

## **Highlights from the seventh day of the 132nd Executive Board (Geneva, Monday, 28.01.13)**

### **Item 9.2 Neglected tropical diseases (Document EB132/19): *Update on Neglected Tropical Disease Resolution***

On Saturday 26th January the amended resolution on NTD's explicitly included the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and the Consultative Expert Working Group on Research and Development: Financing and Coordination - by Brazil and Cuba – into the preamble and sections 'calling on WHO partners' and 'requests the DG'. It also included textual amendments by the EU, Australia, Russia and the US. In the discussion on Monday the EU sought deletion of the added sections on the CEWG because it thought this was not directly relevant to combating NTDs. This was supported by the US and Australia. Cuba made no objection to this deletion. The resolution was adopted as amended.

### **Item 10.1 Substandard/spurious/false-labelled/falsified/counterfeit medical products (Document EB132/20)**

Member States (MS) have agreed on the Chair and Vice Chair for the working group. MS expressed disappointment and regret for the slow progress made so far and supported the urgent need for the Steering Council to be set up before WHA66. MS supported the Member State Mechanism (MSM) as a way of developing a shared understanding of the scale of the problem of SSFFC, sharing data collection and analysis, and exchanging information on lessons learnt. MS affirmed that SSFFC are a threat to public health. Australia also linked it to 'global health security' and anti-microbial resistance, as did the UK. MS called for countries to invest in regulatory capacity, technical support, and the provision of resources. Iran also called for the tracking of medical products from production to consumption. The EU requested that the Steering Council work in a transparent manner and in coordination with regional offices. The UK argued that the Steering Committee should be open for MS concerns on the work of the mechanism. The EU also included the need to manage potential of conflicts of interests, as did Panama.

Lebanon emphasised ensuring affordable access to quality medical products through technology transfer and the promotion of generics, which was supported by India. Thailand, Brazil, India and Nigeria argued that the work must be public health oriented and should not be confused with IP enforcement.

Monaco identified itself as a candidate for the Steering Committee. It also requested that the cost of this be included in the programme budget 2014-2015. Brazil suggested renaming the MSM to

“Mechanism of Buenos Aires”. Nigeria and India emphasised national efforts while India supported Brazil chairing the working group.

The Secretariat committed to provide as much assistance as possible and to do fundraising. The EB took note of the report and MS views.

### **Item 10.3 Universal health coverage (Document EB132/22)**

The discussion on Universal Health Coverage (UHC) welcomed the report with general support. All the MS emphasised the strategic role that UHC can play and recognized it as a priority in the post 2015 agenda towards sustainable development. The discussion was immediately opened by Mexico on the need to strengthening health care systems through a strong political will. This argument was underlined also by USA which affirmed that, while WHO can provide technical support, the implementation of UHC is under the responsibility of each national government. This issue was supported by Norway, Lebanon, Timor-Leste and Japan, among others. During the discussion, most of the MS highlighted also the need to strengthening data collection and the importance of setting specific indicators in order to develop evidence-based interventions. Senegal, speaking on behalf of the African Region, affirmed that the implementation of UHC should be considered just the first step to reach equal access to health, and highlighted that, while WHO is supporting some countries in developing health financing strategies, African States are facing different levels of development and different needs for external support. Lebanon, among others, highlighted the need to strengthening health systems and clouted the fact that many countries still need assistance supported by the private sector, while Maldives called for public funding for health care and social protection. The European Region asked for more precise information on the technical support that WHO will provide to MS to facilitate the implementation of UHC at local level, and fostered a multi-sectoral approach that involves also other sectors (such as the Ministries of Finance, Labour, Social Policy and Foreign Affairs) in order to address the broader social determinants of health (SDH) with a cross cutting approach. Panama welcomed the strategy of prioritising UHC as a tool to combat poverty and to provide social protection, but urged MS to consider the importance of internal financing policies in order to implement long term coverage. Ecuador arose the fact that WHO has to provide clear guidelines and policies on what it is meant by UHC and which policies can lead to it, and reported their national example with a public financed system based on SDH. Ecuador also expressed the interest to attend the meeting on UHC that will take place in February 2013 organized by WHO and the World Bank, and expressed its concern about the fact they have not received any invitation. While Iran and Mongolia called for the support of WHO for the development of financing models, Malaysia expressed its concern about the growth of the private sector in financing health services. An

unexpected concern was raised by Yemen, that clearly asked DG what are the interplays of existing initiatives on UHC and stressed the challenges they face in some contexts of their region. Cuba highlighted that health, as a human right, will not be achieved until we won't face the unequal distribution of wealth, affirming that without equal distribution there is no development, and this is strictly related to a strong political will. Thailand stressed the importance of capacity building and proposed sideline meetings during the 66th WHA. Singapore expressed its concern about the lack of a universal agreement on what UHC consists and on the fact that different contexts can lead to different implementations and financing policies, so jeopardising what UHC means in principles. After the MS contributions, the civil society took the floor: the International Federation of Medical Students' Association (IFMSA) started focusing on the right to health, especially for the most vulnerable people. Then Medicus Mundi International and People's Health Movement drove the attention from the concept of universal health coverage to universal health care (PHM statement is available at the following link:

[http://www.ghwatch.org/sites/www.ghwatch.org/files/EB132\\_PHM\\_UHC%20statement.pdf](http://www.ghwatch.org/sites/www.ghwatch.org/files/EB132_PHM_UHC%20statement.pdf)). Save the Children closed the floor affirming that health is not a commercial commodity that some people can buy and some can not.

The Assistant DG on Health Systems and Innovation closed the session on UHC reporting that they are engaging regional offices in the definitions of indicators and monitoring framework and will develop technical assistance packages with regional offices. Finally, concerning the use of the term "Care" instead of the term "Services", ADG clarified that they are not talking about therapy but referring to all the continuum of care, including diagnosis, therapy and rehabilitation.

#### **Item 10.4 The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs (Document EB132/23)**

MS called for a greater and more comprehensive strategy on the health workforce – including education and training of health workers considering the shortage of professionals that many of them experience.

Nigeria emphasised south-south and north-south collaboration and supported a special training fund in developing countries to address the negative effects of migration; it said "Africa needs more aid workers now more than any time in history". Nigeria called upon WHO to mobilise resources for training and retention of aid workers, and stressed that this must be included in the post 2015 agenda and the twelfth General Programme of Work. Morocco, on behalf of EMRO, emphasised the importance of strengthening national capacities and the need for educational and financial support for countries to train health professionals. Ecuador referenced its recent program 'please return' – urging workers to return to Ecuador, which included increases in pay for

physicians and nurses. Switzerland and Norway expressed concern that only forty eight countries had submitted a report on the Code of Practice for Recruitment of Health Professionals, with thirty five of these countries being European ones. They stressed that this should be investigated before 2015 and raised a question on the next steps to be taken. They also affirmed that further cooperation with OECD for statistical trends is needed. Norway argued that strengthening health systems and UHC are not realistic without a global health workforce. The US sought clarification on WHO no longer providing staffing on the global code related to migration. Brazil affirmed that it will host the global forum on human resources for health in November in Recife, Pernambuco ([fro more information see the following link: http://www.who.int/workforcealliance/forum/en/](http://www.who.int/workforcealliance/forum/en/))

From the international agencies perspective, ILO also affirmed that the health workforce is critical for achieving UHC. Addressing shortages is not just a number game – it requires investment in the health sector especially in public services - particularly nursing and midwifery. The World Health Professional Alliance welcomed the progresses and sought comprehensive sustainable programmes. The Secretariat, through the ADG/HIS, stated it will produce a more in-depth analysis for the next WHA, along with some suggestions for solutions, including regional platforms. The Secretariat urged MS to go home and ‘rattle their country's cage so to speak so they set up a focal point’. At the moment the work is included in the Program Budget but financing is not ensured. Four technical officers are responsible for the application of the code in Geneva, with six further staff for the regional offices.

#### **Item 10.5 e.Health and health Internet domain names (Documents EB132/24 and EB132/CONF./6)**

Australia and the US were wary of WHO seeking safeguards for internet health domain names because of limitations on oversight capacity and liability for WHO. The US stated that WHO has no special claim to the world ‘health’ and agreed with Australia for a paper to come to WHA, with the resolution to be put on hold. There was no consensus on the draft resolution. NGOs Medicus Mundi International/Health Innovation in Practice/Democratising Global Health coalition called on WHO and MS to take action to make sure that “.health” was managed in the interest of global public health. The DG stated that “.WHO” should be protected, but that WHO could only advise ICANN and had no authority on the allocation of “.health”. The DG thanked civil society for concerns raised – noting again that the applicants so far for the domain name “.health” are all commercial. The EB agreed to delay the draft resolution on “internet domain names related to health” to the WHA.