

People's Health Movement

Background and Commentary on Items coming before EB142 (and PBAC27), January 2018

This analysis and commentary on items coming before the WHO Executive Board in Jan 2018 has been prepared by the People's Health Movement as a contribution to WHO Watch, a civil society initiative directed to the democratisation of global health governance ([more about WHO Watch](#)).

This PDF version of the PHM Commentary is taken from PHM's who-track.phmovement.org website which provides links to the secretariat documents and previous governing body discussions including debates, decisions and resolutions as well as the PHM commentary.

Comment and feedback is welcome. Write to globalsecretariat@phmovement.org.

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PBAC27 - 2 Report of Independent Expert Oversight Advisory Committee

In focus

Highlights of the Advisory Committee report (in [PBAC27/2](#)) include comments on:

- internal oversight services - general approval but facing budget pressures;
- external audit - no substantive comments;
- overview of EMRO regional office and compliance and internal controls - general approval but notes a range of issues facing the regional office;
- risk management - appreciates progress with risk register but urges more focus on risk management;
- post-polio transition planning - concerns about risks to regional revenue (and in some cases country office revenue) as polio winds down;
- implementation of FENSA - critical of the lack of a “structured, cohesive, project management plan for implementation of the Framework”;
- evaluation and organisational learning - no substantive advice;
- reform in management of health emergencies especially in EMRO - “key external challenges to the programme are sustainable, predictable and multiyear funding. It is crucial that partners and donors understand the business costs of operating in fragile and weak countries with high security risks”; reviews a number of challenges associated with emergencies in the EMRO region;
- visit to Egypt country office - general appreciation of the work of the country office; comments on some of the challenges facing the country office including communications with the Ministry of Health and inadequate and unpredictable funding;
- investment function - approval;
- information technology - notes new governance structure for ICT development; and
- procurement policy roll-out - general appreciation.

PBAC advice on this report is in [EB142/25](#) (PBAC report to EB142).

Background

[Tracker links](#) to previous IEOAC reports

[Tracker links](#) to previous audit reports

Useful further reading:

- [Internal controls framework](#);
- [WHO principal risks \(2017\)](#);
- [A70/14 Add.1 - Risks ass'd with wind-down Global Polio Eradication Initiative](#)
- [A70/9 'WHO response in severe, large-scale emergencies'](#)

PHM comment

PHM notes the repeated examples, particularly in relation to emergencies and polio transition, of the harmful impact of the ACs freeze, budget ceiling, tight donor earmarking and donor dependence generally.

PBAC27 - 5 Financing of the programme budget

In focus

[PBAC27/3](#) presents an overview of financial implementation of programme budget 2016–2017 and the financial outlook for the biennium 2018–2019. The document summary is reproduced below.

1. *The document provides an overview of the financial situation of WHO's programme budget for the biennium 2016–2017 and an outlook for the biennium 2018–2019, based on the figures available as at 30 September 2017. Figures are provided for the two main components of the Programme budget, namely: (a) "base" programmes; and (b) poliomyelitis (polio), outbreak and crisis response and special programmes. The key points highlighted in the document are as follows:*

- *the Health Assembly approved the Programme budget 2016–2017 at a level of US\$ 4385 million, and approved an increase to US\$ 4545 million in 2016;*
- *financing for most of the Programme budget is dependent on voluntary contributions, whose timing and alignment do not always facilitate the most effective implementation; overall, 85% of financing in 2016–2017 comes from voluntary contributions;*
- *overall financing for 2016–2017 stands at 98% for base programmes, although for some programmes the financing level is significantly lower (e.g. noncommunicable diseases (74%) and the new WHO Health Emergencies Programme (79%));*
- *the revised programme budget for polio and for outbreak and crisis response is significantly higher than the initial budget, reflecting the fact that these programmes are event-driven;*
- *the projected full-biennium financial implementation (expenditure) is US\$ 4432 million.*

2. *The Programme budget 2018–2019 highlights include details on the following:*

- *the World Health Assembly approved the programme budget for the biennium 2018–2019 at a level of US\$ 4422 million;*
- *the current projected financing for the biennium 2018–2019 is US\$ 3180 million.*

3. *In order to sustain progress in WHO's enhanced emergency response operations and align funding more effectively with approved Programme budget priorities, more predictable and flexible financing is needed. This is a priority of the Director-General's transformation agenda.*

This is an important report and should be widely read and publicised.

PHM comment

PHM has commented repeatedly on the underfunding of WHO. See "[WHO Reform: For what purpose](#)" pp 247-67 in Global Health Watch 4 (2015).

In a nutshell PHM argues that the combination of the budget ceiling, the assessed contributions freeze and the tight earmarking of voluntary contributions is a deliberate strategy to prevent WHO from fulfilling its mandate where implementation of Assembly resolutions might limit the profitability and investment freedom of transnational corporations.

It is no accident that the most underfunded budget line (see Fig 1 in [PBAC27/3](#)) is NCDs because of the possibility that a more activist WHO (implementing agreed resolutions) might impact on the food and beverage industry, including transnational food corporations selling highly processed and packaged foods.

Nowhere has the pressure on WHO been greater than in relation to trade and health where the funding boycott has been tightest and the bullying of low and middle income countries has been most blatant.

The threat of cuts in the US contribution to WHO (ACs and VCs) over shadows discussions of WHO funding. The recent cuts to the UN budget, for which President Trump claimed responsibility, could presage similar cuts in US funding to WHO.

A crisis precipitated by cuts in US funding might be a boon in the long term for WHO if it led to other member states (in particular, the 'emerging economies') accepting the need for substantial increases in assessed contributions.

PBAC27 - 8 Human resources: update

In focus

Some of the highlights of the HR Update ([PBAC27/4](#), based in large part on [Workforce data at 31 July 2017](#)) include:

- slight increase in proportion of total workforce on non-staff contracts;
- slight progress towards gender parity in professional and senior positions; not so good in country offices;
- less progress in geographical parity (see T3 in Workforce Data); developing countries underrepresented generally, particularly among senior staff at headquarters; (note that norms for representation are strongly influenced by financial contribution as well as population size which is why the USA is registered as “under-represented”);
- slight increase in staff mobility in the professional and higher categories; mandatory staff mobility commences in 2019;
- new internal justice system seems to be working;
- internships remain dominated by women and developed countries (see T17 in Workforce Data); DG looking for sponsorships to help redress the balance.

Some of the highlights in the statement from the staff associations ([EB142/INF./1](#)) include:

- morale affected by “unprecedented number of changes to staff rules” and job insecurity “due to ineffective resource mobilization or erratic restructuring”;
- encouraged by statements from new DG and the prospects of ‘transformation’;
- acknowledgement of internal justice reforms as ‘successful’; and
- a number of specific (and sensible) proposals for HR policy reform (from para 9-18).

A further range of challenging HR issues arising from polio transition planning are referred to in [EB142/11](#) (see further comment under [EB142 Item 3.4](#) below). Funding via the GPEI is scheduled to cease after 2019. Attention is being directed to:

- managing the financial risk facing WHO;
- putting in place the necessary assets and systems to manage the polio risk post certification;
- repurposing polio staff into other priority programs depending on country circumstances;
- mobilising funds to support ‘tier 1’ countries in transferring polio staff to national employment;
- assisting tier 2 and tier 3 countries to mobilise domestic funds to enable the transfer of polio staff to national employment.

Highlights from the report of the Ombudsman ([EB142/INF./2](#)) include:

- description of the role of the Ombudsman and how it operates at WHO;
- increasing numbers of staff using the ombudsman service, commonly relating to ‘evaluative relationships’ between supervisors and supervisees;
- need for WHO to invest in its managers to improve communication, team climate and morale, particularly in country offices;
- WHO to express its core values, notably respect, in its practices and culture; concern regarding apparent prevalence of abusive behaviour and harassment
- WHO’s duty of care towards staff: counselling, career development, recognition;
- equal access to informal resolution regarding work-related issues.

PBAC advice to the EB on this item is in [EB142/25](#) (PBAC report to EB142, NYP).

[Tracker links](#) to previous reports on HR

Background

Useful further reading:

- Revised human resources strategy ([EB134/INF./2](#), Jan 2014)
- [Update on implementation](#), Oct 2016

PHM comment

The staff associations' proposals for HR policy reform (from para 9-18 of [EB142/INF./1](#)) and the Ombudsman's suggestions ([EB142/INF./2](#)) all appear to be very sensible.

EB142 - 3.1 Draft Thirteenth General Programme of Work 2019-2023

In focus

The Board will review the draft thirteenth global program of work ([EB142/3](#)). EB142/3 will be considered by PBAC27 before EB142 (PBAC report in [EB142/25](#)) and will be further developed after EB142 before being submitted to and adopted by WHA71.

See [Fig 1](#) for an overview of the draft GPW13.

See Box 3 for an overview of 'what is new in GPW13; the chief selling points of the GPW from the Secretariat point of view.

Background

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

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

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

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

A [consultation paper](#) was published in August 2017 discussed by regional committees and opened for public feedback. The first full draft [GPW13](#) (plus the more detailed [Impact Framework](#)) was published at the beginning of November and discussed in the EB Special session 4 (EBSS4) in November.

The draft GPW released in November promised a forthcoming 'investment case' to support the GPW. There is no such reference in the version submitted to EB142. The November draft also mentioned that quantitative methods for impact accounting are being explored; In the January version new 'impact and accountability framework' is described (para 123-129, Fig 6 and Box 8).

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

PHM comment

Old wine in new bottles

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

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

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

Financial crisis

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

Given the integrated nature of the work that is required to implement GPW 13, more flexible financing will be critical. The quality of funds is almost as important as their quantity. The Director-General has asked Member States to un earmark their contributions. This is a sign of trust and enables management to deliver. Increasing assessed contributions would also give WHO greater independence.

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

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

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

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

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

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

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

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

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

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

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

Operational priorities.

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

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

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

PHM appreciates the acknowledgement that UHC needs to be based on primary health care (PHC) but this needs further elaboration given the ambiguity regarding WHO’s position on selective primary health care vis a vis comprehensive health care. Several of WHO’s large donors would reduce “PHC” to the delivery of a ‘basic benefit package’.

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

The GPW’s unquestioning acceptance of the SDG framework papers over critiques suggesting that the laudable SDG goals may be unattainable given that they are premised on the same neoliberal model – increased unsustainable consumption and economic growth, driven by a liberalised trade regime. The GPW is silent about the impact of contemporary ‘free trade’ agreements on health and barely touches on the threats to healthcare and to population health associated with market power and self-interest of transnational corporations in diverse sectors including pharmaceuticals, food and beverages and mining.

The GPW appears to promote a charity model of health development through its several references to the ‘vulnerable’ and ‘hard to reach’ people who need support. It is imperative that the larger vision of the WHO be informed by a rights based approach that incorporates the redistribution of power and wealth, within countries and between countries.

Inverting the pyramid

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

In this context PHM appreciates the references to closer engagement with civil society at the country level, including participation in policy dialogue, leveraging civil society pressure to increase domestic investment in health system strengthening. Civil society mobilisation is an important driver of health development, locally, nationally and globally and the caution of

country offices in engaging with local civil society has been a significant weakness in WHO's country work.

PHM also appreciates the commitment to 'drive impact in every country'. The draft promises a 'differentiated approach based on capacity and vulnerability' which means varying emphases on policy dialogue, strategic support, technical assistance and service delivery depending on the capacity and vulnerabilities of particular countries. However, "WHO will strengthen its role in driving policy dialogue in all Member States (p16)".

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

From outputs to outcomes and impacts

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

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

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

However, moving the emphasis from measuring 'outputs' to 'outcomes and impacts' brings to the fore the question of attribution: who contributed what to measured outcomes?

Responding to this the draft GPW comments (p38):

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

It appears that the attribution question will be managed through greater and more systematic use of qualitative narratives including case studies, supported by quantitative data where appropriate. This runs counter to the continuing pressure on the Secretariat to produce

quantitative indicators spanning the full 'results chain', even where such indicators are clearly meaningless.

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

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

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

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

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

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

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

further steps towards 'alignment' and 'harmonisation' across regions and strengthened regional accountability.

Multisectoral action

PHM applauds the recognition of the need for more systematic engagement by WHO in multisectoral action across all of the SDGs (paraS 79-80). Figure 1 in the new PB18-19 ([A70/7](#)) highlights the significance, for WHO's health priorities, of the various 'non-health' SDGs (goals for which other intergovernmental agencies have coordination responsibility). A stronger foreign affairs capacity in the WHO secretariat would greatly facilitate WHO's engagement in progressing these goals, including their health related aspects.

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

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

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

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

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

In this context the references (in the draft GPW) to 'focusing global public goods [normative functions] on impact' are intriguing, given the explicit inclusion under WHO's normative functions of binding agreements as well as guidelines and technical advice. One of the reasons the rich countries are so determined to maintain the donor chokehold over WHO is the potential significance of the Organisation's treaty making powers. Previous debates

around the strategic use of WHO's treaty making powers have focused on the marketing of breastmilk substitutes and the 'ethical' promotion of pharmaceuticals. In the present era the potential application of these powers to food labelling, sugar and fat taxes and an R&D treaty underlie the determination of the TNCs and their nation state sponsors to maintain the donor chokehold.

Summary

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

EB142 - 3.2 WHO reform

In focus

[EB142/5](#) addresses issues concerning the rules of procedure of the governing bodies including:

- A. Measures to improve the efficiency of the governing bodies and their focus on strategic issues;
 - strengthen the strategic role of the Executive Board - suggestions (a) to (d)
 - improve agenda management - suggestions (e) and (f)
 - streamline management of the session - suggestions (g) to (i)
- B. Interpretational ambiguities and gaps in the process for the inclusion of additional, supplementary and urgent items to the Assembly agenda - options for Rule 5 revision
- C. Further ambiguities, gaps and other shortcomings in the rules of procedure of the governing bodies - suggestions (a) to (j).

The analysis presented in EB142/5 is accompanied by a corresponding series of questions and draft decisions for the Board to consider.

[EB142/6](#) reports on the evaluation by the Officers of the Board of their experience in using the criteria and prioritization tool in respect of proposals for additional agenda items including an amended tool and draft decision.

[EB142/7 Rev.1](#) presents a strategy and implementation plan for value for money in WHO. Document [A70/INF./6](#) addressing value for money was considered briefly during WHA70 discussion of PB18-19 (see [PSRA3](#)).

Background

Rules of procedure for governing bodies

Responding to [WHA69\(8\)](#), OP (5), the Secretariat produced [A70/51](#) which presented two options regarding the role of the January EB in determining the provisional agenda for the Assembly. Discussing this in the 3rd meeting of Committee B ([A70/B/PSR/3](#)) Switzerland, the US, UK and Australia argued for Option 1 giving the Board the power to exclude 'additional items' from the Assembly provisional agenda. Thailand, China, Zimbabwe, Liberia (for Afro) and Argentina argued for Option 2 which would give the Board the right to recommend deferral of 'additional items' subject to further decision by the General Committee of the Assembly. The item was reopened at the [5th meeting](#) where the lack of consensus was still evident and the item was deferred to EB142.

In EB141 following WHA70 the Board decided (in [EB141\(8\)](#)) broadened the request to the Secretariat for further analysis of possible improvements in the Rules of Procedure.

[EB142/5](#) responds to these requests. In developing EB142/5 the Secretariat, in consultation with the officers of the Board, prepared a [discussion document](#) which was subject to consultation with member states in Aug and Sept of 2017,

Prioritisation of 'additional items' proposed for EB consideration

Responding to [WHA69\(8\)](#), OP (3), the Secretariat produced [EB141/5](#) for the consideration of the EB141 in May 2017. The Board decided (in [EB142\(8\)](#)) to proceed with the trial of the tool. It is this trial upon which the officers of the Board report in [EB142/6](#).

Value for money in WHO

A big issue for WHA70 was the proposed 3% increase in assessed contributions which was considered in the context of the Programme Budget 2018-19. Among the papers tabled for consideration under this item was an information paper [A70/INF./6](#) entitled "Better value, better health Towards a strategy and plan for value for money in WHO".

The PB with the 3% increase was endorsed by the Assembly in [WHA70.5](#) including a request (OP11(4)) to control costs and seek efficiencies. It maybe that the 'value for money initiative' was part of a deal to get the 3% through. During the debate over the PB18-19 the UK representative said that:

While he supported the 3% increase in assessed contributions, it was not sufficient to solve the situation; voluntary funds were also required. Furthermore, WHO should ensure that its funding expenditure was set with a focus on value for money. The Secretariat must communicate its plans in that regard to assure Member States of the optimum use of the funds they contributed. He commended the preparation of document A70/INF./6, which set out possibilities for the implementation of a value for money plan. He would welcome further information concerning value for money plans and ways to engage Member States in such efforts, which would be vital to the proposed programme budget and forthcoming thirteenth general programme of work

The report tabled for this discussion at EB142 ([EB142/7 Rev.1](#)) represents the next step in elaborating the 'value for money' plan.

See [Tracker Links](#) to previous discussions of WHO Reform including documents, debates and decisions as well as previous PHM commentaries.

PHM comment

Rules of procedure for governing bodies

There is clearly scope for improving the efficiency and strategic focus of the governing bodies. Many of the suggestions included in EB142/5 make sense and maybe worth trialling.

However, there does appear to be a trade-off, between efficiency and voice, in the decisions before the Board. In view of the progressive transfer of operational priority-setting from the governing bodies to the donors a reduction in opportunity to be heard will further disempower L&MIC member states.

The proper response to this threat is lift the freeze and to restore sovereignty to the member states.

Value for money in WHO

At face value, no-one could object to a value-for-money initiative.

However, allegations of inefficiency (waste, lack of transparency, duplication, lack of prioritization) have been used by a clique of the rich member state donors for many years to resist calls for lifting the freeze on ACs, lifting the budget ceiling and untying earmarked voluntary contributions. It appears that the Secretariat has been forced to acknowledge that it has a value for money problem as a condition of getting a miserable 3% increase in ACs.

WHO is a unique organisation delivering unique outputs which are extremely hard to measure and cost. Producing valid and reliable measures of economy and efficiency would be extremely difficult and expensive. WHO's outcomes and impacts (and hence its effectiveness, as depicted in the Figure in EB142/7 Rev.1) are co-produced by the Secretariat, member states and other partners. Apportioning the influence of various players is virtually impossible.

There is scope for increasing value for money in virtually all organisations but pursuing such opportunities is a management responsibility at all levels. It cannot be imposed as a separate top down intervention.

What is missing from EB142/7 Rev.1 is any mention of the degree to which WHO's funding crisis contributes to inefficiency and ineffectiveness, in particular:

- time spent mobilising funds, developing and redeveloping 'investment cases' for different donors;
- managing the uncertainties associated with unpredictable, delayed and tightly earmarked voluntary contributions;
- working collaboratively despite the competition between different units, and programs, for donor attention;
- managing for collaboration in a vertically fragmented institutional environment (a consequence of donors refusing to contribute funds to WHO and instead setting up new global health initiatives (GHIs).

PHM urges the Secretariat to focus its efforts on continuing improvement in the quality of management at all levels and to avoid applying unnecessary and unproven methodologies, meetings and metrics in the name of value for money.

PHM urges member states to recognise how the ACs freeze, budget ceiling and tight earmarking constitute barriers to achieving value for money in WHO's work.

EB142 - 3.3 Public health preparedness and response

In focus

In response to resolution [EBSS3.R1](#) (2015) and decision [WHA68\(10\)](#) (2015), three Secretariat reports are tabled:

[EB142/9](#) provides

- (a) an update on all Public Health Emergencies of International Concern, WHO Grade 3 and United Nations Inter-Agency Standing Committee Level 3 emergencies in which WHO took action;
- (b) a description of the work WHO is undertaking at global, regional and country levels to improve coordination during health emergencies; and
- (c) an update on the progress made to improve research and development for potentially epidemic diseases.

In [EB142/10](#) a draft five-year global strategic plan to improve public health preparedness and response, developed in accordance with decision [WHA70\(11\)](#) (2017), is presented. The draft plan comprises guiding principles, three pillars for public health preparedness and response and strategic orientations for sustained implementation of the International Health Regulations (2005).

In [EB142/8](#) the third report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme is presented. The report will provide the Committee's observations and recommendations for the WHO Health Emergencies Programme based on its review of the Programme, including field visits, conducted during the period June–December 2017.

Background

Health emergencies

[EB142/9](#) reports on WHO's work in health emergencies, updates previous reports on coordination and response in large-scale emergencies, and reports on the development of the Research and Development Blueprint for Action to Prevent Epidemics for potentially epidemic diseases.

See WHO webpage on [WHO in emergencies](#). Includes:

- overview of HEP with useful links;
- links to report on funds mobilisation for WHO's work in emergencies; and
- descriptions of current health emergencies in Yemen, Bangladesh/Myanmar, Nigeria, South Sudan, Syria, Iraq; and
- overviews regarding plague, conflict, famine and MERS-CoV.

The [reform of WHO's emergency capabilities](#) has included:

- unification of the different emergency functions of the Secretariat;
- development of a global emergency workforce;
- strengthening country level IHR capacities and developing resilient national health systems;
- improving the IHRs;
- accelerated research and development, including provision for emergency response R&D;
- international financing and the Contingency Fund.

See [A69/30](#) for further background material on the implementation and establishment of WHO's HEP.

For a summary account of the paleohistory of the Health Emergencies Program see [PHM Background note for Item 12.1](#) at WHA70.

The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

The Board will consider the third report of the Independent Oversight and Advisory Committee (IOAC) of the WHO Health Emergencies Programme (HEP), presented in [EB142/8](#).

See [A69/30](#) considered by WHA69 (May 2016) which provided an overview of the implementation and oversight of the Health Emergencies Programme. See also Decision [WHA69\(9\)](#) welcoming the establishment of the IOAC.

See WHO webpage on the [IOAC](#). Includes terms of reference, reports on meetings of the Committee (and field visits) and background on membership.

See second report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme ([A70/8](#)) considered by WHA70 in May 2017 (the first report was submitted to EB140 as [EB140/8](#)).

See report of discussion at WHA70 during:

- [CtteeA.Mtg1](#) (from p5),
- [CtteeA.Mtg2](#) (from p3),
- [CtteeA.Mtg3](#) (from p14),
- [CtteeA.Mtg4](#) (from p2).

See in particular the summary remarks of the Chairperson of the IOAC and the Executive Director of the HEP at the commencement of the debate in [CtteeA.Mtg4](#).

Draft five-year global strategic plan to improve public health preparedness and response

[EB142/10](#) presents a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in [Annex 2 to A70/16](#), as requested in decision [WHA70\(11\)](#).

In 2016 WHA69 considered the final report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response ([A69/21](#)) and decided in [WHA69\(14\)](#) to develop a global implementation plan regarding the recommendations of the 2016 Review Committee report.

WHA70 considered the draft global implementation plan (in [A70/16](#)). Annex 1 to [A70/16](#) summarises the key elements of the action areas, cross referenced to objectives and timelines, with reference to the recommendations of the Review Committee.

One of the recommendations of the Second Extensions Review Committee was the development of a Global Strategic Plan to Improve Public Health Preparedness and Response and the [Annex 2 to A70/16](#) proposed twelve guiding principles upon which the draft Global Five Year Strategic Plan might be based. These were:

- consultation;
- country ownership;
- WHO leadership and governance;
- broad partnerships;
- intersectoral approach;
- integration with the health system;
- community involvement;
- focus on fragile context: “we are as strong as our weakest link”;
- regional integration;
- domestic financing;
- linking the global five-year strategic plan with requirements under the IHRs;
- focus on results, including monitoring and accountability.

The provisional official summary reports of the discussion of this item at WHA70 are in: [PSRA1](#), [PSRA2](#), [PSRA3](#), [PSRA4](#), and [PSRA7](#).

The Assembly finally adopted Decision [WHA70\(11\)](#) which, as noted above, requested the DG:

- to develop a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 of document [A70/16](#), for consideration by EB142 and forwarding on to WHA71;
- to continue to support Member States in the full implementation of the International Health Regulations (2005), including through building their core public health capacities.

For a summary account of the paleohistory of the IHRs see [PHM Background note](#) for Item 12.4 at WHA70.

Research and development blueprint to prevent epidemics

[EB142/9](#) provides an update on progress under the R&D blueprint (to be read in conjunction with the previous report in [A70/10](#)). The new report deals specifically with the list of priority diseases and road maps for R&D, with stakeholder coordination, and with regulatory capacity.

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

PHM comment

WHO’s Health Emergency Program

The need for emergency preparedness, response and recovery is huge. The humanitarian crises described in [EB142/9](#) and in more detail on the [emergencies webpage](#) are dreadful.

The third report of the IOAC (in [EB142/8](#)) confirms that the health emergencies reform was well conceived and to this point appears to have been implemented well. However, the Committee has identified several areas requiring further attention:

- information sharing and internal communications;
- WHO business processes which are not fit for emergency response:
 - recruitment,
 - procurement,
 - delegations of financial authority,
 - contracting for implementing partners,

- deployment of consultants in country,
- cumbersome and redundant requirements of FENSA requirements;
- the continuing financial shortfall in the funding of the programme, in particular the underfunding of the Contingency Fund and the instability and inflexibility of tightly earmarked funding.

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

PHM regrets that WHO's Health Emergencies Programme is focused only on emergency preparedness and response without any reference to the geopolitical crimes which have contributed so much to the crises in the Eastern Mediterranean or to the economic injustices (corruption, tax evasion, unfair trade rules, etc) in the African region which have contributed to humanitarian crises in that region. It seems that the public health principle of understanding upstream determinants does not apply in relation to health emergencies.

R&D blueprint to prevent epidemics

The R&D blueprint ([A70/10](#) and [EB142/9](#)) is a very constructive initiative. The processes for prioritisation and the development of target product profiles are very promising.

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

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

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

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

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

Draft five-year global strategic plan

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

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

respond to the questionnaire. Presumably these countries are facing more serious challenges.

It is evident that simply giving countries a deadline by which to implement the required capacities is unrealistic. The review committee appointed following the H1N1 pandemic in 2009 ([H1N1 report 2011](#)) was critical of the failure of many member states to establish the required core capacities and a series of deadlines were set (and passed) for full implementation by all countries. This criticism was reiterated by the review committee appointed following the West African Ebola outbreak in 2014 ([Ebola report 2016](#)). There was a certain degree of finger pointing during governing body discussions of IHR implementation during this period.

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

Nonetheless, PHM has reservations about the 'principle' of Domestic Financing (see Appendix 1 of [EB142/10](#)). EB142/10 argues that for "long-term sustainability, the ... financing of core capacities ... should be supported to the extent possible from domestic resources".

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

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

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

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

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

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

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

PHM welcomes the new orientation of the draft global strategic plan, in particular: the emphasis on health systems strengthening, the commitment to assist with funds mobilisation for countries facing difficulties, the systematic approach to 'additional measures' and the more developmental approach to continually strengthening preparedness and response capacity.

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

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

EB142 - 3.4 Polio transition planning

In focus

The report by the Director-General ([EB142/11](#)):

- locates polio transition planning in the context of the three strategic objectives of the 13th GPW;
- presents the key elements of a high-level strategic action plan for polio transition:
 - National polio transition plans (Annex 2) aligned with the scaling-down of Global Polio Eradication Initiative resources (details in Annex 1)
 - sustaining a polio-free world after eradication:
 - the draft post-certification strategy (cost estimates in Annex 3)
 - strengthening immunisation
 - strengthening emergency preparedness and response
 - Other elements of the strategic action plan contributing to achievement of the Sustainable Development Goals and universal health coverage
 - addressing the strategic priorities identified in WHO country cooperation strategies (Annex 4)
 - Strengthening IHR core capacities in polio transition countries (Annexes 5 and 6)
 - WHO transformation agenda: functional reviews of country office capacity in the African region
- provides an update on human resources and budget planning
 - human resources (Annex 7)
 - budget planning
- provides an update on Secretariat actions in latter half of 2017 (referring to the list of proposed actions in the [Annex to A70/14 Add.1](#))
 - active high level oversight at all three levels of the Organization;
 - coordinated human resource planning and budget management;
- presents a draft decision for the EB to consider.

The draft decision (para 84) broadly endorses the directions outlined in EB142/11. However there are some aspects which may be contentious.

This is the first of two items on polio. The report prepared for Item 6.4 ([EB142/37](#)) provides an overview of progress with respect to the four objectives of the Polio Eradication and Endgame Strategic Plan.

Background

The challenges associated with transition planning were outlined in [A70/14 Add.1](#), the discussion of which is recorded in [PSRA5](#) and [PSRA6](#). See the responses by Secretariat officials on [page 4 of PSRA6](#).

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

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

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

[A70/14](#) noted that “the Secretariat is also working with its Global Polio Eradication Initiative partners to develop a post-certification strategy that will define and cost the essential functions needed, after certification, to maintain a polio-free world”.

[The Post-Certification Strategy](#) will specify at a global level the technical standards for functions (e.g. containment, vaccination, and surveillance) that are essential to maintain a polio-free world in the decade following certification. The strategy has three goals:

1. Contain poliovirus sources: Ensure potential sources of poliovirus are properly controlled or removed.
2. Protect populations: Withdraw the oral live attenuated polio vaccine (OPV) from use and immunize populations with inactivated polio vaccine (IPV) against possible re-emergence of any poliovirus
3. Detect and respond: Promptly detect any poliovirus reintroduction and rapidly respond to prevent transmission

See [August 2017 version](#) of the PCS. [The Post-Certification Strategy](#) (PCS) was scheduled to be discussed by the GPEI Oversight Board in December 2017, to be reviewed at EB142 in January and in May to be presented to the WHA71.

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

The Global Polio Eradication Initiative (GPEI) has been in operation since 1988, now spends \$1 billion annually, and operates through thousands of staff and millions of volunteers in dozens of countries. It has brought polio to the brink of eradication. After eradication is achieved, what should happen to the substantial assets, capabilities, and lessons of the GPEI? To answer this question, an extensive process of transition planning is underway. There is an absolute need to maintain and mainstream some of the functions, to keep the world polio-free. There is also considerable risk—and, if seized, substantial opportunity—for other health programs and priorities. And critical lessons have been learned that can be used to address other health priorities. Planning has started in the 16 countries where GPEI’s footprint is the greatest and in the program’s 5 core agencies. Even though poliovirus transmission has not yet been stopped globally, this planning process is gaining momentum, and some plans are taking early shape. This is a complex area of work—with difficult technical, financial, and political elements. There is no significant precedent. There is forward motion and a willingness on many sides to understand and address the risks and to explore the opportunities. Very substantial investments have been made, over 30 years, to eradicate a human pathogen from the world for the second time ever. Transition planning represents a serious intent to responsibly bring the world’s largest global health effort to a close and to protect and build upon the investment in this effort, where appropriate, to benefit other

national and global priorities. Further detailed technical work is now needed, supported by broad and engaged debate, for this undertaking to achieve its full potential.

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

PHM comment

PHM appreciates the concerns regarding WHO's exposure to financial risk in the event that the funding dries up faster than the workforce shrinks. PHM supports the DG's proposal that polio transition be planned and managed in a way which is aligned with (supportive of the) strategic objectives set out in the (draft) GPW13.

PHM shares widely held concerns regarding the damage to health systems and public health that would occur if the personnel and systems currently deployed through the GPEI were simply discharged and dismantled. PHM supports the proposed absorption of GPEI staff and systems into general primary health care and public health systems as platforms from which they can continue to support polio functions post certification as well as immunisation, epidemiological surveillance, food system interventions and maternal and child health.

PHM supports the different approaches proposed (in para 7) for first tier (the most vulnerable countries), second tier and third tier countries. We recognise that some second and third tier countries will face difficulties in absorbing and funding existing polio assets and capacities. PHM urges the donors to give the highest priority, in transition planning, to the repurposing of polio assets and capacities in first tier countries and to support a carefully planned transition to domestic funding in the second and third tier countries.

PHM urges member states to support the draft decision set out in para 84.

EB142 - 3.5 Health, environment and climate change

In focus

The report, [EB142/12](#):

- summarises the continuing disease burden associated with environmental degradation and global warming;
- reviews the current status of the public health response to environmental risks including global warming;
- calls for transformational change for more effective upstream action in accordance with the SDGs;
- calls for WHO to play a stronger role and for a renewed mandate for such a role;
- calls for continuing development of research, evaluation and evidence-based policy options;
- calls for integration of action on climate and environment into the core functions of public health;
- proposes a draft decision requesting the DG:
 - to develop an action plan for the flagship initiative to address health effects of climate change in small island developing States and vulnerable settings;
 - to develop a comprehensive global strategy on health, environment and climate change; and
 - to ensure that the regional committees contribute to the proposed global strategy.

Background

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

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

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

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

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

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

PHM comment

See [PHM comment](#) at EB139.

This is an important initiative. The DG is to be appreciated for his commitment to action on global warming and other issues of environmental destabilisation.

PHM particularly appreciates:

- the emphasis on the urgency of these issues and the need for transformative change;
- the emphasis on the intersectoral nature of the policy issues, including “production methods that pollute, deleterious consumption and distribution patterns and disruption of ecosystems.” (Para 18)
- the focus on the SDGs;
- the references to research, evaluation and evidence.

Unfortunately the report casts the challenge largely in institutional/sectoral terms “ensuring that health occupies a more dominant position” in relation to the various SDGs (Para16). Somehow it is expected that the drive for ‘transformative’ change will come from the bureaucratically defined ‘health sector’ advocating to ‘other sectors’.

This approach to strategy:

- ignores the power of corporate vested interests; eg the oil and mining companies;
- fails to acknowledge the weak position health ministers commonly hold in cabinet;
- fails to recognise the degree to which health ministries are often held hostage by the power of corporate interests, operating on a “whole of government’ basis; and
- underplays the role of civil society / social movements and specifically the potential of the health workforce as active players in such social movements.

PHM supports the Action Plan and Global Strategy proposed in the draft decision.

However, while the Secretariat report recognises the role of “politically and economically powerful and multinational, private-sector actors” (para 11) and acknowledges the health and economic benefits of carbon pricing/taxation (para 20) there is no mention of these in the draft decision.

PHM urges member states to include, in the final decision, commitments to:

1. Work with other UN agencies and civil society organizations developing carbon taxation schemes to ensure that some of the revenues from such schemes are allocated globally and proportionately to those countries in greatest need of climate change prevention and mitigation efforts;
2. Work with other UN agencies, public institutions, civil society organizations and private sector organizations that are leading in the fossil fuel disinvestment movement, again advocating that some of the revenues arising from disinvestment are allocated globally and proportionately to those countries in greatest need of climate change prevention and mitigation efforts;
3. Ensure that the WHO’s own FENSA policy extends to corporate actors that continue to initiate new exploitation of fossil fuel reserves contrary to evidence on the need to cease such exploitation as advanced by IPCC research and UNFCCC/Paris Accord commitments; and

4. Ensure that the WHO's own investments and expenditures are in line with climate change reduction 'best practices'.

EB142 - 3.6 Addressing the global shortage of, and access to, medicines and vaccines

In focus

[EB142/13](#) presents a series of possible actions which WHO could undertake to overcome the barriers to affordable reliable access to safe, effective and appropriately used medicines and vaccines. It also provides a brief interim report on the specific tasks arising from Resolution [WHA69.25](#) from 2016 on addressing the global shortage of medicines and vaccines.

In the Annex to [EB142/13](#) the Secretariat provides a whole-of-supply-chain analysis of a range of barriers to affordable access to safe, effective and appropriately used medicines and vaccines. These barriers are discussed under 11 headings:

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

From the surveys presented under each of these headings a total of 33 'key considerations' are drawn and on the basis of this list of 'key considerations' a series of possible actions for the Secretariat are identified in the main body of the report; actions for which a mandate already exists through previous resolutions (listed in Appendix 1 to the Annex). These are then prioritised in terms of impact, complexity and cost with three packages (in addition to work already underway - paras 7 and 9):

1. high impact, low complexity and low cost (para 6);
2. high impact but more costly and more complex (para 8)
3. highly complex and expensive (para 10)

EB142/13 notes that WHO is already engaged in activities which address most of the recommendations of the [Secretary-General's High Level Panel on Access to Medicines \(HLP\)](#). Appendix 3 to the Annex lists the recommendations of the HLP report and summarises relevant work currently undertaken by the Secretariat.

It appears that the DG is hoping to focus the discussion at EB142 on the three packages of possible actions in paras 6-10 of the main report and perhaps avoid overt discussion of the HLP report on the grounds that the survey from which the possible actions have been drawn included full consideration of the HLP report (as presented in Appendix 3).

It appears that the development of technical definitions (of shortages and stockouts etc) which was requested of the DG, in OP3(1) of WHA69.25, and which was so contentious at WHA70 has been deferred to WHA71.

Background

How this item has emerged

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

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

Meanwhile the High-level Panel was finishing its work and its report was published in September 2016. In the lead up to EB140 in Jan 2017 the officers of the Board elected not to include the HLP report on the EB agenda. This was controversial and during the adoption of the agenda the Board agreed to discuss it under Item 8.5 CEWG. In the subsequent debate (at [PSR11](#)) the US expressed strong criticisms of the HLP report (supported by Switzerland and Japan) whereas Colombia, Thailand, Algeria, India, Brazil, Iran, South Africa and Venezuela all spoke in favour of the HLP being discussed. Accordingly the Board decided to add reference to ‘access to medicines’ to the WHA70 agenda item on ‘shortages’.

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

In preparing for the discussion at EB142, the DG has elected to step back and address the issues of shortages and access across a broad whole-of-supply-chain canvas as well as providing a brief interim report on the specific tasks arising from [WHA69.25](#).

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

See [PHM comment at WHA70](#) for a useful summary of the pre-history of WHO’s consideration of access to medicine and intellectual property.

PHM comment

PHM urges member states to support the proposed 'possible actions' in paras 6-10 of the main report although at this stage these actions are cast in general terms and all of them would need further analysis and specification.

Having regard to their likely impact on affordable, reliable access to safe, effective and appropriately used medicines and vaccines all of the listed 'possible actions' ought to be regarded as priorities and WHO should be funded at such a level as to be able to carry them out.

As [EB142/13](#) makes clear, all of the 'possible actions' have been mandated by previous resolutions of the governing bodies as summarised in Appendix 1.

That actions such as, *Support the development, implementation and monitoring of national medicines policies to reinforce strategies for the appropriate use of medicines* cannot be carried out unless additional funds can be raised reflects the ongoing funding crisis facing WHO.

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

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

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

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

It was not until 2015 that the 'companion workbook' was published ([Trade and health: towards building a national strategy](#)). The workbook is a very useful edited collection of

short papers by experts in various aspects of trade and health. In his preface Dr Mirza states:

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

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

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

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

Rather we cite this case as illustrating how the 'possible actions' identified in [EB142/13](#) must be contextualised in terms of the donor chokehold over WHO and the determination of big pharma's nation state representatives to prevent WHO from taking effective action on affordable, reliable access to safe, effective and appropriately used medicines and vaccines.

However, times are changing with the status of trade and investment treaties now in flux (Trump's America First protectionism, country withdrawals from investment treaties, the flawed CETA investment court proposal, continuing WTO stalemates).

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

Lift the freeze, now!

EB142 - 3.7 Global strategy and plan of action on public health, innovation and intellectual property

In focus

In [EB142/14](#) the Director-General sets out the Priority Actions identified in the final report of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property (full report [here](#)). The review assesses the continued relevance of the global strategy and plan of action, together with their achievements and remaining challenges they face. The report presents recommendations on the way forward for the next stage of implementation of the global strategy and plan of action, with respect to the addition, enhancement and conclusion of relevant elements and actions.

The Secretariat comment conveying the Priority Actions includes estimates of the cost of implementing all the recommendations of the Overall Programme Review or just the Priority Actions in across the four years 2019-22: \$31.5m for the full set of recommendations; \$16.3m for the high priority actions. The proposed budget is not covered within existing resources.

Background

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

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

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

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

The Overall Programme Review in a nutshell

From the report of the Review

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

Research and development is still not sufficiently directed at health products for diseases that mainly affect developing countries. Resources devoted to R&D on these diseases have not sustainably increased. There is evidence of progress for some diseases but for many diseases we still lack the tools and financial resources

necessary if we are, for example, to meet the health targets set in the Sustainable Development Goals.

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

The focus of the Review is on:

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

The 17 high-priority actions include:

- Member States to establish sustainable financing for the Global Observatory on Health Research and Development and the Expert Committee on Health Research and Development.
- Member States to support the WHO Secretariat in promoting transparency in, and understanding of, the costs of research and development.
- The WHO Secretariat to establish an information-sharing mechanism to promote collaboration and coordination in research and development linked to the Expert Committee on Health Research and Development and the Global Observatory on Health Research and Development.
- The WHO Secretariat and Member States to develop and support collaboration programmes between internationally recognized centres for research and development and relevant institutions in developing countries to enable those countries to enhance their capacity across the research and development pipeline
- The WHO Secretariat to identify mechanisms to increase health technology transfer in the context of the Technology Facilitation Mechanism established by the Sustainable Development Goals.
- The WHO Secretariat, in collaboration with other international organizations working in intellectual property, to advocate for the development of national legislation to fully reflect the flexibilities provided in the TRIPS Agreement, including those recognized in the Doha Declaration on the TRIPS Agreement and Public Health and in Articles 27, 30 (including the research exception and “Bolar” provision), 31 and 31bis of the TRIPS Agreement.
- Member States to commit to dedicating at least 0.01% of their gross domestic product to basic and applied research relevant to the health needs of developing countries.
- Member States to encourage the implementation of schemes that partially or wholly delink product prices from research and development costs, including actions

recommended by the Consultative Expert Working Group on Research and Development

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

The Review proposes that the Secretariat draft an implementation plan for publication in 2018, establish a monitoring mechanism to support implementation and publish reports at least annually.

PHM comment

The report of the Comprehensive Evaluation was weak. It did not attempt to assess the status of drug development for Types II and III etc. Rather it relied upon a survey of opinion and a limited range of case studies. The Evaluation concluded that 'lack of awareness' of the GSPOA was a factor in its failure to significantly alter the dysfunctions and imbalances of the current regime of pharmaceutical R&D. The evaluator strayed well beyond their boundaries in their dark comments about the dangers of SFC products associated with increased research and development funding in developing countries.

The Evaluation failed to acknowledge the ridiculously inadequate funding available to the WHO Secretariat for implementation of the GSPOA (see the [PHM comment on Item 13.4 at WHA70](#) for further notes on the funding) and failed to acknowledge the fierce opposition of Big Pharma and its nation state allies, led by the USA to any significant reform of the current regime of pharmaceutical R&D. Despite the GSPOA recommendations regarding the full use of TRIPS flexibilities and technology transfer the US, Europe and Japan were driving trade agreements which precluded the use of those flexibilities.

It is apparent that despite some marginal progress (eg the underfunded Global Observatory and Expert Committee) the reform of pharmaceutical R&D remains at a stalemate. The elaborate dance around the CEWG has gone nowhere, except to maintain the appearance of action.

The [report](#) of the Overall Programme Review recognises the funding crisis

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

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

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

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

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

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

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

PHM calls on member states to lift the freeze on assessed contributions and cease the earmarking of member state donor contributions.

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

EB142 - 3.8 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018

In focus

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

The requested report, in [EB142/15](#), includes:

- an overview of the magnitude and distribution of the burden of disease attributable to NCDs, showing a widening gap between high income countries and low and middle income countries; and demonstrating that the world is not on track to achieve SDG target 3.4 (reduce by one third premature mortality from NCDs);
- an overview of member state implementation of national commitments showing a substantial shortfall in implementation;
- a list of obstacles to national implementation including lack of political leadership, weak health systems, weak policy, program and regulatory capabilities, inadequate development finance for NCD action and industry interference;
- a recognition that a lack of consensus among member states regarding such obstacles is a critical barrier to progress (para 16);
- an outline of the process through which the Outcome statement from the Third High Level Meeting is to be developed and a brief review of key resources which will be drawn upon in developing that statement;
- a report on action undertaken by the WHO Secretariat on 10 assignments arising from the Second High Level meeting in 2014; and
- four annexes reporting on
 - progress in implementing the Global Action Plan;
 - progress made by the Global Coordination Mechanism;
 - progress in implementing WHA70.12 on cancer prevention and control; and
 - progress made by the UN Interagency Taskforce.

In addition [EB142/15 Add.1 \(NYP\)](#) reports on a preliminary evaluation of WHO's Global Coordination Mechanism.

Background

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

- WHO's first global strategy adopted in May 2000 ([WHA53.17](#));
- the 2008 Action Plan (2008-2013) ([WHA61.14](#));
- the Moscow Ministerial Meeting and Statement (May 2011, [WHA64.11](#));
- the Political Declaration of the UNGAss (September 2011, [EB130/6](#));
- the Global Action Plan 2013-2020 ([WHA66.10](#)) including the global monitoring framework and the nine voluntary global targets; (report in Annex 1 of EB142/15);
- the 'limited set of action plan indicators' for the WHO Global Action Plan (Annex 4 to [A67/14](#));

- the establishment of the Global Coordination Mechanism (see para 8 of the Annex to [A67/14 Add.1](#)) and the proposed work plan for the mechanism (at para 5 of [A67/14 Add.3 Rev.1](#)); see the [GCM/NCD](#) webpage and also the [working group reports](#); (report in Annex 2 of EB142/15; preliminary evaluation in EB142/15 Add.1)
- the establishment of the United Nations Interagency Task Force (para 17 of [A67/14](#)); see [IATF](#) webpage; (report in Annex 4 of EB142/15);
- the [Outcome document](#) of the 2nd HLM of the UNGAss on NCDs in 2014 (report in Table 6, para 25 of EB142/15).

PHM comment

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

This is a substantive report including detail across a number of important areas. In summary the material included in EB142/15 and EB142/15 Add.1 demonstrate:

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

It is apparent that high income countries are making some progress in the prevention and control of NCDs. This reflects strong health systems; strong policy, program and

regulatory capacity; supported by strong professional and community support for effective action.

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

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

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

The donor restrictions on WHO's work are directly linked to the corporate interests which drive the epidemic and which continually interfere with WHO's work. Both the June 2017 workshop (see Table 5 in EB142/15) and the report of the IATF (in Annex 4 to EB142/15) highlight the role of industry in driving the epidemic and obstructing WHO's work.

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

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

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

assistance is all the more hypocritical in the light of their own efforts to prevent and control NCDs domestically.

PHM calls upon WHO member states to:

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

EB142 - 3.9 Preparation for a high-level meeting of the General Assembly on ending tuberculosis

In focus

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

Document [EB142/16](#) provides background information, including reference to [WHO's End TB Strategy](#), and an overview of actions taken by WHO by way of preparation for the high-level UN GA meeting on TB in 2018.

Background

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

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

PHM comment

EB142/16 describes the purpose of the planned High Level UNGA discussion as 'to galvanize the political commitment needed to step up the battle against tuberculosis and help the world and individual countries accelerate progress on the path to ending the epidemic'. This is an important goal and the proposed options and modalities described make sense in this context.

It appears (from para 4) that the G20 discussion in July 2017 may have been informed by the notion of 'global health security' (and the threat to the rich world of MDR and XDR) rather than health as a human right.

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

EB142 - 4.1 Global snakebite burden

In focus

In June 2017 WHO included snakebite envenoming in the list of neglected tropical diseases. The Secretariat report ([EB142/17](#)) summarizes the global situation regarding snakebite envenoming and the actions WHO is undertaking.

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

The Secretariat's [Factsheet on Snakebite envenoming](#):

- notes that WHO has formally listed snakebite envenoming as a highest priority neglected tropical disease at the request of several UN member states;
- notes that an assessment of antivenom products in sub-Saharan Africa will be published in 2018;
- highlights two tools which have been produced to guide the development of antivenoms: first, [guidelines on production and regulation of antivenoms](#); and second a [venomous snake distribution database](#); and
- urges regulators, producers, researchers, clinicians, national and regional health authorities, and international and community organizations to work together to improve the availability of reliable epidemiological data on snake bites, the regulatory control of antivenoms and their distribution policies.

Background

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

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

PHM comment

EB142/17 provides a very useful overview of global, national and local initiatives needed to reduce the global burden of disease associated with snakebite. These include:

- effective regulation of antivenoms;
- decent primary health care including prompt availability of antivenoms and other treatment modalities;
- closer monitoring and data collection; more support for research.

EB142 - 4.2 Physical activity for health

In focus

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

[EB142/18](#) includes a report on physical activity and health and an overview of the four strategic objectives and 20 proposed actions from the draft global action plan.

The full draft action plan is [here](#). This includes an annex linking the draft action plan to the SDGs and an annex listing proposed actions for member states, the WHO secretariat and 'other stakeholders'.

The Board may consider developing a draft resolution for WHA71.

Background

Previous governing body discussions of physical activity include:

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

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

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

PHM comment

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

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

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

The structure of the draft plan as currently presented is problematic. In the full draft action plan the 20 'strategic actions' are all accompanied by a further set of 'proposed actions' for member states, the WHO Secretariat and for 'other stakeholders'. This has the effect of dispersing closely related initiatives across different 'strategic actions' and risking a certain incoherence across the plan. This fragmentation of the action suggestions for 'stakeholders' will not make it easy for them to develop appropriate organisational policies. PHM urges further attention to the structure of the plan.

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

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

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

Thus a comprehensive approach to encouraging physical activity should include:

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

The draft action plan includes actions around:

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

Managing corporate opposition and interference

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

While [EB142/15](#) speaks explicitly about industry opposition and industry interference in the context of NCDs generally there is no discussion in the current draft of the physical activity plan of the comparable challenges in creating urban settings which support physical activity.

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

Social exclusion and marginalisation

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

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

Under proposed actions for member states:

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

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

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

Intersectoral and community engagement

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

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

EB142 - 4.3 Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): early childhood development

In focus

[EB142/19](#) provides a useful update on the current status of women's, children's and adolescents' health globally, referring in each case to recent statistics and current policy documents. (A statistical report across all of the 60 indicators adopted for the Global Strategy will be posted in the Global Health Observatory portal in 2018.)

Key points in the report include:

- the harms associated with humanitarian crises and conflict including sexual violence and neglect of children;
- the continuing disease burden associated with unsafe abortion;

The report reviews in more detail a range of issues and initiatives relating to early childhood development. The report advises that WHO is working (with UNICEF, PMNCH and the Action Network for Early Childhood Development) on a draft global framework for nurturing care.

The report foreshadows a focus on midwifery in 2018.

Background

The Global Strategy (2016-2030)

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

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

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

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

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

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

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

Operational plan

In May 2016 (in [A69/16](#)) WHO outlined an Operational Plan to take forward the Global Strategy (which was endorsed in [WHA69.2](#)). This plan emphasises country leadership and sets out five key activities for countries to follow. It notes the commitment of the 'H6 partnership' in the provision of technical support and the Global Financing Facility (WB) in providing finance for L&MIC countries. Finally it emphasises accountability based on the agreed indicator framework and the Independent Accountability Panel.

The first report following the adoption of the Operational Plan (in [WHA69.2](#)) was carried in [A70/37](#) in May 2017. This report provided an overview of progress in women's, children's and adolescents' health and included a separate section focused on adolescents' health. [EB142/19](#) is the second annual report.

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

Independent Accountability Panel

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

Pre-history: the development of the Global Strategy

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

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

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

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

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

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

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

The UN SG appointed the [Independent Accountability Panel \(IAP\)](#) at the same time as the launch of the revised Global Strategy. The IAP is hosted and supported by the PMNCH. The IAP was to produce an annual 'State of the World's Women's, Children's and Adolescents' Health' report and in so doing identify areas to increase progress and accelerate action. See [Inaugural Report 2016](#) and [2017 Report](#) (focusing on adolescents).

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

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

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

Finance

As explained in [A69/16](#) the bulk of the funding required for the implementation of the Global Strategy is expected to be raised domestically. However, financial assistance will be made available for 62 low and lower middle income countries through the new Global Financing Facility sponsored by the World Bank. According to A69/16 (para 19):

The newly established Global Financing Facility in support of Every Woman Every Child aims to accelerate efforts towards the implementation of the Global Strategy by coordinating and harmonizing external funding flows in support of national plans, assisting governments in identifying strategies to increase domestic resources for health progressively, and reducing inefficiency in health spending over time. The Facility will provide an opportunity for 62 low- and lower middle-income countries to access substantial new funding for women's, children's and adolescents' health,

including through the World Bank's Global Financing Facility Trust Fund. Currently 12 countries have the option of support from the Global Financing Facility Trust Fund linked to International Development Association loans.

The [GFF](#) was launched in July 2015, out of the World Bank's Health Results Innovation Trust Fund and with funding from World Bank Group and governments of Canada, Norway, and the United States. According to its director, [Mariam Claeson](#), the GFF was launched in 2015 as "the new approach to smart, scaled and sustained financing across reproductive, maternal, newborn, child and adolescent health". More on the GFF [here](#).

EB142/19 (para 18) reports that funding from the GFF has been allocated to 16 out of the 50 countries seeking such funding.

Human rights approach

Following the 2014 recommendation of the independent Expert Review Group for the establishment of a global commission, on the health and human rights of women and children, to propose ways to protect, augment and sustain their health and well-being, WHO and OHCHR convened in 2016 a [High Level Working Group for the Health and Human Rights of Women, Children and Adolescents](#) to recommend ways in which human rights can be integrated into health programming.

Recommendations from the Working Group are conveyed in the [Annex to A70/37](#). EB142/19 reports ([para 19](#)) that "WHO and the Office of the High Commissioner for Human Rights are working on a framework cooperation agreement to implement the Working Group's recommendations, build institutional capacity and expertise, and ensure ongoing monitoring of progress."

Previous discussions

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

PHM comment

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

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

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

- the bureaucratic complexity associated with the Global Strategy;
- worrying aspects of the Global Financing Facility arrangements (including the 'private sector' platform);

- the neglect of process indicators - as opposed to outcome indicators - in the Indicator and Monitoring Framework;
- the lack of any recognition of the macroeconomic and geopolitical determinants of poverty, inequality and undernutrition.

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

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

Unsafe abortion

Unsafe abortion is a major contributor to [avoidable maternal mortality](#). EB142/19 (para 6) advises:

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

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

EB142/19 (para 7) advises that:

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

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

Gender inequalities in power: domestic, political and marketplace

[EB142/19](#) mentions gendered power inequality in relation to violence (para 9) and in this context cites SDG5 (gender equality and empowerment).

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

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

Human rights

PHM appreciated the collaboration between WHO and the Office of the HCHR in relation to women's and children's rights.

EB142/19 (dated 4 Dec) reports ([para 19](#)) that "WHO and the Office of the High Commissioner for Human Rights are working on a framework cooperation agreement to implement the [Working Group's recommendations](#), build institutional capacity and expertise, and ensure ongoing monitoring of progress." In fact the agreement was signed on 21 Nov ([here](#)).

PHM strongly supports this initiative.

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

Accountability and advocacy

Attempts to strengthen the accountability of country governments, regional committees, philanthropies and various intergovernmental organisations have been a prominent part of the planning of the Global Strategy including in particular the Commission on Information and Accountability (2011), the Independent Expert Review Group (2012), the Indicator and Monitoring Framework (2016), the Unified Accountability Framework (2015) and the Independent Accountability Panel (2016).

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

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

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

EB142 - 4.4 mHealth

In focus

[EB142/20](#) provides an overview of progress in the use of mobile wireless and other digital technologies for public health and health care. There are grounds for optimism and for scepticism. The penetration of mobile telephony globally has been extraordinary. There are thousands of apps promising extensive benefits in a wide range of fields. EB142/20 lists a wide range of applications where digital technologies and mHealth in particular are said to have great potential.

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

EB142/20 outlines a set of priorities for the Secretariat in the near to medium term.

The debate on this item at EB139 ([PSR3](#)) was dominated by developing countries. Thailand offered caution in the midst of enthusiasm. India foreshadowed a resolution which will presumably be forthcoming before EB142.

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

Background

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

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

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

	<ul style="list-style-type: none"> • Digital forms • Mobile web (WAP/GPRS)
6. Electronic decision support (information, protocols, algorithms, checklists)	<ul style="list-style-type: none"> • Mobile web (WAP/GPRS) • Stored information “apps” • Interactive Voice Response (IVR)
7. Provider-to-provider communication (user groups, consultation)	<ul style="list-style-type: none"> • Short Message Service (SMS) • Multimedia Messaging Service (MMS) • Mobile phone camera
8. Provider work planning and scheduling	<ul style="list-style-type: none"> • Interactive electronic client lists • Short Message Service (SMS) alerts • Mobile phone calendar
9. Provider training and education	<ul style="list-style-type: none"> • Short Message Service (SMS) • Multimedia Messaging Service (MMS) • Interactive Voice Response (IVR) • Voice communication • Audio or video clips, images
10. Human resource management	<ul style="list-style-type: none"> • Web-based performance dashboards • Global Positioning Service (GPS) • Voice communication • Short Message Service (SMS)
11. Supply chain management	<ul style="list-style-type: none"> • Web-based supply dashboards • Global Positioning Service (GPS) • Digital forms • Short Message Service (SMS)
12. Financial transactions and incentives	<ul style="list-style-type: none"> • Mobile money transfers and banking services • Transfer of airtime minutes

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

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

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

PHM comment

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

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

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

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

PHM is concerned that the tone adopted in EB142/20 is unduly optimistic, at least as far as the short to medium term is concerned. Para 8, in particular, promises that digital technologies, and in particular mHealth, could play a major role in accelerating member states' progress "towards achieving universal health coverage including ensuring access to quality health services". The para lists the ways in which mHealth could help to realize this potential including:

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

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

EB142/20 notes that the Secretariat is collaborating with the International Telecommunications Union (ITU) to raise awareness, record trends, build capacity, establish guidance, and generate and document evidence on digital health, including mHealth, as a tool to promote person-centred, integrated service delivery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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EB142 - 4.5 Improving access to assistive technology

In focus

[EB142/21](#) defines assistive technology, reviews the need, outlines some of the barriers to ensuring universal access to appropriate assistive products and summarises WHO's approach to supporting member states in this field.

A draft resolution outlining steps needed to implement the WHO's priority assistive products list will be considered.

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

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

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

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

Background

See [Tracker for links](#) to previous governing body discussions of disability and assistive technologies. See in particular the WHO [Global Disability Action Plan 2014-2021](#) adopted in [WHA67.7](#).

PHM comment

This is a very constructive initiative.

EB142 - 4.6 Maternal, infant and young child nutrition

In focus

[EB142/22](#) provides:

- a progress report on the comprehensive implementation plan (CIP) on maternal, infant and young child nutrition, including
 - an update on the final four core indicators;
 - a proposal to extend the term of the CIP so that it aligns with the SDG agenda to 2030; and
 - a draft decision;
- a progress report on the implementation of the Code of Marketing of Breast-milk Substitutes.

[EB142/23](#) conveys a proposed approach for preventing and managing conflicts of interest in the policy development and implementation of nutrition programmes at the country level.

Background

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

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

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

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

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

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

At WHA68 in May 2015 the Assembly decided (see [WHA68\(14\)](#)) to approve the additional core indicators ([A68/9](#)) to be reported from 2016; and approved in principle the remaining indicators and requested further work on the operationalisation of these various indicators;

see paras 20 and 29 of [EB142/22](#) regarding these additional indicators. See [PHM comment](#) at WHA68 on the politics of this debate over indicators.

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

- progress made in carrying out the CIP;
- progress in implementing the Code on the Marketing of Breast-milk Substitutes;
- progress with respect to risk assessment and risk management regarding conflict of interest in nutrition programmes - see [EB142/23](#) for the latest phase of this work;
- development of draft guidance regarding the inappropriate promotion of foods for infants and young children (articulated fully in [A69/7 Add.1](#) and adopted in [WHA69.9](#)).

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

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

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

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

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

This brings us to Jan 2018 and Item 4.6 at EB142.

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

PHM comment

The nutrition situation is poor, particularly in South Asia and Africa, and progress is slow (in some cases non-existent). See biennial reports on the CIP in 2018 ([EB142/22](#)), 2016 ([A69/7](#)) and 2014 ([B134/15](#)). The implementation of the 'commitments' of the Decade of Action has been glacial.

The field is populated by a confusion of UN agencies, global public private partnerships, global philanthropies all with different mandates, accountabilities and strategic frameworks. In this system, there is a huge emphasis at the global level on (voluntary) 'commitments' (under the decade of action) and policy / institutional reform (under the CIP).

In the context of strategies designed to avoid the key issues, the investment in independent monitoring and effective regulation is quite inadequate. The fundamentals are being

obscured by the dance of bureaucracy. In this context it is useful to return to the [PICSO&SM Statement on Nutrition](#) at ICN2 in 2014.

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

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

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

Climate change, soil degradation and water waste throw up new challenges for farmers and for food production. The threat of climate change demands fundamental reforms to energy systems. Soil degradation and water waste are inherently part of the food systems of neoliberal capitalism.

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

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

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

It is imperative to tackle the political, social, cultural and economic determinants of malnutrition in all its forms, including undernourishment, stunting, wasting, micronutrient deficiencies, overweight and obesity, and diet-related non-communicable diseases. However, the framing of any policy, programme and action plan on food and nutrition should be the unambiguous understanding of the rights to adequate food and nutrition, health and

safe water, as fundamental human rights, which identify people as rights-holders and states as duty-bearers with an obligation to respect, protect and fulfil these and other related rights.

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

EB142 - 5.1 Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

In focus

In accordance with decision [EB140\(5\)](#) (2017) and section 6.14.5 of the [Pandemic Influenza Preparedness \(PIP\) Framework](#), the Executive Board is invited to endorse the DG's proposal (in [EB142/24](#)) that the current proportions of PIP Partnership Contribution funds to be used for inter-pandemic preparedness measures or to be reserved for pandemic influenza response activities should remain unchanged.

The decision regarding the current split of partnership contributions (70% preparedness support and 30% response contingency fund) expires in February 2018. See [Financial Report at Annex 1](#) of 2016 PIPF PC 2013-16 Annual Report. The Nov 2017 advice of the PIP Framework Advisory Group is to leave this split unchanged and this is the advice of the DG.

In addition to the issue of partnership contribution funds, there are further issues for report arising from decision [WHA70\(10\)](#) which requested the DG to:

- take forward the recommendations of the PIP Framework Review Group ([A70/17](#));
- conduct a thorough and deliberative analysis of the issues raised by the Review Group's recommendations concerning seasonal influenza and genetic sequence data; (note Nov 6-7, 2017 consultations on the inclusion of seasonal influenza and genetic sequencing data; see [Scoping Paper](#));
- to continue supporting the strengthening of regulatory capacities and carrying out burden-of-disease studies;
- to continue encouraging manufacturers and other relevant stakeholders to engage in PIP Framework efforts, including, where applicable, by entering into Standard Material Transfer Agreements 2 and making timely annual PIP Partnership Contributions;
- to request the External Auditor to perform an audit of PIP Partnership Contribution funds;
- to continue consultations with the Secretariat of the Convention on Biological Diversity regarding, in particular, the relationship between the PIP Framework and the Nagoya Protocol, (see [EB140/15](#) and WHO webpage on [WHO negotiations with the Secretariat of the CBD](#)); and
- to report to the Seventy-first World Health Assembly, on progress in implementing this decision ... and make recommendations on further action.

It appears that the Secretariat does not expect that these issues will be reviewed at EB142..

Background

About the Pandemic Influenza Preparedness Framework (PIPF)

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

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

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

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

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

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

More recently

See provisional official report of debate at WHA70 from [PSRA6](#) and summary of highlights of debate in PHM comment on WHA70 [Item 12.5](#).

Debate at EB142 may touch upon the requests contained in [WHA70\(10\)](#) as listed above as well as those arising from [EB140\(5\)](#) regarding the split of partnership contributions.

PHM comment

PHM supports the continued 70:30 split of PCs. However, we note in passing that the funding available to support IHR capacity building in L&MICs is in total inadequate and that the WHO Health Emergencies Contingency fund remains seriously undersubscribed.

See previous PHM comment on [Item 12.5 at WHA70](#) (Review of PIP Framework)

During the Nov 6-7 Consultation the Review Group proposal that the PIP Framework references to the sharing of genetic sequence data be changed from a specific reference to the GISAID database to a form of words which leaves the specific database to the donor's choice.

PHM believes that databases that wish to host sequence data should implement a standard user agreement that applies the Framework's benefit-sharing obligations to users accessing sequence data and allows such users to be tracked. GISAID has such a user agreement.

EB142 - 5.4 Evaluation: update and proposed workplan for 2018–2019

In focus

The report published for this EB ([EB142/27](#)) includes

- a brief progress update on the ongoing work; and
- a draft evaluation workplan for the biennium 2018–2019, for EB approval.

This item was deferred from EB141 to EB142 because the report ([EB141/7](#)) was quite late and the PBAC (see para 14 in [EB141/2](#)) judged that it needed to be reviewed at EB142 for more extensive consideration (see [PSR2](#) for EB141 discussion).

Background

WHO's [Evaluation Policy](#) was approved at EB131 in May 2012.

In 2014 the Secretariat adopted a [Framework for strengthening evaluation and organisational learning](#), responding to concerns that project/programme evaluation was not contributing to organisational learning as strongly as it should.

The [Evaluation Workplan 2016-17](#) was approved at EB138 in Jan 2016.

The 2016 Evaluation Annual Report ([EB139/9](#), May 2016) **reviewed 13 recent evaluations** with a view to their contribution to organisational learning.

[EB141/7](#) (May 2017) described the decision framework, policies and procedures governing WHO's evaluation function. It **described the range of evaluations** undertaken in the previous year. The report emphasised the need to strengthen the organisational learning aspect of WHO's evaluation function; evaluations for learning rather than solely evaluations for accountability.

[EB142/27](#) (Jan 2018) briefly **describes a range of completed evaluations**. More detail is available on the [Evaluation Office website](#).

[EB142/27](#) also sets out the Secretariat's proposed evaluation workplan for 2018-19 including an overview in the Annex.

See [Tracker links](#) to recent governing body discussions of WHO evaluation policies and practices including various PHM commentaries.

PHM comment

For a long time evaluation coordination and oversight was embedded in the Office for Internal Oversight along with the internal audit and compliance functions. During this time the summative / accountability purpose dominated evaluation practice (in contrast to formative purposes and the learning objective). In 2015 the evaluation function was moved into the DG's office as an independent unit. It does not have the autonomy and independence of the World Bank's Internal Evaluation Group. Since moving into the DG's

office there has been increasing talk of strengthening the organisational learning purpose of evaluation activities. It is not evident that this has been achieved in practice.

Useful evaluation is dependent on some degree on clarity of planning. WHO has been repeatedly criticised for its 'results chain' and lack of clarity regarding the theory of change underpinning various programs and units. The [2015 evaluation of country presence](#) finds that WHO does not have a theory of change informing the work of country offices. This finding is questionable. It may not have an overt explicit theory of change but the deliverables specified in the programme budget clearly express assumptions about what needs to be done.

The 'results chain' is the hierarchy of objectives, outcomes, outputs and deliverables around which the programme budget is structured. The indicators adopted for outcomes and outputs are in many cases meaningless, not reliable or valid. The deliverables which provide the most practical expression of what staff are expected to do are not tracked because it would be generally impractical to do so. However, it appears that they are also disregarded in the various evaluations which have been undertaken since the Evaluation Office was established. For example the country presence evaluation looks at country cooperation strategies but does not examine the activities / deliverables specified in the programme budget.

There is no indication that much progress is being made in terms of organizational learning. The evaluation report goes to senior management who decide which recommendations they will run with and which they will ignore. Senge's account of organizational learning (*The fifth discipline*, 1994) emphasises organisational coherence with respect to values, mission and purpose, linked to a degree of local autonomy, judgement and entrepreneurship.

Part of the problem is the way in which the politics of governing body decision making is ignored in evaluations. Many WHO decisions and programmes are fiercely contested with opposed alliances strategising and negotiating to achieve particular outcomes. Out of the debate a consensus resolution or decision emerges, cast in the impenetrable bureaucratise of health diplomacy. This then becomes the policy or programme which is to be evaluated. On the ground the issues and perspectives which were central to the debate, including the conflict, remain alive and part of the context of practical work on the ground. However, the evaluation is conducted in a parallel universe in which the political differences have been reduced to diplomatic consensus despite the fact that they are still part of the lived experience of the implementers. Thus the [evaluation of the SSFFC Member State Mechanism](#) manages to almost completely avoid consideration of intellectual property and the attempt by big pharma to harness the statutory powers of medicines regulatory agencies to police their intellectual property claims. Notwithstanding the elision of intellectual property from the evaluation the tension between public health and the commercial interests of big pharma have been part of the *real politik* of the MSM.

It is hard to see how such evaluations can contribute effectively to building the learning organization at all levels if they do not engage with the lived realities of the implementers.

The proposed evaluation workplan for 2018-19 offer more of the same. The priorities for evaluation are set by senior management and largely address management concerns.

The evaluation paradigm promulgated in the [WHO Evaluation Practice Handbook](#) is highly bureaucratic and top down with all the trappings of pseudo objectivity. The Handbook does have an annex which discusses participatory evaluation but this discussion does not inform the official evaluation guidelines. The annex describes a range of benefits of participatory evaluation but concludes that such evaluations have ‘many limitations’:

Such evaluations tend to be less objective because participants have vested interests which they articulate and defend in such workshops. Moreover, they are less useful in addressing complex technical issues, which may require specialized technical expertise. Yet another limitation is that, although they may generate useful information, their credibility is limited because of their less formal nature.

WHO staff are commonly working in unstable, uncertain and politically charged environments. Pseudo-objective top down bureaucratic evaluations do nothing to assist local and programme implementers to work more effectively in such environments, far less build WHO as a learning organization.

In fact participatory action research focused on ‘deliverables’ could materially assist WHO staff to reflect locally, in consultation with local partners, on the context of their work and what they are trying to do and how (and contribute to building the learning organisation).

EB142 - 5.5 Engagement with non-State actors

In focus

In [EB142/28](#) the Secretariat provides the second annual report on engagement with non-State actors. The first annual report was presented in [EB140/41](#).

In [EB142/29](#) the Board, with the advice of the PBAC ([EB142/40?](#), NYP), is asked to consider applications for admittance of non-State actors into official relations and to review collaboration with one third of the non-State actors in official relations in order to decide whether to maintain their official relations.

Background

The FENSA has emerged from a long and complex discussion arising out of Dr Chan's WHO Reform program, which included an initiative directed at WHO playing a more proactive role in global health governance, and in particular, helping to coordinate the anarchy of multiple 'global health initiatives' providing 'development assistance for health'.

It is unfortunate that this element of the WHO reform project has been so completely extinguished.

The finalised FENSA ([WHA69.10](#), May 2016) is also long and complex. It provides for annual reports ([EB142/28](#)) and for more formal review of the Official Relations relationship ([EB142/29](#)).

See the [Tracker links](#) to previous documents, debates and decisions relating to the FENSA and to previous PHM commentaries.

PHM comment

The biggest flaw in the FENSA arrangements is that they only deal with the Secretariat's engagement with non-state actors. Member states remain free to advance the interests of private sector entities through the governing bodies, through the financing dialogue and behind closed doors, with no provisions for public accountability (recalling [IMPACT](#), [sugar](#), [psoriasis](#) and [sepsis](#)). See [PHM comment](#) at WHA68.

It appears that the Secretariat's due diligence procedures are being applied somewhat selectively.

The International Telecommunications Union

In our [comment](#) on agenda item 4.4 on mHealth we have pointed to possible links between the Secretariat's over-enthusiastic assessment of mHealth applications (in the short to medium term) and its receipt of significant donor funds from the International Telecommunications Union (ITU), a global public private partnership including 193 governments and over 800 private sector and academic entities. In particular we have pointed to the involvement of pharmaceutical and private insurance companies as partners in the *Be He @lthy Be Mobile* initiative and the possibility that they are contributing to ITU

donations to support this initiative. It appears, from the [WHO Register of non-State actors](#), that the ITU is not in official relations with WHO.

Croplife International

We note that “The Secretariat proposes to defer the review of the collaboration with CropLife International to the 144th session of the Board to allow CropLife international sufficient time to clarify its and some of its members’ positions and actions with regard to WHO’s activities.” CLI has been previously listed as in Official Relations but the relationship became due for review in accordance with the FENSA policy.

In terms of the FENSA framework CropLife International is technically an ‘international business association’ and in accordance with [clause 50](#) may apply for Official Relations with WHO.

Para 55 sets out the privileges of Official Relations:

55. Entities in official relations are invited to participate in sessions of WHO’s governing bodies. This privilege shall include:

- (a) the possibility to appoint a representative to participate, without right of vote, in meetings of WHO’s governing bodies or in meetings of the committees and conferences convened under its authority;
- (b) the possibility to make a statement if the Chairman of the meeting (i) invites them to do so or (ii) accedes to their request when an item in which the related entity is particularly interested is being discussed;
- (c) the possibility to submit the statement referred to in subparagraph (b) above in advance of the debate for the Secretariat to post on a dedicated website.

Para 52 provides that official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget and consistent with this framework. This plan shall also be published in the WHO register of non-State actors. [...] These plans shall be free from concerns which are primarily of a commercial or profit-making nature.

Croplife International lobbies to advance “the role of agricultural innovations in crop protection and plant biotechnology to support and advance sustainable agriculture”. It lists among its [membership](#): BASF, Bayer, Du Pont, Monsanto, Dow Agrosiences, syngenta and a range of national and regional business associations.

It is concerning that the pesticide / herbicide / agri-biotech industry should maintain Official Relations with WHO.

We note the [concern expressed](#) by civil society organisations in February 2016 at the role of various private sector entities, including Croplife International, at an FAO symposium on agricultural biotechnologies.

It seems likely that CLI is keen to get its feet under any table which is discussing:

- regulatory strategies to prevent pesticide/herbicide toxicity; or
- the role of transnational food corporations in driving the NCDs epidemic; or

- the role of intensive industrial agriculture in driving antimicrobial resistance and
- in increasing the risk of new pandemic influenza threats from intensive pig and poultry farming.

We anticipate that CLI is presently working on a draft 'plan of collaboration' promising some kind of co-regulatory approach to pesticides/herbicides exposure.

PHM calls on the member states of the WHO and the Secretariat to discontinue its 'official relationship' with CLI. In particular we call upon those member states whose agricultural workers suffer from pesticide exposure to support this call.

PHM urges other organisations which are involved in global health ([G2H2](#)), public health nutrition (eg [World Public Health Nutrition Association](#)), pesticide regulation (such as [PAN International](#) and its regional affiliates), food politics ([IATP](#), [Food First](#), [FIAN](#), etc) or agroecology / food sovereignty ([Via Campesina](#)), to publicise and add their voices to this call.

EB142 - 5.9 Statement by the representative of the WHO staff associations and report of the ombudsmen

In focus

Statement by the representative of the WHO staff associations - [EB142/INF./1](#).

Report of the Ombudsman [EB142/INF./2](#)

Background

The annual statements by the Staff Associations and the report of the Ombudsman both provide useful windows into the mood of staff and the HR function within the Organisation.

Some of the highlights in the statement from the staff associations ([EB142/INF./1](#)) include:

- morale affected by “unprecedented number of changes to staff rules” and job insecurity “due to ineffective resource mobilization or erratic restructuring”;
- encouraged by statements from new DG and the prospects of ‘transformation’;
- acknowledgement of internal justice reforms as ‘successful’; and
- a number of specific (and sensible) proposals for HR policy reform (from para 9-18)
 - 9. Create more core P1 and P2 positions. End the over-reliance on junior professional officers, consultants and interns for so-called entry-level work in the international professional category.
 - 10. Develop clear career pathways for colleagues working in the general service category. This should include routes of progression from general service to international professional or national professional officer. This would open up the opportunities for development and growth in staff’s contributions to WHO.
 - 11. Pay interns and fellows a stipend, so that WHO can attract a diverse and highly qualified group of young professionals from around the world, particularly from low-income countries. Demonstrate to the world that WHO supports international labour standards. Access to internship should be based on merit, not on ability to pay.
 - 12. Modernize parental leave: four months for all staff members who become parents, plus an additional two months for the staff member who gives birth to the child. This would be a bold contribution to the United Nations Secretary-General’s gender equality agenda and would inspire others.
 - 13. Rapidly establish a global network of health care facilities that recognize WHO staff health insurance, offering preferred prices for health services and direct-billing arrangements. Reinforce quality and solidarity by ending the two-tier policy that exists for staff in some countries, a policy that currently creates unfair, discriminatory financial burdens simply because of the duty station location or health status of the staff member.
 - 14. Invest in a staff health and well-being programme and campaign, designed to respond to the findings of the staff health risk survey, with a strong focus on mental health and supporting colleagues serving in difficult field environments.

- 15. Promote mobility as mutually beneficial for staff and the Organization. There should be a focus on professional growth, family-friendly environments, and ensuring the framework advances gender equality and women's leadership across offices.
- 16. Create more short-term exchange and growth opportunities through filling posts during parental leave and sick leave with current WHO staff (i.e. "backfilling"), fostering cohesion across WHO and broadening the skills and perspectives of staff. Fund all backfilling and exchanges through a central mechanism thus streamlining implementation.
- 17. Communicate internally more effectively, maintaining a positive dialogue, sharing successes and experiences, influencing and inspiring others. Build a global network of internal communication experts throughout all major offices. Remove the antiquation of our current internal communications system and invest in robust tools, including a globally connected intranet network, knowledge management hubs and collaboration software.
- 18. Building on the successful internal justice reform, demand more accountability from the Organization for those who work in its care. Serve the vulnerable. Enable the Organization to live up to its values by taking swift and specific action against those who choose to undermine it through the bullying and harassment of others. This should be done while removing the full burden of responsibility from those most directly affected: those who are at their weakest.

Highlights from the report of the Ombudsman ([EB142/INF./2](#)) include:

- description of the role of the Ombudsman and how it operates at WHO;
- increasing numbers of staff using the ombudsman service, commonly relating to 'evaluative relationships' between supervisors and supervisees;
- need for WHO to invest in its managers to improve communication, team climate and morale, particularly in country offices;
- WHO to express its core values, notably respect, in its practices and culture; concern regarding apparent prevalence of abusive behaviour and harassment
- WHO's duty of care towards staff: counselling, career development, recognition;
- equal access to informal resolution regarding work-related issues.

See also [PHM comment](#) on Agenda Item 8 (Human Resources: Update) at PBAC27.

See [Tracker Links](#) to previous staff associations' statements.

PHM comment

The staff associations' proposals for HR policy reform (paras 9-18 of [EB142/INF./1](#), above) and the Ombudsman's suggestions ([EB142/INF./2](#) and summarised above) all appear to be very sensible.

EB142 - 6.2 Global vaccine action plan (GVAP)

In focus

After a brief overview of the development of the Global Vaccine Action Plan (GVAP) [EB142/35](#) conveys the Executive Summary of the [2017 Assessment Report](#) by the Strategic Advisory Group of Experts on the implementation of the Global Vaccine Action Plan. Key points:

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

Para 9 of Annex 1 of [EB142/35](#) summarises the 12 recommendations of the Assessment Report.

[EB142/35](#) also provides (in Annex 2) a summary of actions undertaken through WHO to implement resolution [WHA70.14](#) (May 2017) which called on member states to 'demonstrate stronger leadership and governance of national immunisation programs' as well as requesting the DG to continue to work in a range of areas to progress the achievement of the GVAP goals. The report highlights:

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

The report of the October 2017 meeting of the SAGE (in [WER,92,729-248](#)) provides further useful information.

Background

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

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

The first update report ([A67/12](#)) on the implementation of GVAP was considered by the Assembly in May 2014 in [A67/12](#). The debate is at [A3](#) and [A4](#). See PHM commentary [here](#).

A further report was considered by WHA68 in 2014 in [A68/30](#) and after a long debate ([A2](#), [A5](#), [A11](#) and [A12](#)) the Assembly adopted a further resolution [WHA68.6](#) which strengthened the GVAP in certain respects including requesting the Secretariat to collect and present data on vaccine pricing. PHM posted a [detailed commentary](#) on the 2014 report.

In May 2016 the Assembly considered [A69/34](#) which included a report on GVAP generally and specifically on the implementation of [WHA68.6](#) which was noted by the Assembly (see debate at [B7](#)). PHM posted a detailed commentary ([here](#)) broadly appreciating the SAGE report.

In May 2017 the Assembly considered (in [A70/25](#)) the Executive Summary of the Midterm GVAP (2010–2020) review by the SAGE (full report [here](#)). The debate is reported in [PSRA10](#) and [PSRA11](#). Responding to the SAGE report the Assembly adopted resolution [WHA70.14](#). PHM's comment on the mid term review at WHA70 is [here](#).

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

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

PHM comment

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

Price

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

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

Technology transfer

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

National / regional immunization technical advisory groups (NITAGs)

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

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

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

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

Health system strengthening

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

EB142 - 6.3 Reports of advisory bodies

In focus

[EB142/36](#) conveys reports of meetings of expert committees and study groups held over the last three years, including a summary of their recommendations and observations on their significance for public health, and implications for the Organization's programmes.

[EB142/36 Add.1](#) reports on the meetings and membership breakdown (by gender and region) of expert committees that met in 2017. It also provides a regional and gender breakdown of all of the expert advisory panels.

Background

Expert committees and study groups whose reports are abstracted in [EB142/36](#) include:

- Joint FAO/WHO Expert Committee on Food Additives:
 - 83rd report, meeting November, 2016;
 - 84th report, meeting June 2017;
- Study Group on Tobacco Regulation, 8th meeting, December 2015;
- Expert Committee on the Selection and Use of Essential Medicines, 21st meeting, March 2017.

[EB142/36 Add.1](#) advises that the following committees met in 2017:

- Expert Committee on the Selection and Use of Essential Medicines (Twenty-first meeting) Geneva, 27–31 March 2017
- Joint FAO/WHO Expert Committee on Food Additives (Eighty-fourth meeting) Rome, 6–15 June 2017
- Expert Committee on Specifications for Pharmaceutical Preparations (Fifty-second meeting) Geneva, 16–20 October 2017
- Expert Committee on Biological Standardization (Sixty-eighth meeting) Geneva, 17–20 October 2017
- Joint FAO/WHO Expert Committee on Food Additives (Eighty-fifth meeting) Geneva, 17–26 October 2017
- Expert Committee on Drug Dependence (Thirty-ninth meeting) Geneva, 6–10 November 2017.

PHM comment

The report of the Study Group on Tobacco Product Regulation reports on topics such as:

- characteristics of the content and appearance of cigarettes and cigarette design features;
- toxic chemicals found in aerosols from electronic nicotine delivery systems;
- toxicants in waterpipe tobacco and smokeless tobacco; and
- the applicability of the standard operating procedures of the WHO Tobacco Laboratory Network for measuring selected content and emission chemicals in cigarette tobacco products including electronic nicotine delivery systems, waterpipe tobacco and smokeless tobacco products

The report provides guidance on specific cigarette design features, as well as on testing and disclosure of the content and emissions of a wide range of smokeless and waterpipe tobacco products and of other devices such as electronic nicotine delivery systems.

The report of the Expert Committee on Essential Medicines notes:

- 55 medicines added to essential list and essential list for children;
- 22 antibiotics added under three headings: access, watch and reserve;
- added medicines also include medicines for HIV, hepatitis C, tuberculosis and malaria and medicines for cancer, cancer pain, reproductive health and anaemia resulting from chronic renal disease;
- three new working groups recommended: a working group on antibiotics; a working group on cancer medicine prioritization; and a working group on timely access to the results of all clinical trials.

EB142 - 6.4 Eradication of poliomyelitis

In focus

This item (informed by [EB142/37](#)) is the second of two items on polio (Item 3.4 - [EB142/11](#) - deals with transition planning); this item provides an update on progress made against the objectives of the Polio Eradication and Endgame Strategic Plan. It summarizes the current situation, including details of:

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

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

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

Progress with respect to eradication and surveillance was reviewed by the Strategic Advisory Group on Immunisation (SAGE) at its meeting in October 2017. See [summary notes here](#).

Background

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

PHM comment

Too much has been invested in the GPEI to allow it to fail now. PHM appreciates the strategic and operational challenges facing the GPEI; commends the technical experts, the managers, the practitioners and the volunteers for their dedication; encourages the governments of the 26 at risk countries; and urges the donors to continue to fund the Initiative up to eradication and beyond.

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

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

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

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