandard and falsified medical products through informal markets
- Activity F: Chair of newly established working group F: the United States of America; Strengthening the supply chain of high-risk excipients and related raw materials.

Reports on the 12th and 13th meetings of the MS Mechanism on Substandard and Falsified Medicines (EB156/11)

During the 12th meeting of the MS mechanism a new priority activity focusing on the identification of and response to "emerging issues" on substandard and falsified medical products was created. The meeting also emphasised the importance of multisectoral engagement. In light of this, it reflected on the fact that a stakeholder mapping would be an important step that could provide additional insight into the ways in which NSAs might be engaged by the mechanism in the future.

The 13th meeting of the mechanism included a report on the independent evaluation of the Member State mechanism. The report notes that the Steering Committee of the mechanism needed more time to consider the recommendations from the evaluation (see EB156/12). The Steering Committee recommended that the Member State mechanism:

- propose that the governing bodies refrain from taking any decisions on the evaluation at their forthcoming meetings in 2025;
- request that the report of the 14th meeting of the Member State mechanism be submitted to EB158 and to WHA79, so that the governing bodies may consider the outcomes of the mechanism's deliberations and take any action that might be required.

During the 13th meeting of the MS Mechanism a proposal was submitted to invite the Bill & Melinda Gates Foundation to give a briefing at a future meeting of the Steering Committee on its efforts relevant to prioritized activity D, i.e. reducing the burden of substandard and falsified medical products. The Steering Committee agreed to this proposal.

Evaluation of the MS Mechanism on Substandard and Falsified Medical Products

EB156/12 summarises some of the key findings of an independent evaluation of the MS Mechanism. These include that:

- HIC and MIC Member States participate in the MS mechanism more than others;
- Robust evidence on the effectiveness and impact of activities was lacking;
- Engagement with non-State actors and other stakeholders (in line with FENSA) is important to ensure the coherence of the MSM work;
- Financial security for the mechanism exists for the short term (approximately the current biennium); the narrow donor base brings risk;
- There was limited evidence that the mechanism has proactively considered gender, equity and human rights in planning and implementing its activities;
- There was generally strong support for increased engagement and involvement of external stakeholders, both from those working in the mechanism (Member States and the secretariat) and from donors and other stakeholders. However, caution is urged with respect to both

dissemination of country-specific information (e.g., in relation to substandard and falsified incidents) and to engaging non-State actors, including the private sector in accordance with the Framework of Engagement with Non-State Actors.

- With respect to equity, the mechanism may wish to consider giving more explicit priority to the needs of the most vulnerable population groups. More needs to be done to promote the active participation of lower income Member States in the mechanism

The evaluation also resulted in recommendations on how the functioning of the MS mechanism might be changed. Highlighted here are recommendations 1 and 5, both of which impact on the MS mechanism's engagement with NSA, and which potentially raise challenges for the MS mechanism around conflict of interest. Quoting from the report, recommendation 1 is as follows:

"Recommendation 1: Member States should consider revising the format of the Member State mechanism to benefit from more relevant technical expertise; better collaboration with external stakeholders; and potentially increased funding and Member State participation. Two options are possible as ways to make progress in these areas.

- Option A: Dissolving the current Member State mechanism and establishing a new format which would report to the WHO Director-General but would still have significant input from Member States. This could be an advisory group or a more bespoke hybrid format. Such revision would need to be proposed by the Member State mechanism and approved by the World Health Assembly through the Executive Board. A task force could be established to guide this process.

- Option B: Using the existing Member State mechanism format and to experiment with increasing the involvement of technical experts in the fields related to the mechanism's working groups, and increasing Member States' participation as well as engagement with external stakeholders, including in formal meetings (in line with relevant World Health Assembly resolutions and decisions, World Health Assembly rules of procedure and within the Framework of Engagement with Non-State Actors).

Option A would have the best chance of success over the long term. Option B would be less challenging to achieve. In choosing between these two options, Member States could first consider exploring option B."

Recommendation 5 as it appears in the report:

> "Recommendation 5: Improve external engagement by developing differentiated engagement strategies (in line with the Framework of Engagement with Non-State Actors). This will include ways to engage with donors, strategic and operational partners. As a basis for developing a stakeholder engagement strategy that targets strategic and operational partners, a full mapping of stakeholders should be conducted. The Member State mechanism, in consultation with the Due Diligence and Non-State Actors unit of the Office of Compliance, Risk Management and Ethics, should specifically develop guidance for engagement with external stakeholders, such as the pharmaceutical industry that has much to offer in the fight against substandard and falsified products, but caution is required due to potential or perceived conflict of interest. At the regional level, efforts should be made to seek increased collaboration, such as by increasing regional involvement in some Member State mechanism working groups and with national focal points."

PHM Comment

PHM urges MS to instruct the secretariat to ensure any changes in the functioning of the MS mechanism ensures transparency regarding its deliberations, with both internal and external stakeholders. We urge that any stakeholder engagement includes all relevant actors, including generics manufacturers, public pharma entities and CSOs advocating for equitable access to medicines; not only big pharma.

We urge MS to urgently turn their attention to interventions that address the high costs of accessing medicines and healthcare services in a timely and appropriate manner, and ensuring the functionality of health systems, and public health facilities in particular. In this regard, it is important that the long-awaited report on social determinants of health, discussed at EB152, be released.

Item 11 Standardised nomenclature for medical devices

In focus

In accordance with decision WHA75(25) (2022) the Director-General has published a report (EB156/13) on the integration of terms, codes and definitions in the Priority Medical Devices Information System (MeDevIS) and their linkage with other WHO platforms. The Board will be invited to note the report and provide further guidance.

Background

EB156/3 provides an overview of the history of this complicated story. See also Tracker links to previous EB &/or WHA discussions of medical devices and the WHO summary of Executive Board decision making related to a standardized nomenclature for medical devices and its use in Priority Medical Devices Information System (MeDevIS).

A standardized international classification, coding and nomenclature for medical devices supports technology assessment, regulation (standard setting, marketing approval), patient safety (adverse event reporting), procurement (discoverability, ordering), and quality of health care (efficacy, cost-effectiveness).

A particular benefit of standardisation from WHO point of view is that it makes WHO's priority medical devices lists more useful by specifying the devices referred to more precisely. These lists presently include:

- reproductive, maternal, newborn and child health,
- cancer management,
- cardiovascular diseases and diabetes,
- eye care,
- emergency surgery, and
- in vitro diagnostics.

Most of these functions will still benefit from the new MeDevIS (including EMDN and GMDN systems) although research and evaluation across international borders will be somewhat more involved than if a single global system had been developed.

A further benefit of having a standardised nomenclature system is that it can be used to support mandated unique device identification (UDI) and the documentation of UDI in clinical records. This requirement can facilitate international collections and analyses for patient safety, clinical research and surveillance post marketing approval. (See TGA and FDA on UDI.)

While the International Medical Device Regulators' Forum originally recommended the development of a globally applicable mandatory UDI (here) this has been shelved for the time being. At the national level mandatory UDI, using either EMDN or GMDN, is still implementable.

PHM Comment

The Secretariat has accepted that a single universal open source, freely available nomenclature system which articulates with other WHO classifications, especially ICD11 is not practicable.

The reluctance of certain countries, currently committed to a particular system, to agree to moving towards international standardisation in accordance with the principles outlined by the Secretariat, is understandable in terms of avoiding disruption to their existing systems.

The medical device industry is huge and politicians are very sensitive to allegations regarding ‘red tape’. Presumably governments have been under pressure from device manufacturers, hospital organisations, and private health insurance organisations all of whom have organised their systems around a particular classification.

The work the Secretariat has done in setting up MeDeIS1 is appreciated.

PHM urges member states to support the Secretariat’s continued development of MeDeIS, expanding its range of guidance resources on priority medical devices, continuing to work towards interoperability with other classification systems (especially ICD, ICPM, and ICF).

Advice on the long term pathways directed to harmonising EMDN and GMDN would be useful.

Item 13 Draft traditional medicine strategy

In focus

In decision WHA76(20) (2023) the Health Assembly decided to extend the WHO traditional medicine strategy to 2025. In response to the request to draft a new global strategy on traditional medicine for the period 2025–2034 in consultation with Member States and relevant stakeholders, the Director-General has posted the draft strategy (EB156/16) for consideration by the Seventy-eighth World Health Assembly through the Board.

Background

Tracker links to previous EB & /or WHA discussions of traditional medicine

See also South-South Dialogue on Sustainability: Traditional Medicine in the Global South webinar program, UTC 1300, 15 and 16 November.

PHM Comment

Traditional (including Indigenous) health knowledges and practices are intrinsic to the identities and meanings of many different cultures. These, and other healing traditions which do not align with allopathic medicine, offer people and communities a sense of autonomy in choosing how to manage their health. It is necessary and proper that WHO should engage in this field as part of promoting Health for All.

Concepts of integration and complementarity are different; they are defined in the context of the relationship of traditional knowledges and practices to the established institutions of allopathic medicine. WHO should exercise caution in offering universal principles to govern such relationships.

PHM appreciates the work that WHO has put into the draft traditional medicine strategy but urges the Board to ask for further work before presenting a revised draft to the Health Assembly.

The present draft has significant weaknesses. To mandate it as it stands risks harmful albeit unintended consequences.

- the present draft is infused with the assumptions of coloniality and it privileges the gold standard status of modernist science;
- the present draft fails to acknowledge the continuing pressures of coloniality (displacement, extractivism) on the cultures and environments of many Indigenous peoples, both in relation to the social (political, economic) determination of their health, and their traditional knowledges and health related practices;
- the discussion of integration and complementarity positions, as the key policy challenge, the relationship of traditional knowledges and practices to an unproblematised and dominant allopathy ; the need for respect and the scope for mutual learning is ignored;
- the contradictions between collectively owned Indigenous knowledges and the norms and institutions of privatised intellectual property are not recognised nor addressed.

Coloniality and empiricist science

The draft strategy uses the terms ‘evidence’ and ‘efficacy’ throughout. ‘Evidence-based’ is the first principle and establishing the ‘evidence-base’ is the first strategic objective. The assumption conveyed is that the norms of empiricist science are the ultimate determiners of value.

There is no acknowledgement of the role of empiricist science in rationalising racism and colonialism. There is no acknowledgement of the continuing use of empiricist science to discount, disregard, and disrespect Indigenous peoples and the objectified, racialised ‘other’.

When referring to ‘evidence’, it is necessary to remember that Indigenous peoples are ancient peoples, whose strength and survival have been enabled by their cultural traditions including their ancestral traditional medicines; these traditions are a necessary part of strengthening health in their lands.

The privileging of ‘evidence’ and ‘efficacy’ raises the prospect of documenting and evaluating ‘non-codified’ medical systems and discounting those traditions which do not meet the standards of Cartesian rationality.

Validating traditional knowledges through the norms of scientific modernity risks stripping Indigenous knowledges and practices from their cultural context including their spirituality.

Health, culture, environment

The discussion of holism in relation to health does not do justice to the intrinsic links between Indigenous spirituality and traditional ancestral medicine in the world. When communities are mentioned, they must be considered within their territories of life, respecting their uses and customs, as well as their own worldview and ancestral spirituality.

The draft approaches traditional medicine as if it were separate from its environmental context including land rights, water sources, and biodiversity. Without these traditional medicine does not exist.

Any future draft of this strategy must address the social determination of Indigenous health including extractivism, global warming and displacement which are contemporary existential risks to the health of Indigenous peoples.

The draft recognises that traditional medicine is rooted in the natural environment but then identifies a need for ‘sustainable TCIM practices’ as part of protecting biodiversity and implementing One Health policies. It is true that there are some well-known instances of the unsustainable sourcing of traditional medicines but the larger threats to biodiversity arise from growth-fixated capitalism and extractivism. In this respect Indigenous spiritualities have a major role to play in promoting a more sustainable relationship between human society and the rest of the natural environment.

The draft endorses the One Health approach to environmental policy and the interactions of humans, animals, and plants in the environment. This is unfortunate because One Health ideas are being widely used to suggest that sustainability, biodiversity, and health security are compatible (can be made compatible) with growth-fixated capitalism.

Integration and complementarity: loose and risky concepts. What about respect?

The draft proposes the ‘integration of TCIM into health services’. There are some settings where this has been successfully implemented although often at the cost of the commodification of therapeutics. However there are other settings where integration into health services suggests the subordination of traditional knowledges and practices to modernist medical science. The idea of complementarity carries some of the same risks, when the price of legitimation is subordination.

What is missing from this discussion in the draft strategy is respect and the possibility of a transdisciplinary accommodation of difference. In this respect the modernist insistence on singular truth constitutes a real barrier to a respectful coexistence of knowledges.

Modernist medical science stands to learn much from traditional cultures of health and healing including the relations of health to the environment (including spirituality) and the empowerment which results from autonomy in health care choices.

Protecting collectively owned intellectual property

The draft strategy touches upon intellectual property in Direction 4.2.

Some streams of traditional medicine have been incorporated within the framework of privatised intellectual property but not all. There is continuing commercial interest in the mining of Indigenous traditions for products which are ‘efficacious’ in the paradigm of modern medicine. The privatisation of such knowledges, previously collectively owned, can amount to theft (in the familiar traditions of colonialism).

The draft should specify that the Convention on Biodiversity and the Nagoya Protocol should be assigned legislative precedence where they run counter to the rules of WIP and TRIPs.

Item 15 WHO's work in emergencies

In focus

In his report (EB156/18), the Director-General describes WHO's response in 2024 to 45 health emergencies across 87 countries and territories and the concurrent operational challenges. WHO will continue to coordinate the health response, collaborate with partners, provide support to Member States in building critical capacities, and advocate for sustainable financing to address the increasing humanitarian health needs. The Board will be invited to note the report and provide guidance on:

- How can the Secretariat work with Member States and partners to secure more sustainable and predictable financing for health emergencies, ensuring that funds are used efficiently to provide life-saving health assistance, sustain essential services and address the growing needs of vulnerable populations affected by conflict, natural disasters and climate change?
- How can the Secretariat enhance its cooperation with Member States and partner organizations to improve coordination, streamline emergency response efforts and foster resilience in communities and health systems to better withstand future crises?

Background

Tracker links to previous EB &/or WHA discussions of emergencies

PHM Comment

The WHO continues to face increasing demand as health emergencies expand (new conlficts, e.g.Sudan), are slow to de-escalate (e.g. Palestine, Ukraine), and as other UN Agencies that might otherwise assist are underfunded (e.g. UNRWA – not mentioned explicitly in this document but likely to be relevant).

PHM welcomes the emphasis on sustaining essential services during health emergencies.

The document notes that:

"The WHO's 2024 Global Health Emergency Appeal called for US$ 1.5 billion to protect the health of the most vulnerable populations facing emergencies. It represents the estimated total amount needed to provide support to 41 ongoing health crises around the world. As at 22 October 2024, WHO had access to US$ 1.02 billion in funding to respond to urgent and complex health emergencies, of which US$ 415 million had been received in 2024. The **remaining funding gap of US$ 478 million** limits the ability of the Secretariat and of Member States to meet the health needs of communities impacted by health crises".

Many of the drivers of the emergencies mentioned in the report are avoidable (e.g. climate crisis; violence and conflict; proliferation of arms industry; disregard of international law; food systems contributing to zoonotic diseases, hunger and malnutrition; IPR and trade policies that prevent diversified regional manufacturing of health products required to manage outbreaks, PHEICs and pandemics) but the report does not frame them in these terms, nor does it discuss the need for structural interventions that address the "causes of the causes".

Item 16 Implementation of resolution WHA75.11 (2022) Ukraine War

In focus

Pursuant to decision WHA77(17) (2024) on Health emergency in Ukraine and refugee-receiving and -hosting countries, stemming from the Russian Federation's aggression, the Director-General will submit to the Board a report (EB156/19) on the Secretariat's response on the implementation of resolution WHA75.11 (2022). The report will detail the impacts on health and WHO's support to the health sector. The Board will be invited to take note of the report.

Background

Tracker links to previous EB &/or WHA discussions of resolution WHA75.11 (Russia Ukraine war)

PHM Comment

There is a lot of data provided in EB156/19 without a lot of context or analysis but this may reflect the difficulties of operating in this environment.

There are no estimates as to causes of death.

The report provides the number of health services with infrastructure damage but not whether this meant they were all not functioning at all or still partially functioning. It reports that 99 facilities (12%) were damaged for non-conflict reasons; how they were damaged is not clear.

Staff shortages are high and the main factor affecting functionality. This is presumably because of displacement but it doesn't specify or indicate what is being done to try and raise numbers (maybe the outreach programmes are considered a more appropriate strategy in the circumstances but the report does not explain).

The cost of medicines for NCDs was a problem for 55% of people surveyed. Where are people buying their medicines or are these from the health facilities? Was this a problem before the conflict? WHO supplied $14.8million in medicine, medical equipment and supplies (presumably also between Jan and August 2024). Is this not enough?

The prevalence of pertussis, hepatitis A and measles are all worrying especially when compared with previous year when the conflict had already started. The report advises that 'additional immunization measures' started by the MoH have been successful.

The report advises that 395 requests for assistance were received via the health requests planning and response platform. It would be useful to know what these were for.

The outreach programme (11) sounds impressive and what is needed but a little more detail would have been helpful. How are the districts prioritised; where is the staffing coming from?

A lot of in-service training is being provided. A lot of organisations seem to be providing such training.

Some activities in neighbouring countries sound interesting. More detail would be helpful.

Funding appeal two thirds of the way through the year 24% funded is worrying.

Item 17 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

In focus

In Resolution WHA77.16 (2024) and Decision WHA77(18) (2024), the Health Assembly requested the Director-General to report "on the public health implications of the catastrophic humanitarian crisis in the occupied Palestinian territory, including east Jerusalem, including with respect to acts of violence against the wounded and sick, medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities, and submit recommendations in this regard to the 156th session of the Executive Board [...] bearing in mind the legal obligations of the occupying power."

The Director-General submitted the report EB156/20, detailing findings based on continuous monitoring and management of public health risks by the WHO emergency teams and in coordination with health partners. The Executive Board is invited to note the report and to provide guidance to Member States on how they can "prevent and mitigate attacks on healthcare" and "secure safe space for humanitarian action."

Background

Tracker links to previous EB &/or WHA discussions of Palestine

An agenda item on the health conditions in the occupied Palestinian territory has been included on the agenda of the World Health Assembly since 1968, the year following the Six-Day War and the Naksa (the displacement of hundreds of thousands of Palestinians).

The validity of the topic as a standalone agenda item has always divided Member States, with most of the global South supporting its importance while a smaller bloc, led by the United States and Israel, tend to reject the item on the basis that it "singles out" Israel for criticism, and "politicizes" the World Health Organization. Nevertheless, the item is discussed every year, centering on a report produced by the Director-General on the health challenges faced by Palestinians. Invariably, debate on the item is heated, and invariably it concludes with a tedious country-by-country roll-call vote before the adoption of a Decision requesting that the DG produce a similar report to present at the following year's edition of the Assembly.

At WHA77, amidst Israel's then eight-month-old campaign of military violence in the Gaza Strip, the health conditions in Palestine were discussed under two separate agenda items.

The Assembly adopted a Decision (WHA77(18)) condemning Israel's violence against the people of Gaza and its targeting of health infrastructure and personnel in the Strip, and a Resolution (WHA77.16) demanding that all parties to fulfill their obligations under international law, and calling for the rapid scale up of humanitarian and medical relief. Both actions requested the Director-General to report on the health implications of the humanitarian crisis in the Occupied Palestinian Territory.

Two weeks before the start of EB156, on January 19, 2025, the first stage of a multistage ceasefire in Gaza between Israel and Hamas came into effect.

PHM Comment

The Director-General's report EB156/20 describes the health and humanitarian crisis in Occupied Palestine, focusing on the period between January and August 2024. The bare statistics of the crisis are devastating, with at least 18,900 being killed and 38,916 injured by Israel's violence in Gaza alone during the reporting period. During the fifteen months since October 7, well over 46,000 deaths and 110,000 injuries have been confirmed in Gaza, the vast majority non-combatants.

As the report notes, the survivors of Israel's unprecedented onslaught have faced a health and humanitarian catastrophe characterized by the forced displacement of virtually the entire population of the enclave and manufactured shortages of food, potable water, sanitation facilities, medicines, fuel and medical supplies. Israel's campaign has generated conditions of hunger, thirst, overcrowding and poor sanitation. The spread of infectious diseases, notably diarrheal illnesses, has been alarming. In the summer of 2024, Gaza's first case of Polio in a quarter-century was detected.

The effects of all of these crises have been compounded by the destruction of Gaza's health care and sanitation infrastructure, which has been systematically targeted by Israeli forces, and the IDF's killing and abduction of health workers.

The morbidity and mortality figures detailed in the report are alarming but almost certainly underestimate the severity of the health crisis in Gaza, likely by a wide margin. The DG's report should have been more explicit about this. The official death toll of 46,000 total (or 18,900 in the reporting period) fails to capture the thousands of Palestinian civilians who are missing and trapped under the rubble of their former homes and communities. The report estimates that 22% of Gazans are living with mental health conditions. However, given the hellish conditions in the Strip, it is impossible to imagine that anyone in Gaza is living without the effects of considerable trauma, mental distress and psychological injury.

The report's chief failing is its absurd use of the passive voice. Notwithstanding Israel's objections to being "singled out" by the presence of this item on the agenda, it is worth noting that the DG's report goes to excruciating lengths to avoid any mention of Israel's criminality. Thus, the report can describe with despair how "[t]he health system in the Gaza Strip has been severely degraded by attacks on healthcare" and "missions carrying fuel, medical and other supplies [have been] largely impeded" without mentioning the state responsible for systematically shelling health care infrastructure and deliberately cutting off a population of two million people from the bare essentials of life.

These reports have not always been so sanitized (indeed, in the 1970s and 1980s, they were explicit in identifying military occupation as a barrier to health and describing the situation in Palestine as settler colonialism).

More explicit engagement with the political determinants of health is required. Even before October 7, 2023, the main factors impacting the health of Palestinians were political.

PHM calls on the Secretariat and Member States to acknowledge the political context of occupation, apartheid, ethnic cleansing and settler colonialism, a context that has direct impacts on Palestinian health, even outside of periods of acute military conflict.

WHO's advocacy for a ceasefire in Gaza has been admirable but not nearly enough. Instead, WHO should call for an end to the occupation – not for better conditions under occupation. Too often, this body shies away from making the political argument for health.

Finally, PHM calls on Member States and WHO to explicitly speak out against the occupying power's crimes of ethnic cleansing, genocide and collective punishment. These crimes directly impact health and, contrary to the claims of some Member States, are well within the remit of WHO.

Item 18 Universal health and preparedness review

In focus

As requested in decision WHA77(10) (2024) on Universal Health and Preparedness Review, the Director-General will submit a report (EB156/21) on the lessons learned, implications, benefits, challenges and options for the next steps. The Board will be invited to note the report.

The Board is invited to **note the report and to identify opportunities to improve and promote the Universal Health and Preparedness Review** as a mechanism to advance health security and solidarity among Member States. The Board is further invited to consider in its discussions the following questions.

- How can the Secretariat, guided by Member States, further improve awareness and understanding of the Review process and promote broader participation while prioritizing health security for those most in need?
- What are the best ways to integrate the Review into existing global health frameworks and regional initiatives to enhance its impact and coherence?
- What partnerships and collaborations with other global health initiatives would best support the Review's goals?

Background

Tracker links to previous EB &/or WHA discussion of UHPR

In November 2020, the DG announced the Universal Health and Preparedness Review as a Member-State-led initiative.

Resolution WHA74.7 (2021) requested the DG to develop a detailed concept note to guide a voluntary pilot phase of the Universal Health and Preparedness Review (hereinafter 'the Review'), based on the principles of transparency and inclusiveness.

A concept note was then submitted to and noted by WHA75; that concept note served as the basis for the development of the present Review

WHA77 noted the progress made and, through decision WHA77(10) (2024), requested the DG in consultation with MS to continue developing the voluntary pilot phase of the Review, including the voluntary pilot global peer review, and to report to the WHA87, through EB156, on lessons learned, implications, benefits, challenges and options for next steps. The present report responds to that request.

To date, 8 countries have completed the national review process under the Review, 3 of which having finished the global peer review stage. These are the Central African Republic, Iraq, Thailand, Portugal, Sierra Leone, Republic of the Congo, Cameroon and the United Republic of Tanzania. This voluntary pilot phase has contributed to compiling best practices and lessons learned have been compiled

Challenges (quoting from document)

As a MS-led process, the Review faced challenges in mobilizing resources, attention and political commitment. Time constraints associated with a heavy global health agenda; ongoing negotiations and multiple reforms, along with the Review's pilot phase status, contributed to varying levels of Member State engagement.

The length of the review phase leading up to the global peer review, which can span several months, was sometimes perceived as a deterrent. One concern relates to the momentum and commitment required to complete the process.

Benefits (based on MS's self-reports)

The report contains glowing language about the benefits of the review stating that "The Review process has led to improve global health security and governance by enhancing solidarity, inclusivity and coherence"; however mostly it speaks about the impact of the process at the national level, including:

- the success of the high-level processes in facilitating multi-sectoral dialogues at national level that encourage buy-in and ownership by high level politicians, stronger influence of health ministries within national leadership and more promotion of health security as a national priority;
- more appreciation for whole-of-government and whole-of-society approaches
- more insight into investment needs and funding challenges,

The report claims that the review contributed to "further promotion of solidarity, dialogue and cooperation at the national, regional and global levels to facilitate peer learning and exchange of best practices and lessons learned". In para 15 the document again states, "The Review process has fostered collaboration by facilitating dialogue among Member States and through regional bodies. In particular, the global peer review enabled global dialogue in the spirit of global solidarity, enhancing partnerships and promoting the sharing of best practices and lessons learned."

PHM Comment

Little information substantiating the successes of the review process is included in the document. However a URL linking to the "Outcome report of the Universal health and Preparedness Review Global Peer Review" is included in footnote 3. Presumably this report informs the analysis contained in EB156/21.

The data in the Outcome Report is largely self-reported by the MS undertaking the review process. While the MS self-reports welcome participation in the review process and feel that it has strengthened their ability to break out of sectoral silos at national level, helps create high-level political support for preparedness initiatives, and helps with cooperation at regional level, it is difficult to know how these benefits translate into greater "preparedness" in responding to health security threats in practice – especially in the absence of the institutionalising the kinds of concrete equity measures being advocated for by the Africa Group and Group for Equity in the Pandemic Accord negotiations.

The Board is being asked to provide guidance and feedback on "partnerships and collaborations with other global health initiatives" that would support the Review's goals. It is interesting that involving "global health initiatives" in preparedness matters is presumed as a matter of course, especially given criticisms in the academic literature and from practitioners that they sometimes undermine national control over emergency response efforts, and weaken national health systems by fragmenting them/institutionalising siloed approaches to national health governance (rather than all-of-society and all-of-government approaches).

The coloniality of global health

From 2008 when the IHRs (2005) came into effect, there was a rising tide of criticism directed at countries – largely low-income countries – who had not implemented the required core capacities. From 2014 the criticism was superseded by moves to put in place external inspections, initially voluntary, as part of holding delinquents accountable. The Joint External Evaluation was the first iteration; now subsumed in the Universal Health Preparedness Review.

The accountability of countries to the ‘international community’ matters, in relation to global health security as in many other respects. However, assessing this history of finger-pointing and diplomatic pressure in relation to core capacities needs to take account of some wider issues.

In our Background Note on Accountability for the Core Capacities we discuss the opportunity costs of the core capacities, the lack of accountability of the global North for the rising threats to global health security, and the coloniality of global health. (In full PDF here.)

Item 20 The impact of chemicals, waste and pollution on human health

In focus

In resolution WHA76.17 (2023), the Health Assembly requested the Director-General to submit a report on the outcome of the intersessional process to prepare recommendations on the Strategic Approach to International Chemicals Management and sound management of chemicals and waste beyond 2020 for consideration by the Seventy-eighth World Health Assembly through the Board, along with a report on any updates needed to the WHO road map to enhance the engagement of the health sector in the new instrument.

The report requested in OP4(9) of WHA76.17 is provided in EB156/23. In para 27 of EB156/23, the Board is invited to note the report and consider:

- how to respond to the International Conference on Chemicals Management's invitation to the governing bodies to endorse or appropriately acknowledge and support the Framework (ICCM5, V/6) and what actions could be taken to strengthen cooperation and coordination between WHO and health ministries, and implementation of the Framework; and
- what actions could be taken to support strengthening of health surveillance, biomonitoring and poison centres at national and regional levels to give greater priority to these areas when updating WHO's Chemicals road map (as requested in ICCM5, V/10).

Background

Tracker links to previous EB &/or WHA discussions of chemicals, SAICM or environment

WHO Chemicals safety and health unit homepage

Chemicals Road Map (A70/36, WHA70(23), May 2017)

WHO's Global Chemicals and Health Network

Inter-Organisation Program for the Sound Management of Chemicals

Global framework on chemicals (adopted by ICCM5, Nov 2023)

Meeting Report of the Fifth Session of the International Conference on Chemicals Management (Nov 2023) (see list of resolutions from page 22)

PHM Comment

This is an important item; the impact of chemicals on human health and on wider environmental values is huge but poorly regulated. However, the issues are complex and are presented in EB156/23, almost entirely in terms of institutional structures, relationships and activities.

To ground this item in the urgency of chemicals management, the paper could have provided a bit more detail of how out of control the situation is. Levesl of protection of human health and the environment are misaligned with, and insufficient in relation to the evident risk levels of harm to present and future generations. Board members are urged to review the public health impact of chemicals 2019 and

consider also the pollution of soils and water and the biodiversity loss consequent on chemical exposures, including loss of insect populations.

The Framework is weak in addressing global inequities which are increasing as the global North outsources its industry and food supply to LMICs where health and environmental protections are weak or absent. Corporations commonly pressure workers to accept exposures and health risks as conditions of employment.

The Framework does not go far enough in terms of strengthening the protections of human health of the environment, from harms association with chemicals. Closer attention is needed to exposure pathways:

- direct exposures in work or domestic settings – though the application / usage of chemicals
- community exposures via environmental contamination of waterways, soils, & oceans
- intergenerational exposures . . via DNA fragmentation, chromosomal abnormalities, and alterations in gene expression;
- environmental contamination via intake of food, water, and air; environmental contamination **IS** a health issue

A further absence from this report is any mention of the politics of chemicals regulation and the involvement of transnational corporations and their nation state allies in opposing effective regulation. The US and Australia were among the leading blockers at ICCM5

In para 6 EB156/23 refers to the Global Framework on Chemicals as a "a voluntary, multistakeholder and multisectoral agreement". The multiple stakeholders include a wide range of private sector entities from the chemicals, mining, petrochemicals, automobile, finance, agriculture and other industries. It appears that there were no representatives attending ICCM5 from the Convention on Biodiversity.

PHM urges WHO to work to increase the participation of L&MICs and of health and environmental NGOs in future international chemicals management conferences.

There were scores of chemical industry representatives at ICCM5 while the health and environmental organisations often had only one or two representatives. While chemicals industry representatives are industry funded health and environmental NGOs are commonly without the funding for effective participation or to fund deep input, document drafting and review. **Health sector engagement needs to be funded**.

The Framework includes many admirable objectives and targets but monitoring, in many respects, will depend upon corporate goodwill and compliance will be voluntary. Corporate interest groups will be free to participate in programs to promote implementation.

The Framework makes no mention of the precautionary principle. Not by accident; its inclusion was opposed by industry and their allies.

These limitations frame the immediate decisions being asked of the Executive Board.

- In para 8 of EB156/23 the Board is invited "to endorse or otherwise appropriately acknowledge and support the Framework, with a view to considering, within the scope of their respective mandates, the incorporation in their programmes of work of mutually supportive activities that also contribute to the achievement of the strategic objectives and targets of the Framework";

- In paras 18-20 the Board is invited to endorse the updating of WHO's Chemicals Road Map as outlined.
- In paras 21-23 the Board is invited to endorse WHO's full participation in the Science Policy Panel in association with UNEP and in accordance with the details provided in EB156/23.

Endorse the Framework

Despite the limitations, PHM supports WHO endorsing the Framework, updating the Road Map, and participating fully in the Science Policy Panel. However, PHM also urges the Board to insist that WHO's participation in 'mutually supportive activities' and in the Science Policy Panel shall be fully aligned with the Framework for Engagement with Non-State Actors.

PHM urges the Board to request the DG to ensure that the strengthening of health and environmental protections from chemical harm shall be a continuing focus of WHO's engagement with the Framework.

Surveillance and monitoring

Developing nations need financial support to routinely and episodically run surveillance and biomonitoring programs . WHO is to be commended for trying to expand such programs.

Surveillance and biomonitoring ought to be foundational in health protection, with all countries having access to results.Some HICs (eg Australia) still do not undertake such monitoring.

Report on the human health implications of chemicals, waste and pollution

WHA76.17 (2023) was a wide ranging resolution which makes a number of requests of the DG including operative paragraph 4(9) which is cited in the annotated agenda and in para 1 of EB156/23 and reproduced above. However, WHA76.17 made a range of other requests to the DG including a request for a report on the implementation of the whole resolution to be submitted to WHA78 through EB156.

OP4(1) of WHA76.17 requested the DG "to publish a report, incorporating science- and risk-based assessments and conclusions on the human health implications of chemicals, waste and pollution as well as reporting on existing data gaps …".

There is no reference to such a report. Board members are urged to seek an update on the preparation of this report.

Item 21 Updated road map for an enhanced global response to the adverse health effects of air pollution

In focus

The road map for an enhanced global response to the adverse health effects of air pollution provides a mechanism for health sector response to address the health effects of air pollution through knowledge synthesis, enhanced monitoring, institutional capacity strengthening and global leadership. The Director-General'sreport (EB156/24) covers the road map's implementation, updates and alignment with organizational priorities.

Background

Tracker links to previous EB &/or WHA discussions of air pollution

See WHO Topics Page on Air Pollution

Global Health Observatory on Air Pollution

WHO report on Mortality attributable to air pollution

Announcement of Second Global Conference on Air Pollution in Cartagena, Colombia from 25-27 March 2025

PHM Comment

PHM congratulates the Secretariat on the very constructive report (EB156/24) and urges member states to support the proposed update and extension of the Road Map.

EB156/24 recognises the huge disease burden associated with air pollution and reviews the major processes generating such pollution. EB156/24 is backed up by the 2024 WHO report on Mortality attributable to air pollution which should be given wide publicity.

Air pollution was sharply contested during the EB136 and WHA68 discussions of the first edition of the Road Map (see references to the debate in PHM's comment at WHA68). Key issues which were contested included:

- naming diesel and coal (opposed by Saudi Arabia);
- linking control of air pollution to the control of greenhouse gas emissions (opposed by Saudi Arabia);
- exploration of the use of TRIPS flexibilities in deploying new technologies in developing countries (proposed by India and Egypt; opposed by USA, EU, Norway, Switzerland and Monaco); and
- various references to technology transfer and the funding of technology transfer.

While fossil fuels are named in EB156/24, including the co-benefits to health of mitigating global warming, there is no discussion of the need to support technology transfer in relation to renewable technologies or the use of TRIPS flexibilities to ease access to such technologies.

Technical innovation and the introduction of clean technologies, in power generation and transport, call for massive investment and reframed policy environments (regulation, incentives, subsidies, etc). Transnational corporations control in large degree the flow of funds to R&D and the production of renewables; the global policy environment which shapes such investment flows is a major determinant of action on clean energy.

Fossil fuel corporations (and their shareholders and the politicians who represent them) have actively sought to prevent investment in clean energy and clean transport and to prevent the reform of policy environments (which shape investment).

Low standard / high protection patent regimes, linked with tight investor protection provisions, constitute together a major barrier to the governments of poorer countries deploying advanced clean energy and transport technologies. Access, by governments of low-income countries, to advanced clean energy technologies can be facilitated by international funds mobilisation and/or by lowering the IP barriers; the latter is more sustainable and less exposed to distortion by vested interests.

PHM urges member states to call for a more strategic and more focused approach to the basic determinants of air pollution. This should include:

- Collaboration with UNCTAD to define the policy environments shaping investment in clean energy and transport and recommend how these might be reformed; such collaboration should include case studies of particular industries, corporations and countries;
- Collaboration with WIPO and WTO to define the ways in which economic integration agreements (in particular IP and ISDS provisions) shape the access to clean energy technologies of developing country governments and what provisions in such agreements would be required to overcome such barriers;
- Partnerships with civil society organisations, such as Corporate Accountability International, in exposing the role of disinformation, corruption and intimidation in the defensive strategies of the fossil fuel industry.

One of the strongest features of the revised Road Map is the emphasis on building civil society understanding and support for the changes called for, and recognising the potential power of the health sector (practitioners, agencies, policy-makers) in helping to build that civil society constituency for change.

The first iteration of the Road Map suggested the possibility of organising a global conference on air pollution. That conference was held from 30 October – 1 November 2018 in Geneva.

The Second Global Conference will take place in Cartagena, Colombia from 25-27 March 2025. PHM urges member states and civil society organisations to support this conference which will give much needed boost to global action on air pollution.

Item 22: Climate change and health

In focus

Pursuant to the request in resolution WHA77.14 (2024), the Director-General will submit a report (EB156/25) on implementing the resolution and provide a draft global WHO plan of action on climate change and health. The Board will be invited to provide feedback on the plan for consideration by the Seventy-eighth World Health Assembly.

Background

Tracker links to previous EB/WHA discussions of Climate change

WHO Topic Page on Climate change

PHM Comment

This draft Global Plan of Action is disappointing. It is weak. PHM urges the Executive Board to send the draft back to the Secretariat with the following requests:

- Articulate more clearly the urgency of action in the face of global warming;
- Affirm that global warming is part of a global polycrisis including loss of biodiversity, environmental degradation, crossing planetary boundaries, deepening economic inequality;
- Demand climate justice;
- Name the opposition;
- Mobilise people power;
- Use the threats to health as a way of encouraging the mobilisation of civil society;
- Use action on health sector emissions to mobilise health care practitioners to demand urgent and sufficient action on mitigation and adaptation;
- Drop the intergovernmental bureaucratese.

Articulate clearly the urgency of action in the face of global warming

There is no sense of urgency in this draft global action plan but urgency is what is needed. Unless things start happening very soon with mitigation and adaptation, it will all be too late/too difficult.

The size of the threat , the enormity of the threat to human existence,is blurred in the bureaucratese of this draft action plan.

Most of the document is about process (leadership, coordination, advocacy, empower, inform, engage, evidence base, research agenda, monitor progress, plans and strategies, etc. etc.). What is at stake and what needs to be done (mitigation & adaptation) is blurred.

It is perplexing that this draft action plan should be so pedestrian because the original resolution (WHA77.14) was much clearer in acknowledging the wider polycrisis and the existential threat to humanity. The preambulatory paragraphs in the resolution set out clearly the present reality and future threat of global warming, including for health; they highlight the need to scale up financial transfers to support adaptation in the developing countries; and recall 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".

Affirm that global warming is part of a global polycrisis including loss of biodiversity, environmental degradation, crossing planetary boundaries, deepening economic inequality

The threats to humanity - loss of biodiversity, global warming, and the degradation of ecosystems should not be siloed - because the recovery strategies must address the full canvas.

The paper prepared for EB154 (EB154/25) highlighted the pathways and choices driving the climate crisis, and the 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 of global warming and directly on health are important because they underpin the logic of the 'co-benefit' argument, see below.

Demand climate justice

The draft action plan recognises climate change as "a fundamental threat to human health [which] 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."

The draft action plan 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. 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 transfers to support adaptation as well as mitigation.

Climate justice also demands that poor and marginalised people who bear the brunt of floods, unbearable heat, and hunger, must be prioritised in global climate action, and through economic justice, not just protection from the worst of global warming.

The draft action plan mentions 'environmental justice' but there is no mention of the different capabilities and historical responsibilities (and therefore differentiated responsibilities/burdens) of developed vs. developing states for climate change mitigation and adaptation. The burdens of energy poverty and vulnerability to the effects of global warming lie disproportionately in the global South stand in contrast to the cumulative emissions and disproportionate wealth of the global North. The contrast underpins the call for an acceptance of common but differentiated responsibilities as a matter of environmental justice.

PHM urges members of the Board to insist on *common but differentiated responsibilities* being included in the Principles section of the draft global plan of action.

The entire report side-lines the climate justice perspective and goes too much with "the world is one" romance.

Name the opposition

The proposition that there is a ‘global consensus that climate change poses a profound threat to human health’ misrepresents reality. The election of Trump in the US and the decision to withdraw from the Paris Agreement illustrates the importance of mapping the opposition and including strategies to enforce action on global warming.

The role of fossil fuel corporations in promoting denialism and buying political power to delay action must be recognised. The ambivalence of governments who are addicted to the export earnings from oil, coal and gas must also be factored in.

The concept of coloniality recalls the racialised dehumanisation of enslaved and colonised peoples as part of naturalising oppression and exploitation; naturalising the disregard for the objectified other. This is happening today in the movement to deny and delay.

The US is the outstanding blocker in view of its disproportionate historical contribution to greenhouse gas emissions. Its opposition to effective action is underlined by its withdrawal from the Paris agrement. See Kanitkar (2025) for recent comment from India.

Part of the wider appeal of deny and delay in the high-income countries is the false security of the ‘gated community’; that wealth will buy protection (air conditioners, electric vehicles, desalination plants, and perhaps geoengineering).

An action plan which does not map the opposition and plan to overcome is not strategic.

Mobilise people power

Any strategy to address the climate, environmental and health crisis must include mobilising people power; promoting the struggle from below with workers, Indigenous peoples, peasants, urban popular processes and intellectuals committed to the systematic construction of an agenda of ecological, environmental and health civilization that allows us to transform “the way we live, work, produce, consume and govern” (from the WHO Global Strategy on Health, Environment and Climate Change).

Looking ahead to COP 30 that will be held in November of this year in Brazil, PHM calls for a People's Alternative COP in Belén del Pará to build an agenda and a global alliance of civil society, with regional and national ramifications. This alliance will strengthen leadership, autonomy, diverse participation and promote the broadest mobilization and capacity for environmental, climate and health advocacy in society.

PHM calls for a global action plan which technically, scientifically, culturally and politically empowers the people and communities from the territories and regions, and the governments committed to building an advanced multipolar world. This will allow us to achieve the necessary political will to move towards an eco-socialist system of good living and substantial democratic reform of the UN, including strengthening the autonomy, leadership and financing of the WHO.

PHM calls on the Executive Board to request the Secretariat to reorient the global action plan to build political and financial support for such an alliance, contribute to raising citizens' awareness of the health impact of climate change and promoting their participation in decisions that lead to mitigating its effects and removing its structural causes.

WHO must open broader, inclusive, meaningful, transparent and timely spaces for the participation of civil society in the processes that lead to the resolutions and decisions of the WHA and its regional and national sections. Expand and legitimize the inclusion and representation of civil society organizations

and movements in the WHO–Civil Society Working Group for Action on Climate Change and Health and facilitate their participation in meetings.

Use the threats to health as a way of encouraging civil society demands

The draft global action plan includes several references to climate change and health as if concern for human health has been missing from the work of the International Panel on Climate Change. Passages such as, “The climate crisis is a global health crisis” and “climate change poses a profound threat to human health” reflect the Secretariat holding closely to its constitutional mandate; anticipating accusations from certain member states that it is going beyond its mandate.

“Promote the consideration of health within the Conferences of the Parties to the United Nations Framework Convention on Climate Change” implies that the COPs have been neglecting health.

This timid health-centric orientation blunts the more strategic orientation which is to emphasise the health consequences of global warming and the co-benefits to health of action on climate change, including both mitigation and adaptation as part of building the constituency for change.

Global warming as an existential threat to humanity overshadows the specific threats to health. However, emphasising the threats to health and the healthy co-benefits of climate friendly technologies remains within the constitutional mandate but can contribute more strategically to mobilising for action.

EB154/25 identified 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.

This more strategic orientation appears to have faded in the current draft global action plan.

Use action on health sector emissions to mobilise health care practitioners to demand urgent and sufficient action on mitigation and adaptation

The global action plan devotes considerable space to action within the health sector to reduce health sector emissions. This objective is important, although the focus should be widened to reducing its environmental footprint generally. However, it is presented simply as the health sector sharing the burden of mitigation.

What is missing is an emphasis on using the health sector to push for action everywhere else.

The paper prepared for EB154 (EB154/2) recognised the importance of people power in overcoming fossil fuel resistance and in pushing for adequate and equitable funding for adaptation. The primary health care approach, elaborated at Alma-Ata, envisages a ‘community partnership’ for health; healthcare personnel (at all levels) actively working with their communities to define the risks and to mobilise against underlying causes. This perspective is missing from the draft global action plan

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 partnership for health in different districts and 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 medical 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 meetings of the UNFCCC Subsidiary Body for Scientific and Technological Advice and the Subsidiary Body for Implementation to ensure that the health community is engaged. Such participation can give global context to localised struggles.

Drop the intergovernmental bureaucratese

The draft global action plan suffers from the deadening effect of intergovernmental blah.

Many reasonable points are made but where the WHO could make a real contribution is lost among the words or not stated because to state it explicitly would sink it politically.

What is perplexing is that both EB154/25 and WHA77.14 offer a bolder and more explicit way forward than this draft global action plan.

PHM urges the Executive Board to ask the Secretariat to rework it before submission to the Health Assembly:

- Articulate more clearly the urgency of action in the face of global warming;
- Affirm that global warming is part of a global polycrisis including loss of biodiversity, environmental degradation, crossing planetary boundaries, deepening economic inequality;
- Demand climate justice;
- Name the opposition;
- Mobilise people power;
- Use the threats to health as a way of encouraging the mobilisation of civil society;

- Use action on health sector emissions to mobilise health care practitioners to demand urgent and sufficient action on mitigation and adaptation;
- Drop the intergovernmental bureaucratese.

Item 23.1 Financing and implementation of the Programme budget 2024–2025

In focus

The Director-General reports on the financing and implementation of the Programme budget 2024–2025 (in EB156/26 Rev.1) . The Board isinvited to note the report and provide further guidance.

In line with decision WHA69(8) (2016), an information document (EB156/INF./1) is posted which contains the preliminary findings of the 2025 country presence report, highlighting progress in strengthening WHO country offices.

Background

Tracker links to previous EB &/or WHA discussions of PB24-25

PHM Comment

WHO's financial crisis continues, albeit slightly ameliorated by the increase in ACs. The VCs remain mostly tightly ear-marked. The withdrawal of the US will leave a $768m hole in a total budget of $6834.

The report notes that the four strategic priorities guiding the base segment are not attracting as much funding as each other – the bias towards disease-specific and health systems programs continues. Technical priorities 2 and 3 have "only minimal projected voluntary contributions".

The heat map (Fig 7, needs to be read with reference to Annex 1) depicts the particularly parlous state of reduced financial hardship (SP1.2); countries prepared for emergencies (SP2.1); emergency detection and response (SP2.3); risk factors (SP3.2); and country data capacity (SP4.1).

Expenditure is up, which is a good thing as it suggests that the efforts of the Secretariat to increase flexible and predictable funds has a positive effect. Having said that, the decline in thematic (from $310m to $183m) and projected (from $243 to $182m) VCs is a concern. The message is that donors need to increase the quantity and quality of their VCs.

In 20/21 the DG

"stated that WHO's reliance on voluntary contributions to fund over 80% of the approved programme budget threatens its ability to deliver the impartial and world-class normative work that Member States expect. With over 2000 awards with different reporting requirements, the constant fundraising and contribution management efforts divert attention and resources away from technical work, which the Chair of the Independent Expert Oversight Advisory Committee identified as the main source of inefficiency" WGSF/4/3, 27 Sept 2021

Donor dependence encourages departments to compete for donor attention (which fragments the coherence of the Secretariat's work). Seeking funds from private sector entities increases the risk of conflicts of interest. The new 'Mental health and social connection' project (Item 8) appears to have been shaped around the interest of the global IT sector in promoting digital interventions to reduce loneliness (see PHM Comment on Item 8).

It's a concern that staff costs are not increasing at a comparable rate to expenditure as this suggests staff are having to do more with fewer resources.

WHO has failed to broaden the donor base. This aim is understandable but optimistic. It is not surprising to learn that the share of funding to the base budget from the top 10 contributors has increased (from 62 to 63%). Obviously, this links to KPI 7 of the report. As the US is the biggest provider of flexible funds (as ACs), if it withdraws then these flexible funds will need to be found from other donors. It's not just the quantity that would be lost but the quality too. This quote from the report is worth noting: "Losing any major donor would create a significant funding gap for the specific outcomes that are dependent on these funds, which the Secretariat would not be able to fill due to limited sustainable and flexible financing".

An increase in flexible funds has come directly from the increase in ACs and indirectly from the PSC from increased VCs from the previous period. There are two problems here: one is that Trump withdrawing may have a domino effect that results in other MS walking away from their commitment to further increase their ACs; another is that the VCs are decreasing, meaning that this experience of increased PSC may not be repeated in the future. The report quantifies the gap in VCs - $564m. This will make it harder to fully fund the base segment. The report notes that there were high hopes for the Investment Round, but these have not been met (less than $2bn of the $7bn have been raised so far).

The greening of the heatmap is another point for optimism – it is nice to see an improvement! But these improvements could again be short lived with Trump's decision to withdraw – we could easily see a return to the left image in Fig 7 as a result of this decision.

The new system of KPIs is useful. KPI4 on the perception of impartiality is really about the concentration of relatively few donors. It is not really a measure of impartiality. Publishing who funds dubious projects like Social connection might be more useful. KPI8 on the transaction costs of multiple small grants is useful.

EB156/INF./1 provides a general overview of country presence. The formal report to be presented to WHA78 will be more useful. The comment on 'Collaborative engagements beyond the health sector' (para 7(e)) is disappointing.

"Despite these efforts, 45% of country offices (including 38% of country offices that have not collaborated beyond the health sector) faced challenges in partnering and collaborating with other sectors. These challenges included a lack of resources (for 74% of countries), limited understanding of WHO's mandate to work across sectors (for 67%) and the lack of an institutional culture of working beyond the health sector (for 57%)."

Item 23.2 Proposed PB26-27

In focus

The Director-General has provided (in EB156/27) the first draft of the Proposed programme budget 2026–2027. The Board is invited to discuss the proposed draft and provide guidance for finalization by the Seventy-eighth World Health Assembly.

Intersessional meetings with Member States are expected to be held between January and April 2025 to receive updates as needed.

Background

Tracker links to previous GB discussions of PB26-27.

PHM Comment

The Draft program budget for 2026-27 kicks off with this observation: “we are acutely aware that the success of our efforts depends on the collaboration and commitment of our Member States, partners and dedicated health workers around the world”.

The draft is all about results, prioritisation, and risk-management. In part this is in response to request from MS following WHA77, but it is also anticipating the Trump withdrawal. The draft provides criteria for priority setting which include a low to high assessment of country need for WHO support. WHO initiated a MS prioritisation exercise, the results of which are presented in the draft. The top three are:

- Priority risk factors for noncommunicable and communicable diseases, violence and injury, and poor nutrition reduced through multisectoral approaches
- The primary healthcare approach renewed and strengthened to accelerate universal health coverage
- Equity in access to quality services improved for noncommunicable diseases, mental health conditions and communicable diseases, while addressing antimicrobial resistance

The least important was: ‘Lower-carbon health systems and societies are contributing to health and well-being’. The report downplays the significance of this: “The priority rankings “high”, “medium” and “low” do not indicate the importance of a specific result but rather the level of technical cooperation that Member States can expect from WHO”.

There is an increase in the PB for the first time since the 2020-21 biennium. It’s not a huge increase - $355m. Unfortunately, Trump’s withdrawal could put this increase at risk and MS may not approve it. If so, then the things that the extra money would have gone to – ‘technical country capacity strengthening’, ‘enhanced accountability’ and ‘global technical centres’ for example – would be shelved. Traditional medicine, pandemic and epidemic intelligence, and education (WHO Academy) will be impacted.

Figure 13 of the report is interesting as it shows the disconnect between the nominal $1bn for Emergency Operations and Appeals and the increasing amount on this that is actually spent. This Fig visualises the reality of a health polycrisis, but the reaction from WHO is disappointing – “Member States acknowledged the current reporting discrepancies, they advised that at this point in time it is wiser to keep the current practice in order to avoid the perception of a large budget increase”. This does not seem like responsible reporting of the health crises and could be interpreted as denialism.

There is much discussion of risk management in the report. For example: “The Secretariat recognizes that the global environment in which WHO delivers its mission is becoming increasingly complex and is filled with uncertainty. In recognition of this uncertainty, WHO will have to take calculated risks to successfully achieve its ambitious mission and the GPW14”. This reads like a strategy document anticipating the US withdrawal, with the Secretariat describing what it will do if funds from the US are not forthcoming. So, we learn that “the Secretariat will prioritize resources to manage risks that are recognized as critically affecting WHO’s work at the country level”. A list of risks is provided with unsustainable financing at the top.

The Investment Round (IR) is described in this report with an optimistic spin. “Taking into account the pledges, signed funding agreements and expected contributions from other partnerships, total projected funding for the next four years amounted to US$ 3.8 billion at that point, representing 53% of the US$ 7.1 billion voluntary funding required”.

In other words, it is anticipating at this point just over half of the required VCs. This could be interpreted as a good thing – a commitment up front to VCs (i.e. more predictability). It’s also good to see more flexible funds and more L-LMIC donors contributing. If Trump withdraws, then this will be important. In the short-term, i.e. the 2026-27 biennium, the IR commitments means that projections are much improved compared to projections at a comparable time for previous bienniums (51% vs 30%). In terms of predictability, again this could be seen as good news.

On the increased ACs – see our comment on EB156/26 Rev.1 – the report makes this point: “the Secretariat is cognizant that such an increase will not be automatically granted”. The report provides some detail of what would happen if the increased ACs are not forthcoming: the increase in the PB would become unrealistic and thus not approved; KPIs would not be met; and ‘pockets of poverty’ would remain.

The Trump withdrawal could have a cascade effect on the commitment of MS to increase their ACs. This will put the brakes on all the efforts thus far that the WGSF did to improve sustainable financing – a great shame and waste. The freeze on the PB will continue as it’s unlikely that MS will approve the increase in the face of the US withdrawal. There are specific things that the Secretariat wanted to do with the increased funds - these won’t happen. The Secretariat will go into risk management mode and start to prioritise in order to meet high risk outcomes. The EOAP budget line will receive less money and so WHO will be less able to respond effectively to the polycrises it will likely face in the coming years.

Item 24.3(i) Global strategies or action plans that are scheduled to expire within one year: Global Strategic Directions for Nursing and Midwifery

In focus

The Director-General has circulated a report (EB156/34) that takes stock of progress by Member States, partners and the Secretariat in implementing the global strategic directions for nursing and midwifery 2021–2025 (A74/13), adopted in resolution WHA74.15 (2021). The Board is invited to consider a draft decision (in para 16 of EB156/34) to extend the global strategic directions for nursing and midwifery 2021–2025 until 2030.

Background

Tracker links to previous discussions of nursing and midwifery.

The Global strategic directions for nursing and midwifery (SDNM) 2021-2025 (A74/13) spanned four policy focus areas: education, jobs, leadership, and service delivery. Each area had a "strategic direction" and goal for the five-year period, and between two and four policy priorities:

1. educating enough midwives and nurses with competencies to meet population health needs
2. creating jobs, managing migration, and recruiting and retaining midwives and nurses where they are most needed
3. strengthening nursing and midwifery leadership throughout health and academic systems
4. ensuring midwives and nurses are supported, respected, protected, motivated and equipped to safely and optimally contribute in their service delivery setting.

The Global Strategic Directions was informed by the State of World's Nursing 2020 and the State of World's Midwifery 2021

Note that the GSD21-25 was a reworking of GSD16-20

PHM Comment

Policy focus areas

Table 2 in EB156/34 discusses future priorities under four headings: jobs, education, leadership and service delivery

PHM urges that the four categories be extended to include: research and evaluation, and occupational health and safety.

Research and evaluation should be core components to ensure the nursing and midwifery workforce are able to meaningfully contribute to the development of appropriate service delivery models in various settings and levels. Strengthening nursing and midwifery research will contribute to all four of the existing policy priorities.

Occupational health and safety. Mental health impacts on nurses and midwives are not restricted to COVID, and as climate change, conflict, displacement and disease outbreaks place further pressure on this workforce, occupational health and wellbeing need to be considered separately to reduce the

impacts of these factors on practitioner welfare and retention and service delivery. This will help to develop workplace environments that retain and attract the workforce, reduce high levels of turnover, and protect the mental and physical health and wellbeing of nursing and midwifery workforce.

Extend the mandate

PHM urges Member States to support the extension of the global strategic directions for nursing and midwifery 2021 – 2025 until 2030, with additional considerations, namely that research and evaluation activities of the current strategic directions should be undertaken, and additional categories to include 'research and evaluation' and 'occupational health and safety'.

Future priorities

Research and Evaluation

- governments should promote and fund nursing and midwifery research and evaluation activities to drive change across all levels of research including quality of care;
- develop collaborative global nursing sites to progress research and evaluation in nursing and midwifery to build capacity in lower- and middle-income countries;
- ensure research and evaluation education is embedded in under- and post-graduate nursing and midwifery education;
- ensure career pathways for research and evaluation pathways are supported, including building publication skills;
- promote cross-professional research and evaluation opportunities.

Occupational Health and Safety

- ensure that occupational health and safety is a key consideration for nursing and midwifery workforce across all environments;
- ensure policies are developed to protect and promote nursing workforce during climate change, conflict, displacement and disease outbreaks
- ensure that nursing and midwifery workplaces are safe and supply basic needs, such as clean water supply, sanitation, electricity or gas, safe transport, housing, and digital technology;
- include a focus on women's safety, health and wellbeing within the nursing and midwifery profession
- address challenging work conditions across multiple areas, including direct care provided in emergencies eg. extreme weather events and disasters, etc.
- ensure appropriate resources are available to support direct and indirect care.

Jobs

"Accelerate growth in demand for nursing and midwifery jobs, securing sustainable domestic and external health workforce investments"

Should also include:

- work towards more equitable global distribution of nurses based on population needs and having regard to international emergencies that may affect needs across countries or lead to workforce losses;
- including a focus on supporting regions and countries with significant workforce gaps, including South-East Asia as well as the African and Eastern Mediterranean Regions.

Education

“Scale up the domestic production of nurses and midwives”

Should also include:

- equip nursing and midwifery educators with research and evaluation capabilities, skills and knowledge;
- build advocacy skills, knowledge and capabilities to promote public health and quality health care;
- integrate climate change in nursing and midwifery curricula globally to ensure workforce readiness to prevent and/or respond to climate emergencies to support population health and patient care outcomes.

Service delivery

Should also include reference to support for nursing and midwifery research directed to examining nursing and midwife practice in various health care and public health settings. Boosting such research is critical for encouraging innovation in service delivery towards efficient and quality healthcare as well as decent jobs.

Leadership

“Establish/strengthen senior government roles for nursing and midwifery planning, input into health policy and capacity-building for data reporting”

Should also include:

- improve diversity in nursing and midwifery workforce across ethnic, /cultural, gender, socio-economic status, and rural backgrounds to build trust in health systems and meet population health needs;
- invest in pipeline and pathway programs including mentorship and internship opportunities to support future career progression for all workforce categories;
- ensure opportunities for leadership development in nursing and midwifery across all levels of health service planning, implementation, delivery, research and evaluation, and funding.

Item 24.3(ii) Global strategies or action plans that are scheduled to expire within one year: Global Strategy on Digital Health

In focus

The Director-General has presented a progress report (EB156/35) on the implementation of the global strategy on digital health 2020–2025 with details of actions taken by Member States, development partners and the Secretariat.

The Board is invited to note the report and to consider a draft decision recommending the extension of the global strategy to pave the way for the development of a new updated draft strategy.

Background

Tracker links to previous discussions in EB & WHA of digital technologies.

PHM Comment

The global strategy on digital health has been extended for two years, now running until 2027 (originally from 2020-2025), with a further phase planned for 2028-2033. While the WHO report on the 2020-2025 strategy highlights certain progress in its implementation, significant concerns remain, both in terms of technical and political aspects.

From a technical perspective, the strategy has failed to adequately address critical questions about who truly benefits from digital health interventions and their societal impact, particularly in developing countries. Governments in these regions face considerable costs in implementing the strategy, compounded by infrastructure limitations such as low internet penetration, which could render goals like equitable access to digital health services out of reach for marginalised populations. Furthermore, the increasing reliance on artificial intelligence and data science in public health necessitates a much stronger regulatory framework to safeguard public health, ensuring these technologies are safe and accurate for all, without room for error. There are also concerns regarding the influence of the private sector, with questions around whether profit-driven corporate interests may compromise the integrity of these initiatives.

Policy making by health system managers must be driven by the efficiencies and outcomes of specific digital applications in specific health care and public health functions/settings. It is not clear whether WHO has properly addressed this aspect of digital health planning in its guidance work.

The gap in health workforce skills in developing countries raises questions about whether the necessary funding will be available to meet the targets set in the next phase of the strategy. Digital health governance is another critical issue: a substantial number of member states, as highlighted in the 2023 survey, lack functional digital health governance, further hindering the effective implementation of these initiatives.

Politically, the WHO's approach has shown a clear bias towards the global North, with much of the strategy focusing on interventions in high-income countries like the U.S. and Europe. This leaves the global South, particularly developing countries, underrepresented and sidelined. For example, while Objective No. 4 advocates for people-centred health systems enabled by digital health, progress has

been largely centred in the U.S. and Europe. Additionally, the creation of a global digital health certification network raises concerns, as it could potentially restrict the mobility of people from the global South, exacerbating inequalities and marginalisation.

The political landscape surrounding this agenda is further complicated by the withdrawal of the U.S. from the WHO. This move creates an opportunity to reframe the agenda and diminish the influence of the U.S.-based corporate interests that have historically shaped global health policies. However, this requires concerted effort and advocacy to ensure that the voices and priorities of the global South are heard and integrated into the strategy.

Furthermore, as the global North continues to drive the narrative around digital health, it is crucial to question whether new standards and technologies will be accessible to countries in the global South. Given the power dynamics at play, there is a real risk that the global South could be left behind in the digital health revolution, perpetuating existing disparities. As such, the focus must shift towards ensuring that digital health strategies are not only innovative and forward-thinking but also equitable and accessible for all.

In the coming years, it will be essential for global health leaders to place a stronger emphasis on supporting the digital health needs of the global South. In addition, the creation of dedicated funding pools for global South-led digital health projects would enable developing countries to drive innovation in their own regions. Such funding pools could be used to support locally relevant solutions, from mobile health applications to telemedicine programs, and ensure that these solutions are designed by and for local populations.

In considering the political dimension of digital health decision-making, the mapping of commercial and institutional interest groups and the naming of the different directions in which they may be pushing is critical. It seems that WHO has rather ignored this aspect of digital strategy.

Item 26.3: Standing Committee on Health Emergency Prevention, Preparedness and Response

In focus

Two reports are submitted to the Board: the first (EB156/44) addresses the dates for the sixth meeting of the Standing Committee and the second (EB156/45) describes the findings of the review on the functioning and impact of the Standing Committee.

The Board is invited to note the report and consider the following questions.

- To what extent does the Board consider that the Standing Committee is fulfilling its terms of reference?
- Should the Standing Committee be extended beyond the closure of the Seventy-eighth World Health Assembly in May 2025? If so, should its terms of reference be amended and what elements should they encompass?

Background

Index page for the Standing Committee

In EB150(6) (2022) and EB151(2) (2022), the Executive Board established the Standing Committee on Health Emergency Prevention, Preparedness and Response ("the Standing Committee") until the closure of the Seventy-eighth World Health Assembly in 2025.

The mandate of the Standing Committee was:

1. to provide guidance to the Board and advice to the Director-General, through the Board, in the event that a PHEIC is determined), on matters regarding health emergency prevention, preparedness and response, and immediate capacities of the WHO Health Emergencies Programme, based on information provided by the Director-General about the event, as well as information and needs expressed by the Member State in whose territory an event arises;
2. to review, provide guidance and, as appropriate, make recommendations to the Board regarding the strengthening and oversight of the WHO Health Emergencies Programme and for effective health emergency prevention, preparedness and response.

In EB150(6), the Board requested the Director-General to report on the functioning and impact of the Standing Committee and submit the results and recommendations based thereon at EB156th.

The Secretariat conducted a review from 16 August to 9 October 2024 and provided an update on the review at the fifth meeting of the Standing Committee, which was held on 3 and 4 September 2024.2

Data collected was based on desk review of activities and outputs of the Standing Committee; an email survey to all MS (9% response rate); 21 key informant interviews (43% of sample members of current standing committee).

The DG's report notes that "While the findings provide some insight into the functioning and impact of the Standing Committee, it is difficult to draw solid conclusions from a limited data sample that cannot be considered representative of WHO membership." (para 7)

The outcome of the review is outlined in the present report.

Benefits of Standing Committee (summarised)

Desk review: activities are consistent with its terms of reference; meetings are well organised and benefits from thorough updates by the Secretariat; meeting reports consistently shared with the EB.

Most MS consider biannual frequency of meetings adequate; and consider the committee an effective platform for MS to engage the EB on health emergency matters; most survey respondents happy with the information sharing function of the first extraordinary meeting.

Key informants are in general agreement that it helps streamline the work of the EB by keeping it informed and provides a supportive role to the EB in terms of strategic planning, policy-setting and decision-making.

Challenges for the Standing Committee (summarised)

Desk review: Terms of reference provide for the committee to provide guidance and recommendations to the EB and to advise the DG through the EB, but to date both regular and extraordinary meetings have focused on health emergency updates – no guidance of recommendations document in Standing Committee reports.

MS survey responses suggest they are "not very familiar with key aspects of WHO Health Emergencies Programme"; identified challenges such as suboptimal engagement in preparing for meetings of the standing committee; infrequent presence of external experts at meetings; short time frame to review

meeting documentation especially given need to consult with various sectors, national experts and regional bodies in preparation for meetings

Key informants: committee's terms of reference partly overlap with IOAC for Health Emergencies Programme, the Global Preparedness Monitoring Board, and some review committees convened under IHR (2005). The volume of information at recent meetings combined with time constraints don't allow for meaningful deliberations. The committee has limited influence on deliberations related to health emergency prevention, preparedness, readiness and response and seems to function mostly as communications platform for information sharing and this role could be filled by other existing channels. It is not clear that the extraordinary meeting of the Standing Committee that can be convened in the event of determining a PHEIC is necessary as existing rules allow the DG in consultation with EB chair to convene special sessions of the Board in relation to events requiring immediate action

PHM Comment

In terms of compliance with rules of procedure and working within its mandate the Standing Committee seems to be functional; however the review suggests its mandate overlaps with those of other (more established structures), its members aren't always well prepared for meetings, that it is largely functioning as an information-exchange platform and doesn't have a track record of providing guidance or recommendations to the EB or DG, and that it is not centrally involved in deliberations of other structures of the HEPPRR architecture.

Based on the data in the report it is difficult to make the case for the extension of its term; however by the Secretariat's own admission the data in the report is not really representative of the MS views (or of the views of the wider set of WHO HEPPRR institutions). No mention is made of the Pandemic Accord negotiations and how these may affect the relevance of the committee, nor of the revisions to the IHR (2005). It is difficult to know what to make of this omission/silence in the DG's report.

In the light of the US withdrawal from WHO and the impact this will have on funding, PHM suggests that the mandate of the Committee not be renewed.