



PHM Commentary on the Agenda of the 136th Session of the WHO Executive Board

Geneva: 24 Jan 2015

The comments below have been prepared by the People's Health Movement (PHM) as a contribution to the deliberations during the 136th Session of the WHO Executive Board.

PHM is a global network of organisations working locally, nationally and globally for Health for All. Our basic positions are articulated in the People's Charter for Health which was adopted at the first People's Health Assembly in Savar in Bangladesh in December 2000. More about PHM can be found at www.phmovement.org.

PHM is committed to a stronger WHO, adequately resourced, with appropriate powers and playing the leading role in global health governance. PHM follows closely the work of WHO, both the Secretariat and the Governing Bodies. Across our networks we have many technical experts and grassroots organisations who are closely interested in the issues to be canvassed in the EB136 debates.

PHM is part of a wider network of organisations committed to democratising global health governance and working through PHM's WHO Watch project. More information about 'WHO Watch' is available at: www.ghwatch.org/who-watch.

The following notes comprise an abridged version of PHM's more detailed background briefings and commentary which can be accessed via www.ghwatch.org/who-watch/eb136 or can be downloaded as a single PDF file [here](#). Please do refer to it for more background information and details on each agenda item.

PHM representatives are attending the EB meeting and will be pleased to discuss with you the issues explored below.

Contents

EBSS3 Special Session on Ebola Emergency and 9.4 2014 Ebola virus disease outbreak.....	3
5.1 Framework of engagement with non-State actors.....	7
5.3 Overview of reform implementation.....	9
6.1 Outcome of the Second International Conference on Nutrition.....	11
6.2 Maternal, infant and young child nutrition: development of the core set of indicators.....	13
6.3 Update on the Commission on Ending Childhood Obesity.....	14
6.4 Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases.....	15
6.5 Global status report on violence and health.....	17
6.6 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications.....	18
7.1 Monitoring of the achievement of the health-related Millennium Development Goals.....	19
7.2A Health and the environment • Addressing the health impact of air pollution...20	
7.2B Health and the environment • Climate and health: outcome of the WHO Conference on Health and Climate.....	21
7.3 Adolescent health.....	22
7.4 Women and health: 20 years of the Beijing Declaration and Platform for Action.....	23
8.1 Antimicrobial resistance.....	24
8.2 Poliomyelitis.....	26
8.3 Implementation of the International Health Regulations (2005).....	27
9.1 Malaria: draft global technical strategy: post 2015.....	28
9.2 Dengue: prevention and control.....	29
9.3 Global vaccine action plan.....	31
10.1 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.....	33
10.2 WHO Global Code of Practice on the International Recruitment of Health Personnel.....	35
10.3 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products..37	
10.4 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination.....	39
10.5 Global strategy and plan of action on public health, innovation and intellectual property.....	40
10.6 Blood and other medical products of human origin.....	41
11.1 Implementation and financing of Programme budget 2014–2015: update.....	43
11.2 Proposed programme budget 2016–2017.....	44
11.3 Strategic budget space allocation.....	45

12.1 Draft financial strategy for WHO and 12.2 Scale of assessments for 2016–2017.....	47
13.1 Evaluation.....	48
14.4 Human resources: update.....	49

The more detailed [background and commentary](#) also covers, item 5.2 Method of work of the governing bodies, item 13.3A Reports of committees of the Executive Board: Standing Committee on Nongovernmental Organizations, and 15.1 Reports of advisory bodies, in addition to the items covered here.

EBSS3 Special Session on Ebola Emergency and 9.4 2014 Ebola virus disease outbreak

Background

On January 25 the WHO's Executive Board is holding a Special Session on the Ebola Emergency. Ebola is also on the agenda of the EB through 9.4 Ebola and 5.3 Overview of Reform (and Ebola). Four key documents are considered at both the Special Session and on item 9.4.

The Secretariat report [EBSS3/2](#) contextualizes the outbreak, summarizes the spread of the virus and country-level and global response, and outlines work on preparedness, research and development and building resilient health systems in the affected countries. [EBSS/3/INF/2](#) includes a report on the December 2014 meeting of Ministers of Health and Finance of Ebola-affected countries, international organizations and development partners, convened by the African Development Bank, the West African Health Organization, the World Bank, and the World Health Organization. [EBSS/3/3](#) contains 5 recommendations and asked member states to agree on a resolution that embodies these recommendations. [EBSS/3/INF/4](#) reviews the history of the IHRs and highlights several issues of concern arising from the experience of the Ebola epidemic: (i) continuing gaps in core capacity; (ii) delays in publication of important information owing to country sensitivities; (iii) disregard by some states parties of the obligations regarding 'additional measures' beyond those recommended by the Emergency Committee.

PHM Comments

PHM salutes the heroism of the local and foreign practitioners, volunteers and experts from WHO, NGOs such as MSF, and other Member States. PHM affirms the dedication and professionalism of the WHO Secretariat once the response commenced.

Delay in WHO's response

The first diagnosed cases in this epidemic were reported in late March in Guinea. By June 2014 philanthropic organisations such as [MSF](#) had over 300 international and national staff working in Guinea, Sierra Leone, and Liberia. In contrast, the WHO did not hold an Emergency Committee until August.

Historical and economic determinants of Ebola and weaknesses in the local response

In [EBSS3/2](#) the Secretariat notes that:

All three countries were suffering economically, following years of civil war and unrest, and in spite of determined efforts, their health systems remained weak, including with regard to surveillance and laboratory capacity. Populations of interconnected families and communities living close to porous borders moved easily and regularly between countries. Timber harvesting and mining over the previous decades had changed the ecology of densely forested areas. Fruit bats,

which are thought to be the natural reservoir of the virus, moved closer to human settlements. Collectively, this presented a favourable context for a virus like Ebola to spread.

This is a useful summary (see also [People's Health Movement 2014](#)). It would also be useful to recognise the role of the global economic regime which encourages transnational tax evasion (see [Health Poverty Action](#)), in constraining the availability of public finance to develop health systems, and the role of IMF austerity programs imposed on the countries of West Africa (see [Rick Rowden](#)) in limiting their responses to the outbreak. It would also be appropriate to note how the profit driven model of pharmaceutical R&D contributed to [the neglect of Ebola](#) vaccine development. This outbreak underlines the importance of delinking R&D funding from the market opportunities associated with monopoly pricing.

Health systems

[EBSS/3/INF./2](#) outlines the devastating impact the Ebola outbreak has had on the health systems and the economies of the affected countries and highlights opportunities for a stronger and more coherent approach to health system development.

The key principles (para 9) adopted in the December 2014 meeting of various national and intergovernmental bodies are of critical importance. In particular: *Instead of creating yet another vertical programme for a specific health condition or to respond to a crisis, investments should be used to build systems that are grounded in primary health care and universal health coverage principles and capable of responding to diverse and unexpected challenges that might arise in the future.*

This welcome conclusion runs counter to the policies adopted over the last 15 years (and longer) by some of WHO's most influential donors, including MSs, philanthropies and global PPPs. The challenge is to build a global movement to reframe what has been the dominant paradigm in development assistance for health.

WHO's Mandate

PHM urges MSs to support the arguments developed in paras 7 & 8 of [EBSS/3/3](#) regarding the need for WHO to expand its emergency risk management mandate, and in particular its operational role in emergency response. PHM urges MS to also recognise a parallel need to re-affirm WHO's mandate in relation to the social and political determination of population health and of effective health care.

[EBSS/3/3](#) notes that "WHO's institutional identity has traditionally been driven by its normative and highly technical work". This is only part of the story.

Several of WHO's rich MSs (and donors) have repeatedly argued for WHO to be restricted in its role to technical and normative issues. The continued freeze on assessed contributions has been justified as a strategy for forcing WHO to stay

away from the social and political determinants of health and of effective health systems.

The Ebola outbreak illustrates the need for WHO's mandate to be reaffirmed, both in relation to emergency response preparedness and in relation to the social and political determinants of health and of health systems (see [above](#)).

Reforming WHO's crisis management systems and structures

Proposal 2 of [EBSS/3/3](#) contains recommendations that:

the emergency response programme would be merged across all three levels of the Organization, with departments or units in each WHO office. The structure would be headed by a lead, or incident command during a response, with substantial delegated authority, giving the programme both singular leadership and direct reporting lines.

Longstanding dysfunctions associated with WHO's regional structures have been revealed by the Ebola crisis. Creating an integrated emergency response capacity across the three levels would be a positive step. At the same time PHM urges MSs to concurrently look at the fundamental need for restructuring the relationships between the centre and the regions (see PHM comment in relation to Item 5.3 on WHO Reform, [here](#)).

IHRs and Ebola

[EBSS/3/INF/4](#) suggests that:

regional meetings could be held in 2015 under the coordination of the WHO Regional Offices and the global IHR Secretariat as part of a global process, including the IHR Review Committee, to further identify issues and to formulate potential solutions for consideration at the 2016 Executive Board and the World Health Assembly.

PHM urges MS support for this suggestion.

5.1 Framework of engagement with non-state actors

Background

WHO's relationship with various non-state actors (NSAs) is a crucial element of the organization-wide 'reform'.

The documents at the EB136 include a revised Overarching Framework of Engagement for Non-State Actors, draft new Official Relations Policy, and four separate Draft WHO Policies and Operational Procedures for engagement with NSAs ([EB136/5](#)); and the reports of discussions at the WHO Regional Committees ([EB136/INF./2](#)).

PHM Comments

The Secretariat's revised Framework for engagement with NSAs has not addressed key concerns raised by Member States. They have highlighted the risks associated with global health partnerships, for example those involving interactions with alcohol, food and beverage industries and corporations involved in labour law violations and environmental damage.

The revised Framework continues to blur the fundamental distinction between NSAs whose mandate is to act in public interest and those driven by commercial interests. It uses wrong interpretation of the conflicts of interest theory, 'tweaking' accepted definitions and confusing conflicts of interests within an actor with 'conflicting interests' between actors. In addition, through the repeated use of language such as 'inclusiveness', 'participation', 'mutual respect and trust', the document contradicts the core principle of avoiding compromising WHO's integrity, independence, credibility and reputation (para 6.f).

The WHO Secretariat has not responded to Member States' requests for clarification of the rationale for widening engagement with private sector nor have they explained where the 'due diligence' and 'risk management' approach comes from and how they link to conflicts of interest. For example, the draft Framework suggests to allow for 'contributions for financing of staff salaries' by private sector entities through clauses on 'real or perceived conflict of interest'. This proposal is in contradiction with the decision by member states to reject staff secondments. Similarly, the proposal that private-funded NSAs can be 'at arm's length' from their commercial sponsor and thus considered as NGOs (paragraph 11) is inconsistent with a correct understanding of conflicts of interest theory.

The draft policy in relation to academic institutions does not address the situation where researchers or whole units are funded by industry, and institutional engagement with these institutions with high risk of conflicts of interest is contemplated. Some of the risks of undue influence in this situation will be covered by individual conflict of interest provisions (CI 4.6) of WHO's Regulations for Expert Advisory Panels and Committees but it is not clear how institutional conflicts of interest are taken into account and how they will be addressed.

PHM urges Member States to insist on further revision of the Framework and ensure that it explicitly acknowledges the underlying conflict between the mandates of corporate actors on the one hand and WHO on the other. This could be pursued through an **expert technical meeting on conflicts of interest and other risks of engagement with non-state actors** informed by independent specialists on conflict of interest and corporate accountability.

Finally, the **long term solution to potential threats to WHO's independence and integrity lies in strategies that would free the Organisation from the debilitating donor dependence which distorts its organisational culture. This will require lifting the freeze on assessed contributions.**

5.3 Overview of reform implementation

Background

[EB136/7](#) is a report by the Secretariat on the status of WHO's reform implementation, in particular in light of the Ebola crisis.

PHM Comments

PHM recognises that much of the work going into the present reform program is very worthwhile. However, there are fundamental issues highlighted by the Ebola outbreak that are not being properly addressed in the reform program.

It is unfortunate that the secretariat Report indulges in victim blaming - pointing to frail health systems, health inequities, deficit in implementation and failures to address social determinants of health (para 8) - instead of recognising its responsibility. The WHO failed to provide guidance in policy. It did not intervene to strengthen the health systems of the countries that became the epicentre of the outbreak. The institution even found itself complicit in positions that contributed to weakening those systems. It is too easy to stand today as a judge. The WHO has to recover its role as a political body in global health governance.

In its report, the Secretariat highlights the strain on WHO's managerial structures and systems, challenges in mobilizing human resources and organizational efficiency (para 6). However, the staff associations' report to EB135 in May 2014 ([EB135/INF./1](#)) commented on the negative impacts of discontinuing long-term appointments on technical depth and institutional memory. PHM urges MSs to demand an evaluation of the impact of human resource budget cuts and layoffs of technical employees on WHO's response capacity. While there has been a trend to push the WHO to be reduced to a mere technical body, today, even its technical capacity stands eroded.

WHO's current budget saw cuts in WHO's outbreak and crisis response of more than 50% from the previous budget - from \$469 million in 2012-13 to \$228 million for 2014-15. This is the very budget line that the organisation needed to rely upon in order to respond to Ebola. The \$71 million deficit the institution faced in order to implement its Ebola response plan could have been avoided. The WHO stands in dereliction of duty.

Finally, WHO's response to the Ebola crisis was severely restrained by the continuing freeze on assessed contributions (see [Gostin and Friedman 2014](#)). Beyond donor capture and the fragmenting effect of internal competition, is the fact that WHO's budget is, in absolute terms, grossly inadequate.

6.1 Outcome of the Second International Conference on Nutrition

Background

In decision [EB134\(2\)](#) the Executive Board requested the Director-General, *inter alia*, to report to the Sixty-eighth World Health Assembly, through the Executive Board at its 136th session, on the outcome of the Second International Conference on Nutrition. This report ([EB136/8](#)) describes the outcomes of the Conference and WHO's role in its follow-up.

PHM Comments

Outcomes of ICN2

The [Rome Declaration on Nutrition](#) recognises that eliminating malnutrition in all its forms will require cross sectoral collaboration, including in agriculture and trade. However, there is no reference to dumping of agricultural commodities, to Transnational Corporations (TNCs) control of food systems or food sovereignty. The document includes several 'needs' and 'shoulds' but little in the way of a firm direction.

The [Framework for Action](#) provides a list of 60 recommendations, but all of them are non-binding. Some of the recommendations are weak critically, for example, the human rights perspective on nutrition --but they do provide a menu for governments , WHO and other actors to work on.

PHM would like to draw the attention of MSs to the Statement by 170 social movements and public interest civil society organisations (PICS&SM: [English](#), [Spanish](#))) that was read in the ICN2 closing plenary.

National and international action

Whether the right to adequate food and nutrition will be progressively realized depends on action at the national and international levels.

The food, nutrition and agricultural circumstances are very different across the world. Action on food and nutrition must therefore be planned and implemented **at the national and local levels**. Member states should develop national nutrition plans as per Rec 2 of the FFA. Such plans should consider the applicability of FFA Recs 1-16, 19-57. We emphasize, in line with Rec.3 , that national mechanisms for food security and nutrition to oversee implementation of policies, strategies, programmes and other investments in nutrition, must contain robust safeguards against abuse and conflicts of interest. They should also express the core principles outlined in the [PICS&SM](#) statement.

However, the political and economic context within which such national planning takes place is strongly shaped by economic globalisation and the increasing power of transnational corporations. There is therefore a need to clearly **articulate the barriers to food security and food sovereignty in current trade and**

investment agreements and to point towards provisions which should be included in such agreements to guarantee food security and food sovereignty (see FFA Recs 17 & 18).

In this context we urge **opposition to the use of Investor State Dispute Settlement (ISDS)** to prevent effective regulatory strategies. We urge a return to multilateral negotiations around trade in agricultural commodities to ensure the elimination of dumping and of protection and subsidies to corporate agriculture. WHO has a mandate (through [WHA59.26](#)) to take the lead in this work.

There is an urgent need for new **international instruments to regulate the TNCs** in areas where their profit objectives run counter to public policy objectives such as food sovereignty and environmental sustainability. PHM seeks the support of MSs to call on WHO to open negotiations with UNCTAD with a view to exploring in more detail possible strategies for regulating TNCs.

There are deep conflicts between the assumptions underlying the principles of **food sovereignty** - which envisages food and agricultural systems based on agro-ecological principles - and the globalised corporate industrial model. PHM seeks the support of MSs to call for a new Commission to be jointly sponsored by WHO and FAO to investigate and report on the role of food sovereignty in addressing the challenges of food security.

The Outcomes Statement and the FFA are both weak in acknowledging that access to adequate food and nutrition, consistent with cultural traditions, is a basic human right (see [OHCHR](#)); the **human rights perspective must permeate all policies and actions in this field**. PHM urges MSs to ensure that WHO works with the Special Rapporteurs on the Right to Food and the Right to Health in preparing a report on the human rights dimension of food and nutrition policies designed to inform the **Post-2015 agenda** as well as national nutrition planning. PHM calls for WHO and its MS to recognise the powerful **role that CSOs play in defending the Right to Food** and advancing the principles of food security through food sovereignty and to explore ways of working productively to this end at both the national and global levels.

UN Committee on World Food Security

PHM asks MS to oppose any attempt to create another mechanism outside of intergovernmental system to oversee food and nutrition issues in the form of what UNICEF and WFP have termed 'United Nations Nutrition' (UNN). PHM sees no advantage in such a move and is concerned about accountability and high risk of undue influence by the corporate sector. Instead PHM urges WHO to **join the Committee on Food Security (CFS) secretariat** so as to fill the current gap with respect to health and nutrition implications of food security. In this context, the responsibilities of the SCN - currently under the umbrella of WHO - can be moved to the CFS.

Monitoring and accountability

PHM endorses Recommendations 58-60 of the FFA on monitoring and accountability. However, **there is no reference, under monitoring and accountability, to FFA Recommendations 17-18 (regarding trade and investment agreements)**. PHM urges WHO, FAO, the UNHCHR and UNCTAD to create a commission to report

on the implications of trade and investment agreements for the right to food in accordance with para 25 of UNGA resolution [A/RES/68/177](#).

Conflict of interest and undue influence

PHM endorses Recommendation 3 of the FFA on the need for robust safeguards against conflicts of interest. PHM urges a **high level of caution in relation to ‘multi-stakeholder platforms’** such as SUN,(Para 21-23 of EB136/8), a multi-stakeholder initiative with inadequate conflicts of interest safeguards and which, according to the just completed external evaluation, generated effective progress in scaling up nutrition responses only in a limited number of countries. Where such platforms include, or even depend upon, private sector participation, this could lead to mission shifts, prevent proper consideration of regulatory or fiscal strategies which might run counter to the corporate interest. Managing such risks of conflicts of interest require: transparency, structural separation and accountability.

PHM calls for the establishment, through the UNHRC, of an Open-Ended Intergovernmental Working Group on a **legally binding instrument on transnational corporations** and other business enterprises with respect to human rights ([A/HRC/26/L.22/Rev.1](#), see also [GPF commentary](#)).

Draft resolution

Finally, PHM urges the EB to adopt the draft resolution ([here](#)) based on the Civil Society Vision Statement at ICN2.

6.2 Maternal, infant and young child nutrition: development of the core set of indicators

Background

The Board will consider the report of a working group ([EB136/9](#)) set up to finalise a core set of indicators to monitor the implementation of the Comprehensive Implementation Plan in Maternal, Infant and Young Child Nutrition.

PHM Comments

The first round of indicators were exhaustive (and accordingly costly). It makes sense to restrict the core indicators, to be monitored in all countries, to relatively few and to develop a panel of further indicators which can be used to follow the specific circumstances of different countries. We also appreciate the proposed disaggregation of indicators by socioeconomic group, sex and geographical variables in order to identify and address inequalities.

We appreciate the inclusion of **nutrition governance** in the extended set of optional indicators and note the regulation of marketing and level of soft drink consumption among the newly suggested indicators in the 2013 consultation. However, according to the November 2014 document ([here](#)) it seems these indicators will be “removed and considered in future” because data are “not systematically collected”.(Table G) Considering the relevance of these indicators, PHM urges MSs to ask that this decision be reconsidered.

The global determinants of food security, food sovereignty and healthy nutrition are shaped by an agro-industrial model of production and by international trade agreements defending it. However, since the Comprehensive Implementation Plan (CIP) is silent regarding the political economy of food sovereignty, and consequently there is still a lack of **policy, program and process indicators able to follow progress in reforming the structures and dynamics of global food supply. Food sovereignty** of many LMICs continues to be undermined by “**land grabbing**” and an increasing number of countries are now net food importers and therefore increasingly food insecure and dependent on imported (often obesogenic) food. PHM stresses the need for nutrition to be understood in the context of food security (and insecurity) of the **poorest quintile of the population**. Unfortunately no indicators have been proposed to establish trends in this area.

6.3 Update on the WHO Commission on Ending Childhood Obesity

Background

The high-level Commission, 'Ending Childhood Obesity' is established by the Director-General and met first in July 2014 in Geneva. It is required to report in 2016. The EB will review [EB136/10](#) which provides an update on the work of the Commission to date. The Board is invited to note the report.

The report of the first meeting (in June 2014) of the Ad Hoc Working Group on Science and Evidence is summarised [here](#) with link to a [detailed report of the meeting](#).

PHM Comments

On this item we would also like to refer to our comments made on agenda item 6.1 Outcome of the Second International Conference on Nutrition.

PHM would strongly support the proposal for mandatory standards as flagged in the report of the Commission's first meeting. The experience of the voluntary Code on the Marketing of Breast Milk Substitutes as compared with the FCTC or the IHRs underlines clearly the importance of mandatory standards.

The rising significance of free trade agreements in shaping global food systems points towards the need for strong countervailing mechanisms as counter to provisions in trade agreements that pose a risk to health. Provisions for investor state dispute settlement have been widely recognised as a threat to policy space in terms of regulating the food environment. Robust standards in a binding agreement would go a long way to protecting such policy space.

The increasing control by transnational food companies of global food systems has been accompanied by increasing presence of highly processed and energy dense foods which contribute to increasingly obesogenic environments. We are concerned about the involvement of those transnational companies in the commission, certainly at a moment when there is no consensus about the Framework of engagement with Non State Actors.

Food sovereignty and relative self-sufficiency allow for employment creation, give an opportunity for producing less energy dense food and is more supportive of local economic development.

WHO must find ways of engaging more effectively with the rising significance of trade and investment agreements in global health governance. This commission could lead the way.

6.4 Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases

Background

The secretariat reports on the high-level meeting ([EB136/11](#)), and invites the EB to provide advice on indicators on the implementation of the 2011 Political Declaration. EB136/11 provides an overview of 11 actions endorsed by the HLM. The Board is also invited to note the Outcome Document (Annex 1 of EB136/11) from the meeting. The Director-General ([EB136/11 Add.1](#)) submits the proposed work plan for the Global Coordination Mechanism on NCDs covering the period 2016–2017.

PHM Comments

From a public health perspective prioritization of resource allocation based on the burden of morbidity and mortality, posed by different diseases, has to be based on sound evidence that is specific to local setting. All diseases that are epidemiologically relevant have to be tackled and there is no pre-defined hierarchy.

Formulations that put type 1 and type 2 disease in competition miss the fact that the root causes of people's vulnerability to the one or the other is to be found in the structural, economic and social determinants of health. The same social determinants that create the conditions for increased burden of type 2 diseases are also responsible for the continuing burden of type 1 diseases. Low and middle income countries (LMICs) are faced with a double burden of Type 1 and type 2 disease.

Traditionally communicable diseases have been the main focus in LMICs. It is important that adequate capacity is built in LMICs to treat and manage NCDs. This should be captured in progress indicators developed for assessing implementation of the Declaration.

PHM urges Member States to ensure that the agenda on NCDs not be hijacked by Big Pharma, who see an opportunity in promoting irrational and expensive treatment regimes to tackle NCDs. At the same time effective action on social determinants of health has been hampered by the food and beverages industry among others.

The discussion on the need of introducing process indicators as opposed to outcome indicators has been at the centre of the HLM in 2014. Indicators that address social

determinants of health and inequality in the distribution of risk factors are crucial to assess progress in the implementation of measures to contain risks by NCDs in different settings. These are entirely missing in the work plan.

The Global Coordination Mechanism was mandated in the GAP for NCDs 2014-20 AND The draft work plan is included in EB136/11 Add.1.

PHM appreciates the inclusion among the proposed functions of the GCM/NCD "Advancing multisectoral action". PHM urges that this be elaborated to include promoting policy coherence across sectors such as trade/investment and health and protecting policy space for NCD prevention/regulation.

The UN Inter-Agency Task Force on the Prevention and Control of NCDs, t(E/RES/2013/12) o has the potential to strengthen global policy coherence on NCDs. However the terms of reference (set out in E/2010/55) contain nothing about action on the social determinants of health, the regulatory challenges of regulating TNCs in a liberalizing environment or on the role of trade and investment agreements in limiting public health policy space for NCDs.

The TOR speak of 'harmonization of activities across the UN system' but not of the need to reduce policy incoherence implicit in the mandates of several of the inter-governmental agencies.

PHM urges Member States to reconsider the proposition to invite non-state actors (NSAs), especially the food and pharmaceutical industry, in the Working Group proposed in Action 3.1. This is a serious danger in a context where the discussions regarding means to manage *conflict of interests as regards NSAs* are yet to be concluded. It is inappropriate to involve the profit-driven commercial private sector in the policy space for global health, which must be driven solely by public interest.

In addition, PHM notes the lack of any reference in the Global Coordination Mechanism to conflict of interest in the NCDs space and urges an additional function to be assigned to the GCM to monitor potential conflicts of interest in the policy processes associated with the Action Plan and to be alert for instances where conflicts of interest may lead to improper influence in such policy processes.

6.5 Global status report on violence and health

Background

The Secretariat report ([EB136/12](#), [EB136/12 Corr.1](#)) describes progress made in implementing resolution [WHA67.15](#) (see page 19).

[EB136/12](#) (as corrected) *provides detail regarding the Secretariat's work to develop the scientific evidence and to provide technical assistance; introduces the [Global status report on violence prevention](#) ; and sets out the proposed timelines for the development of the draft global plan of action.*

PHM Comments

PHM regrets that there is an extensive focus on **interpersonal violence** in contrast with the comprehensive definition of violence used by the WHO in the past. This approach is also in contradiction with recent scientific work done by the U.S. Center for Disease Control and Prevention that encourages linking multiple forms of violence. (interpersonal, self-directed and collective)

PHM also regrets the focus on the proximal causes of violence and its consequences. Responses are conceived largely in terms of government policies and programs. The discussion of the **wider political economy and geography of violence** is very inadequate. Thinking across and relating different forms of violence with individual, relationship, community, and societal factors is key in measuring, understanding and addressing violence.

Countries were not asked about information on **victim-perpetrator** relationships or about the circumstances surrounding violent deaths. PHM considers this as a missed opportunity for adopting more innovative and effective prevention and treatment strategies. Victims or those who are more vulnerable are in need of protection and services, yet a more relational approach that aims to heal rather than punish might be best for all parties involved.

Most, if not all, of the language is heteronormative. There appears to be little to no specific mention of hate crimes or violence motivated by or involving **prejudice** based on race, religion, sexual orientation, or ethnicity, etc. Sex workers and transgender women are largely excluded from this report and other studies and discussions of violence and violence prevention strategies.

The report completely neglects the potential role of **primary health care** agencies and practitioners in engaging with communities at the local level to work together for the social conditions which provide security against violence.

PHM hopes that in the future reports, research and discussions of this topics, WHO will use a more comprehensive approach, where the discussed missing elements could be covered.

6.6 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications

Background

At the request of a Member State, the Secretariat is providing information ([EB136/13](#)) on the global burden of epilepsy and the need to raise the priority accorded to coordinated action at country levels in order to mitigate its health and socioeconomic consequences. The Board is invited to note the report and provide further guidance.

PHM Comments

Even though most cases of epilepsy can be treated in primary health care settings, the disability, the exclusion and the amount of deaths associated with untreated epilepsy are huge. Nevertheless after two to five years of successful treatment, drugs can be withdrawn in about 70% of children and 60% of adults without relapses; yet **about three fourths of affected people in developing countries do not get the treatment they need.**

The continued price barriers to epilepsy treatment reflects the failure of the user pays model for health care financing. The epilepsy treatment gap demands a renewed commitment to the full implementation of comprehensive primary health care. This includes procurement and supply chains systems, strong referral, support relations between primary care and secondary and tertiary services.

Health systems need to be strengthened to ensure that people with epilepsy can be managed within a comprehensive primary health care environment, with access to specialist care when needed. This requires developing the primary health care workforce, in order to **improve knowledge and ability to manage the disease** and to **promote awareness** to reduce stigma and discrimination. Inter-sectoral policies need to be developed to reduce structural barriers to health, education, transport, employment and social participation.

The impact of trade negotiations and of trade agreements on access to newer drugs through intellectual property restrictions should be included as part of any evaluation. Specific indicators for epilepsy, such as **treatment coverage would be an excellent measure of successful implementation of such a commitment.**

7.1 Monitoring of the achievement of the health-related Millennium Development Goals

Background

In 2000 191 UN member states committed to combat poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women by the target date of 2015. [EB 136/14](#) is a report of the WHO Secretariat on progress towards achieving the health-related Millennium Development Goals and their specific targets.

PHM Comments

The MDGs failed to recognise that health is not merely the absence of disease but is a state of complete physical, mental and social well-being.

The MDGs were adopted at a time when, in the words of the WHO's Macroeconomics and Health report: "globalization is under trial, partly because these benefits are not yet reaching hundreds of millions of the world's poor, and partly because globalization introduces new kinds of international challenges...".

The MDG response was based on a charity model with new vertical disease programs and technical solutions to palliate the effects of an unfair global dispensation rather than progressing the necessary structural reforms. While technical solutions are necessary, they must be accompanied by structural changes directed to:

- reforming an unfair trading regime (which sanctions the dumping of subsidised agricultural products driving small farmers off their lands and into huge informal settlements in the cities);
- an unstable financial regime (in which policy priority is given to banks which are too big to fail rather than the communities who suffer as a consequence of greed and lack of effective regulation);
- a global tax regime which drives tax competition and facilitates capital flight and tax avoidance;
- an IP regime which is a major barrier to urgently needed technology transfer; an investment regime which privileges the interests of transnational corporations at the cost of reducing the regulatory and policy space of sovereign governments (as in ISDS provisions in contemporary trade agreements);
- a global regime which because of greed and competition is unable to deal effectively with global warming.

PHM urges member states and WHO to ensure that social development goals are on WHO's agenda.

7.2A Health and the environment: Addressing the health impact of air pollution

Background

This item was introduced at EB135 in May 2014 [EB135/4](#), because the Member States Panama, France and Bangladesh requested that air pollution as a major global health issue should be discussed separately. At EB135 28 MSs endorsed the importance of air pollution and spoke in support of WHO taking the issue further. It was agreed to review it further at EB136, presumably with a view to a new resolution and perhaps a global strategy and action plan.

PHM Comments

PHM recognises the serious burden of disease associated with air pollution and urges WHO to strengthen the health sector's engagement around clean air policy and practice. Rapid urbanisation is an important driver of air pollution. A focus on strategies such as rural electrification, investment in rural education and support for small farmers are necessary to turn the tide on rapid urbanisation.

Additionally, we urge attention to the geographic distribution of pollution within global production chains. It is too easy today for transnational corporations to displace polluting production to L&MICs.

PHM endorses the package of strategic actions listed in EB136/15 but notes that the document does not address the political challenge of effecting change in this field.

There are already massive inequities with respect to the exposure of different populations to indoor and outdoor air pollution. Urban populations in developing country megacities and women cooking with open polluting fuels compare sharply with the conditions in the rich strata of rich countries.

PHM urges that in the conception and development of this strategy serious attention is paid to the development of meaningful partnerships with civil society organisations and networks, in particular those community based organisations who work with the communities who have most to gain. This includes workers who are exposed to air pollution in unsafe mines and workplaces.

There are significant international dimensions to this project which will need attention as it develops. We need strong international norms regarding air quality to protect national policy makers from the threat of corporate intimidation under investor state dispute settlement provisions in trade and investment agreements. We urge full consideration to the role of binding international instruments to achieve change, as opposed to voluntary codes of conduct.

7.2B Health and the environment: Climate and health: outcome of the WHO conference on Health and Climate

Background

The WHO Conference on Health and Climate (Geneva, 27-29 August 2014) was a response to the request made to the DG by the Health Assembly by the resolution [WHA61.19](#). The report [EB136/16](#) summarizes the proceedings and conclusions of the conference period and presents a revised work plan of the WHO Work Plan on Climate Change and Health. There may be an accompanying resolution as well.

PHM Comments

PHM notes the reference in paragraph 7 to the evidence presented concerning the principal role played by the burning of fossil fuels in changing global climate systems. PHM is also aware of the evidence that the international and national policy changes required to reduce and then eliminate fossil fuel consumption must be made in the next 5-10 years if we are to avoid catastrophic global warming by 2100.

PHM urges WHO to take a strong leadership role in pressing international organisations and national governments to set targets and implement policies over the next 5 years to achieve a rapid and dramatic reduction in fossil fuel use, leading to elimination by mid-century.

The revised WHO Work Plan on Health and Climate focuses mostly on mitigation, while adaptation to the adverse effects of climate change is also a priority that needs to be pursued.

Additionally it's important that WHO ensures that less developed countries have access to alternatives and are equipped to build local climate resilience before the enforcement of mandatory regulations on greenhouse gas emissions. Transfer of capacity, technology and finances to less developed countries is crucial to ensuring that climate related regulations do not become another layer of discrimination against LMICs..

We would like to see a stronger and more explicit reference to WHO promoting the role of primary health care practitioners in working with their communities to understand, assess and respond to the threat of climate change (as described in Para VII of the Alma-Ata Declaration).

Some of the fundamental driving forces of climate change are not addressed in the document. Free Trade Agreements not only make it very easy for transnational companies to relocate their polluting production, but also drastically increase the international supply chain. WHO should advocate for a fundamental shift in energy, transport and agriculture policies to stop the evolution of climate changes and his consequences.

7.3 Adolescent health

Background

In May 2011 the Assembly considered A64/25 on youth and health risks and adopted Resolution A64.28. One of the flow-ons from this resolution was the multi-media report on 'Health for the world's adolescents' released in early May 2014.

PHM Comments

The main thrust of EB136/17 is to propose the development of a formal framework for action on adolescent health. A broad sketch of the proposed framework is provided. The framework would address five domains: health services, diet and nutrition, safe and supportive environments, physical activity and safe sex. The framework will focus particularly on the role of the health sector and notes the crucial role of families and communities as well as young people. The report envisages a framework which will encourage young people to play an active part in its development and its implementation.

There is no mention to education, jobs and employment. These issues are important, because of their links to marginalisation and exclusion.

Health for the world's adolescents is also tied to the distal or macro determinants but EB136/17 appears to focus largely on more immediate or proximal risks. There is a need to focus on the macro determinants of adolescent health (marginalisation, exclusion, patriarchy) as well as immediate behavioural and health care access issues.

7.4 Women and health: 20 years of the Beijing Declaration and Platform for Action

Background

There has been some progress over the last 20 years but comparing the Beijing Platform of 1995 with the situation sketched in [EB136/18](#) it is apparent that such progress has been limited.

PHM Comments

Diversity and discrimination

Health policy needs to recognise the full breadth of diversity and accommodate the needs and voices of marginalized and excluded groups such as indigenous, transgender, sex workers, migrant, HIV +, adolescents, elderly, differently abled, persons with mental health issues. It is necessary to address all forms of discrimination and include, equity, participation, inclusive partnership, accountability and human rights.

Health systems

The underfunding of public health care impacts particularly heavily on women. A strong primary health care base is essential in ensuring universal access, equity and quality of care. It is also essential in addressing the social determinants of health and in strengthening women's participation in health decisions.

Access to safe quality abortion services without discrimination

The role of institutionalised patriarchy in denying women access to safe and affordable contraception and safe and quality abortion services illustrates one of the major on-going barriers to women's health.

The implications for WHO are several:

1. Encourage new partnerships with women's organisations at all three levels of WHO's work, including in the governing bodies.
2. Strengthen the effectiveness and accountability of WHO's member states (including the Holy See) for action on the innumerable declarations, statements and policies which have accumulated around women's health, in particular, the Platform for Action from 1995.
3. Return to the PHC model in addressing the social determinants of health and in health system strengthening; enrolling PHC practitioners to work with their communities (in particular the women of their communities) on the factors which shape their health and access to health care, but in ways which also help to reframe gender relations.
4. Re-invigorate WHO's gender mainstreaming strategy including implementing the recommendations of the 2011 mid-term review ([here](#), from page 19).
5. Ensure accountability for implementing a human rights based approach in all of WHO's work.

8.1 Antimicrobial resistance

Background

In response to resolution [WHA67.25](#), the Secretariat presents a draft global action plan to combat antimicrobial resistance ([EB136/20](#)), to be submitted to the 68WHA through the EB. In a separate report ([EB136/19](#)), details are provided of progress made in implementing the other aspects of resolution [WHA67.25](#).

PHM Comments

PHM commends the secretariat for the initial sections of the report (para 1 to 19) which highlight among other critical issues; misuse and overuse of antimicrobial medicines in humans and animals, unethical promotion of medicines, the need for laws to ensure that medicines are safe, effective, good quality and accessible, and the need for research and development to mitigate the effects of resistance.

However, the report does not acknowledge the importance of strong health systems to prevent the spread of AMR.

Unfortunately, the operational sections are disappointing. The Way Forward (para 20 and 21) has not made use of the insights provided in the previous sections to frame a comprehensive plan to tackle the threat posed by AMR. Most worrying is the entry of new 'partners' and 'shareholders', such as the World Bank and industry associations and foundations. This is surprising as earlier sections identified the controversial role played by the private sector. We urge MSs to include in Objective 5 the regulation and control of promotional practices by industry and explicitly state the principles that need to be met in this respect.

PHM welcomes that, under Objective 4, the need to strengthen medicines regulatory systems is recognised, and the need to regulate promotional practice. Promotion and advertising of antibiotics, including marketing for inappropriate uses or incentivising medical and veterinary personnel to overuse or inappropriately prescribe antibiotics, is harmful to health and should indeed be prohibited. However, the plan proposes to consult with pharmaceutical industry associations. It is important that such a consultation does not water down measures that need to be put in place. In this regard, MS should also consider Investor State Dispute Settlement provisions in trade agreements which have the potential to greatly limit the capacity of governments to regulate for antimicrobial stewardship.

Under Objective 3: MSs are invited to promote vaccination as a method of reducing infection in food animals and OIE is invited to update its codes and manuals to take account of new developments in vaccines. There is no recognition that intensive industrial food production is a driver of illness and hence the need for antibiotics. Farm practices such as overcrowding, unhygienic conditions, inappropriate diets, and early weaning drive the requirement of routine antibiotic administration (see [ARC Declaration](#)). PHM urges MS to consider including the “phasing out of use of antibiotics for animal growth promotion and crop protection, and reduction in non-therapeutic use of antimicrobial medicines in animal health”.

Objective 4 should mention explicitly monitoring of hot spots for horizontal

resistance gene transfer such as in wastewater treatment facilities and should be linked with a recommendation under Objective 2 for MSs to undertake monitoring and research in relation to the risks associated with microbial mixing in health care sewage. The pollution of the environment via livestock waste, sewage, industrial meat processing waste, and hospital disposal needs to be monitored and controlled.

Finally, under Objective 4, MS are urged to include the “collection and reporting of data on the use of antimicrobial agents in human and animal health and agriculture so that trends can be monitored and the impact of action plans assessed”. Clause 14 of the ARC Declaration provides additional language.

8.2 Poliomyelitis

Background

In [EB136/21](#), there are a range of issues under review, related to the Polio Eradication and Endgame Strategic Plan 2013–2018, the Public Health Emergency of International Concern declared on 5 May and the requirements that were imposed on polio active countries as part of the emergency response. The report includes a draft decision that encourages member states to fully implement the IHR and ensure the coordinated withdrawal of oral poliovirus vaccines containing the type 2 component.

PHM Comments

PHM appreciates the creativity, persistence and dedication of practitioners at all levels in confronting the technical, logistic and resource barriers to polio eradication. The sacrifices of vaccinators (and their support teams) who have been murdered is a terrible part of the cost of eradicating polio.

The struggle for Health for All is not just a technical or institutional struggle but also includes action around the determinants of inequality, poverty and war. The battle against Poliomyelitis indicates that disease control and eradication programmes cannot stop at national country borders, they require international solidarity based measures.

In the short term the main uncertainties pertain to whether the instructions of the Emergency Committee and DG are feasible in circumstances of conflict and whether they will be implemented.

There are also continuing uncertainties about the medium to long term strategy. We urge member states to two sets of issues that need to be addressed while thinking through these uncertainties: first, the eradication versus elimination debate; and second, the vertical program approach versus comprehensive PHC debate.

Smallpox eradication has been used as an example to promote eradication. But there is continuing uncertainty about how feasible and cost-effective the eradication of poliovirus might be in the circumstances of the Middle East, northern Nigeria, central Africa and Pakistan. We urge member states to bring back this debate into the agenda of the WHO while discussing the best strategies to battle against polio. It is inevitable that polio eradication will face escalating costs during the so called “endgame” of polio eradication, as is illustrated by what is presently happening in Pakistan. In part the high costs of the endgame are a consequence of the continuing reliance on vertical programming. In situations of conflict and disruption embedding vaccination and surveillance in comprehensive primary health care is impossible while continuing to implement vertical vaccination campaigns..

Notwithstanding the example of smallpox (which has a very different ecology from polio) a strong case can be made for reducing programmatic ambition to ‘elimination’ or ‘control’ until the social conditions for integrated universal health systems based on PHC are established.

8.3 Implementation of the International Health Regulations (2005)

Background

The Director General's report [EB136/22](#) provides an overview of the international response in 2014 to public health events and emergencies, with a particular focus on the role of WHO and the International Health Regulations (2005) in preventing, detecting, reporting and responding to such events. [EB136/22 Add.1](#) is a report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.

PHM Comments

PHM is keen to see full implementation of the capacities specified by IHRs. PHM supports the recommendation to shift from a mere focus on country compliance to the progressive realization of rights and obligations at the country level.

Continuous capacity improvement

The Review Committee has recommended that implementation of the Regulations, and public capacity strengthening in particular, should be seen as a continuous process, as opposed to one that comes to an end at any particular date, including in 2016.

While the term is not used PHM would argue for the concept of continuous capacity improvement to guide the progressive installation and improvement of the capacities specified by IHRs.

Antimicrobial resistance

PHM regards the emerging crisis of antibiotic resistance and antimicrobial resistance more generally as a public health emergency of international concern. PHM urges the EB to commission a study of the feasibility of using the IHRs to gain increasing control over AMR including requiring appropriate surveillance.

Adequate funding for WHO

The installation of required capacities is a global public health good. WHO should be funded at a level that enables it to provide the necessary support for implementation in low income countries. The continued freeze on assessed contributions is preventing the WHO from supporting member states to adequately respond to outbreaks and emergencies.

9.1 Malaria: draft global technical strategy: post 2015

Background

In response to a request by the Malaria Policy Advisory Committee (MPAC) in 2012, and an expression of support by member states at the 2013 World Health Assembly, WHO's Global Malaria Programme (GMP) is coordinating the development of a Global Technical Strategy for Malaria (GTS) for the 2016-2025 period. The GTS will articulate the goal and global targets for malaria over the next decade.

The Board is invited to consider the draft WHO global technical strategy for malaria 2016-2030 [EB136/23](#), and to recommend its submission to the Sixty-eighth World Health Assembly.

PHM Comments

The new strategy focuses on vertical programmes such as vector control, chemoprevention, diagnosis and treatment (Pillar 1). Health system strengthening is missing in this vision. Effective primary health care services with strong community involvement are critical in diagnosis, treatment and local action for vector control, while vertical programs are not well placed to support the development of comprehensive PHC. In fact vertical disease focused programs jeopardise PHC development by fragmenting management and competing for human resources. Stand-alone vertical programs also weaken disaster preparedness.

Malaria disproportionately affects the poor and rural communities but the scope for integrating broad based development strategies into malaria control programs is quite restricted given the vertical structure of the RBM program. The concept of addressing the social determination of malaria morbidity and mortality does not figure in the policy documents of either the GMP or the RBM.

The links between vector control and land use planning, housing development, urban infrastructure and rural development are also well known although the specific relationships vary with local context. Unfortunately that integrated vector management which might address land use planning, housing, urban infrastructure and rural development does not play a very prominent role in either WHO's GMP or the RBM. Reliance on vector control, in the absence of social, economic and infrastructure development, risks creating ecological space for alternative infective agents or vectors. The magnitude of this risk is not clear but such risks need to be adequately explored in the context of malaria control.

9.2 Dengue: prevention and control

Background

In 2012, the “Global strategy for dengue prevention and control 2012-2020” was launched. Its goal is to reduce the burden of dengue worldwide, with specific objectives to reduce mortality by at least 50%. This EB will consider [EB136/24](#) which provides an overview of the prevention and control of Dengue.

PHM Comments

Strong health systems built around the principles of primary health care, supported by more dengue control, surveillance and communications capabilities, constitute the critical infrastructure for dengue control.

It is evident that some countries are doing better than others in dengue control. There may be value in encouraging more learning and sharing of experience.

The increasing incidence of dengue reflects, in part, the negative effect of fragmented health systems as a consequence of the proliferation of vertical disease control programs. The creation of new vertical programs cannot be an optimum solution to dengue or the other neglected tropical diseases. The importance of integrated surveillance and preparedness is underlined by the warnings of the IPCC regarding the implications of climate change.

The core capacity requirements for surveillance and response set out in the IHRs are particularly relevant to dengue control. A strong case can be made for international support for countries that are deficient in capacity.

Likewise the increasing geographical spread of dengue is in some degree a reflection of increased travel and trade as part of globalisation. This underlines the importance of international cooperation as provided for through the IHRs.

[EB136/24](#) highlights new vaccines in the pipeline, and mentions the intent to seek the advice of the Strategic Advisory Group of Experts on immunization. We urge member states to be cautious about the introduction of new vaccines into national programmes and seek more robust evidence-based clinical data on vaccine effectiveness, safety and cost-effectiveness. Available clinical trial data on new vaccines demonstrate that many vaccines under development are not effective for all serotypes of dengue and only target one age group.

Learning from Cuba

The publication by Bhatt and colleagues cited above raises questions about the surveillance and reporting of dengue. The predictive estimates of Bhatt and colleagues (for 2010) are generally well above WHO estimates (see pages 68-74 of the [supplementary document](#) from the Nature website). However, for some countries, and Cuba is an outstanding case (also Hong Kong), the gap between the predictive estimates and the WHO estimates is quite huge. These wide gaps can either be explained by under-reporting or very efficient prevention programs.

Cuba has an efficient primary health care system with a strong emphasis on community involvement and public health. [Fitz \(Feb 2012\)](#) describes the mobilisation of medical students to look for dengue cases and identify collections of still water where *Aedes aegypti* may be breeding. Solidarity as a core value in public health and primary health care has an important role to play in dengue control and preparedness.

There is a strong case for closer attention to the Cuban model of UHC, budget funded and public sector delivery, as opposed to the insurance model, based on the 'purchasing' of defined benefit packages and currently being promoted by the WHO Secretariat.

9.3 Global vaccine action plan

Background

In line with resolution WHA65.17, EB136/25 reports on the progress made towards the achievement of the global immunization targets, using the monitoring and accountability framework approved by WHA66 (SAGE). EB136/25 is a summary of the 2014 Assessment Report by the Strategic Advisory Group of Experts on immunization (SAGE) which itself is based on the GAVI Secretariat 2014 Draft Report. The Executive Board is invited to take note of the report and to consider the recommendations for actions.

PHM Comments

PHM appreciates the recognition by the Report of the **fragmenting impact of vertical programmatic silos**. The domination of vaccination assistance by GAVI reflects and perpetuates the fragmentation which the report criticizes. SAGE recommends that GVAP secretariat agencies approach the World Economic Forum to seek funds for the Decade of Vaccines. It is likely that such a support, if provided, will further entrench the vertical programmatic silo approach to global health priorities.

The SAGE report comments on the failure to progress maternal and neonatal tetanus elimination. Elimination of maternal and neonatal tetanus depends on comprehensive primary health care provision and strong referral to secondary and tertiary facilities. The report speaks of “gross underfunding”, but, surprisingly, **there is no reference to comprehensive primary health care** as a model which explicitly promotes integration of services.

Furthermore, EB136/25 recommends giving civil society organisations (CSOs) ‘substantially more formal involvement in the delivery and improvement of vaccination services’. This is the route for further disintegration of primary health care systems.

Reaching out to 100% of the population (in order to cover the last 5% that can work as a reservoir) require an additional cost in terms of an extra effort in logistics, infrastructures and supply. Such an effort can withdraw resources from routine vaccination if implemented through a vertical approach. Integration of immunization goes beyond 'basic integration' (para 10 and 11) and requires it being part of a horizontal approach that furthers strengthen the entire health system.

The 2013 SAGE meeting recognised the importance of integrating immunisation initiatives with other critical public health interventions, such as clean water and sanitation programs. It noted "**Social determinants of health** should be taken into consideration when integrating routine immunisation into primary health care...". This insight is lacking from the 2014 evaluation report.

A recently released [MSF report on vaccine pricing](#) shows that between 2001 and 2014, the introduction of new vaccines pushed the cost of vaccine packages up by 68-fold in the poorest countries. In a context where production of specific vaccines is concentrated in few companies, typically based in high income countries,

proposing transparency as a response (para 9) is, at best, naive. PHM urges the EB to include an assessment of the scope for support for **technology transfer, local production and pooled regional procurement** as key actions to deal with affordability of vaccines.

New vaccines are not a success in itself - though this is suggested in para 2. The GVAP recognises that national strategies for vaccination should respond to priorities and needs of local populations and the efficacy and cost effectiveness of vaccines have to be evaluated on a case by case basis. The **opportunity costs of introducing new vaccines** has to be measured in terms of cash and health outcomes forgone. In health care systems which cannot deliver DTP3 to more than 50% of infants it makes more sense to allocate additional resources to primary health care, including basic vaccination and effective treatment of diarrhoea. Effectiveness will depend on the cost of 'absolute risk reduction'.

Poor data quality and use (para 6 and 7) are a crucial issue. Many MSs are concerned to strengthen their capacity to produce sound evidence before deciding to add vaccines to national immunisation schedules. WHO should be concerned about the introduction of new vaccines in the absence of **surveillance and information systems** to provide baseline data, and sound evidence of safety and efficacy. It is crucial that adverse evidence also be included. It is hard to understand why these find no mention under the relevant section.

10.1 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage

Background

In L&MIC, the need of trained health staff is crucial: a huge lack of doctors is evident, and often there is a brain drain tendency, which aggravate the already serious situation. Surgeons, anaesthesiologist and trained staff in general are often hard to find. Besides, facilities are grossly inadequate: the city-centered-location of hospitals, not enough to cover the need in terms of number of beds, makes the access to Surgical care very hard. The price of cares themselves is also a matter of wide exclusion of the population. EB136 will be asked to consider a draft resolution on surgery for recommendation to the WHA68. The focus of the resolution will be on strengthening surgical programs in low resource settings, including the mobilisation of financial and technical support.

PHM Comments

Strengthening capacity to deliver basic surgical and anaesthetic services at first referral facilities is an essential health necessity to reduce death and disability and support progress towards universal health coverage. Emergency, essential surgical care and anaesthesia must be considered as priority in the access to healthcare, and must be treated as indispensable.

One of the key issues for L&MICs is ensuring training and deployment of appropriate human resources. Surgery in most high income and many middle income countries is often highly specialised and categorised into a range of super-specialities, and involves long training programs. The over-emphasis on specialisation and long training modules contribute to the high cost of surgical interventions and the high demand of remuneration from surgical specialists. However, many surgical (and anaesthetic) procedures can be performed by personnel with more limited training. Developing models of service delivery will involve identifying in broad terms the types of surgery which might be carried at different levels of care – primary, secondary and tertiary. In many L&MICs properly equipped mobile surgical teams play a critical role in facilitating access. Provision should be made for adequate supplies, maintenance and technical support to ensure that surgical facilities in isolated areas and for mobile teams are safe for both patients and staff. Mobile teams can also play an important role in providing in-service training. However, it is important to ensure that such mobile units are not seen as ‘stand alone’ solutions, but are integrated into the PHC based structure of the health system. Thus, surgery should be integrated within existing PHC programs; it should not be constructed as a new vertical program.

PHM urges a return to the district health system model. The roles assigned to the district hospital are critical. Organisational policies and information systems are essential to ensure that surgical services provided are efficacious and effective. Developing models of service delivery will involve identifying in broad terms the types of surgery which might be carried out in local hospitals, those which might be restricted to the referral centres, and the more complex but less urgent surgery

which can be scheduled for visiting teams. We urge that expert committees assembled for this exercise include people with experience in delivering surgery in low resource settings and that the process includes careful documentation and analysis of existing models of service delivery. We ask for policies to limit brain drain and to provide carefully designed training programs for practitioners. There is the huge need of sustainable surgical healthcare.

It is necessary to explore and evaluate evidence-based options for different local needs, in order to avoid 'one size fits all' model for expanding surgical services. While general principles and strategies can be elaborated, institutional arrangements and operational details will need to respond to local and national context.

Ensuring a high return on investment with respect to any expansion of surgical services will depend on: focusing surgery for conditions where surgical treatment has demonstrated efficacy; ensuring high quality and safety with respect to environments and practice; sustainable financing and payment arrangements; and appropriate workforce policies.

10.2 WHO Global Code of Practice on the International Recruitment of Health Personnel

Background

The Executive Board is invited to consider (in [EB136/28](#)) the process of the first review and progress made to date in the implementation of the WHO [Global Code of Practice on the International Recruitment of Health Personnel](#). Resolution [WHA63.16](#) provides for a review (and perhaps redevelopment) of the code at WHA68 (May 2015).

PHM Comments

The HRH crisis continues to be a major barrier to the full enjoyment of the right to health in L&MICs. Unethical recruitment and inadequate investment in domestic self-sufficiency in the rich countries are critical contributors to this crisis, underlying the continuing relevance of the Code.

However, this report clearly shows **lack of commitment to the Code**. Para 11 highlights that most first round reports on implementation came from the European region. This suggests that the implementation of the Code has not been prioritised in the other regions, despite that Africa, Asia and Latin America and the Caribbean pay the price of the international movement of health personnel. [Dambisya and colleagues \(2014\)](#) suggest that the weaknesses of the Code, in particular the lack of attention to compensation, may have contributed to its loss of traction in Sub-Saharan Africa.

[Mills et al.](#) estimate that the overall loss of returns from investment for all doctors currently working in the destination countries was "\$2.17bn (95% confidence interval 2.13bn to 2.21bn), with costs for each country ranging from \$2.16m (1.55m to 2.78m) for Malawi to \$1.41bn (1.38bn to 1.44bn) for South Africa". Remittances do not compensate the health system for lost resources, which are due to a deliberately constructed **brain drain**. In 2009 the African Regional Committee called for a 'mechanisms for facilitating fair compensation of source countries by destination countries' ([RC59/R6](#)). Clause 3.3 of the Code suggests that financial assistance could be provided. The **need for fair compensation** needs to be put back on the agenda.

The Code is one of the few regulatory instruments developed and adopted by WHO over the last years. The success or failure of its implementation will be seen as a case study for the capacity of WHO – and its members – in the field of global standard setting and regulation. Five years after the adoption of the Code, the HRH capacity of the WHO Headquarters is reduced due to financial austerity, while the regional offices appear to have insufficient resources to even adequately liaise with Member States on the issue. This links the technical issue of Code implementation with the overall issue of WHO reform and the role of WHO in global health governance.

Resolution [WHA63.16](#) requests the Director-General to make proposals, if necessary, for the **revision of the text of the Code** and for new measures needed for its effective application. The proposed HRH strategy (Resolution

[WHA67.24](#)) scheduled for consideration in WHA69 proposes a more comprehensive set of strategies to address the HRH crisis. PHM believes that it is urgent that the WHO move to the **negotiation of a binding instrument** to address unethical recruitment and destination countries continuing to staff their health care facilities at the cost of depleting urgently needed human resources from the Global South in the context of a more broadly based HRH strategy.

10.3 Substandard / spurious / falsely-labelled / falsified / counterfeit medical products

Background

[EB136/29](#) is a report of the third meeting of the Member State mechanism for substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFCMPs), which was held in Geneva, Switzerland 29 October to 31 October.

PHM Comments

Need to define terminology and prevent the conflation of IP by removing the term ‘counterfeit’

The attempt by the MSM to put in place a rules-based and transparent mechanism to control the very real public health problem posed by medicines of poor quality is a step forward. However, after six years of negotiations the processes are still confused, politicized and without clear guidance from WHO Secretariat. The use of the term ‘counterfeit’ continues to conflate intellectual property with issues of quality and safety.

In transit seizures

The lack of agreement on item 7 in Annex 2 appears to reflect a continuing defence of the in-transit seizures of generic medicines notwithstanding that they are “in compliance with the regulatory requirements of the country of export and the country of final destination”.

The MSM should make it clear that in transit seizures of generic medicines that are “in compliance with the regulatory requirements of the country of export and the country of final destination” belong clearly on the list of actions, activities and behaviours which lie outside the mandate of the MSM.

WHO should advocate through the World Customs Union and the World Intellectual Property Organisation against such practices on the grounds that they are an attack on access to legitimate generic medicines and treatment affordability and that they have no justification in terms of standards of quality, safety and efficacy.

The MSM should resolve remaining differences before the World Health Assembly and then move to consider terminology, including removing the term counterfeit.

Cease collaboration between national and regional regulatory agencies and IMPACT

PHM urges member states to discontinue existing collaborations between IMPACT and their regulatory agencies and customs authorities. Such collaborations can seriously jeopardize access to affordable generic medicines of proven quality, safety and efficacy.

Trade agreements and patent linkage

While WHO debates SSFFC, several new trade agreements are being negotiated and signed which explicitly seek to harness the status and authority of national and regional medicines regulatory agencies in the policing of intellectual property claims. PHM calls on member states to protect public health and on WHO to support member states in matters on trade and health.

Budget shortfall

The continuing budget shortfall in relation to the implementation of the MSM workplan is a major concern. The pledged contributions for implementation of the report are in the form of voluntary contributions from a few countries.

10.4 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

Background

The Board is invited to note the Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination ([EB136/30](#)) and to consider the establishment of a pooled fund for voluntary contributions towards research and development for type III and type II diseases and the specific research and development needs of developing countries in relation to type I diseases to be hosted by the Special Programme for Research and Training in Tropical Diseases.

PHM Comments

PHM urges member states to establish a pooled fund that is based on **mandatory** contributions to ensure sustainability.

PHM calls on member states to return to the original purpose of the **demonstration projects**, namely to create and demonstrate innovative funding mechanisms based on the principle of delinkage.

Scope of R&D to be supported

The purposes of the CEWG initiative should be widened to include the development of new antibiotic drugs, better low cost diagnostics, basic research in areas of particular interest to all member states, and the funding of independent clinical trials to evaluate the efficacy of pharmaceutical drugs.

There is a need to confront more directly the barriers to access to treatment which arise from **trade agreements**. Proceeding with the new system does not preclude WHO taking a more active stand in relation to the full use of TRIPS flexibilities and a moratorium on trade agreements which raise new barriers to affordability.

Establishment of working group

PHM notes that WHA66.22 requested the Secretariat to convene another open-ended meeting of Member States prior to the Sixty-ninth World Health Assembly in May 2016, in order to assess progress and continue discussions on the remaining issues in relation to monitoring, coordination and financing for health research and development.

10.5 Global strategy and plan of action on public health, innovation and intellectual property

Background

In response to a request by the Executive Board at its 133rd session, the Secretariat has prepared the present report ([EB136/31](#)) that provides a proposed timeline for the evaluation of the GSPOA.

PHM Comments

Extend the mandate of the GSPOA as a whole

The important objectives of the GSPOA have not yet been achieved, yet the mandate of the GSPOA only extends until December 2015. There is need for an interim extension of the mandate of the GSPOA from Jan 2016 to at least May 2018.

Terms of Reference and Evaluation Methodology

The Secretariat paper provides no framework regarding purpose, process or personnel for the evaluation and the timelines proposed provide no opportunity for the EB to contribute.

PHM urges EB members to put together a decision for adoption by the 136th EB which spells out in more detail the purposes of the evaluation and the kind of expertise that will be needed.

One option would be to simply evaluate whether the GSPOA had achieved the indicators set out in [A62/16 Add.2](#) and the magnitude of any shortfall. This would be quite insufficient. Many of the indicators are quite superficial and further exploration will be needed to explore the context and implications of such indicators. Where there are significant shortfalls in meaningful indicators, WHO needs to know why and needs evaluators who can point to useful lessons for the future.

PHM urges member states to clarify who will be involved in the evaluation. We note (from EB131/3) that an evaluation management group 'may comprise external experts and/or WHO staff'. However, in the discussion of the evaluation in May 2013 ([from page 78](#)) the DG suggested that the Evaluation *Monitoring* (sic) Group comprise the officers of the EB. Useful comment on these processes calls for diplomatic expertise and insight into the engagement of various stakeholders in the process, rather than management consulting.

Financing WHO

In some degree the shortfalls in the GSPOA reflect the funding crisis that WHO is in and the reluctance of some donors to support the kind of work required by the GSPOA. PHM calls on member states to adequately finance WHO and to address the gap between voluntary and assessed contributions.

10.6 Blood and other medical products of human origin

PHM Comments

Medical products of human origin are derived wholly or in part from the human body and intended for clinical application. Over the years, their type and use have broadened, and many are widely used. Donors and recipients face a wide range of risks, depending on the type of product used. A global consensus is needed on some guiding principles for the donation and use of medical products of human origin, including the promotion of good and harmonized practices. Three principles concern respect for human dignity, availability and safety, and good governance.

EB136/32 sets out the main policy issues and sketches the directions for further development. The EB is requested to advise on further action.

There are two broad policy objectives involved:

- access according to need to blood and tissue products and services; and
- reducing the need for (and inappropriate use of) blood and tissue products.

The analysis underlying this argument is not clear. First, there is no evident reason why blood, organ and bone marrow donation are presented together, instead of having three singular documents for each different specific topic.

Then the report is confused and confusing regarding incentives for donation: there is no clear position against it. Any material incentive or inducement (other than genuine reimbursement) that causes someone to do something that they would not otherwise do negates the idea of donation. Besides, payment for giving medical products of human origin can become an income source for poor people, despite dignity and ethical issues. Further work is urged to develop a more useful and ethical position on the use of medical products of human origin.

Moreover, the document does not clarify nor what are the principal barriers to addressing these inequities as fast and efficiently as possible, neither if there is a progress in redressing the current inequities with regard to access to needed medical products of human origin. It is not expressed what is been made and what will be done. The directions suggested under the heading 'The way forward' are quite general.

PHM recommends that the Board consider the development of a standardised protocol for health impact assessment regarding both the costs and benefits of the use of medical products of human origin and the costs and benefits of various methods of increasing availability. We urge the Board to request a more comprehensive report regarding availability and use with quantitative indicators reflecting on progress, trends, barriers, and Secretariat activities at all three levels. A health impact protocol as suggested above could provide the basis for comparative indicators.

The report notes the need to ensure evidence based use of medical products of human origin and to avoid inappropriate or overuse. The emerging evidence of wide-

spread inappropriate blood transfusion with considerable morbidity and mortality is of deep concern.

PHM calls for Real Reform: there is the need of the culture of donation, the possibility to test medical products of human origin and to stock them, in order to conserve them and to use (just) when needed.

11.1 Implementation and financing of Programme budget 2014-2015: update

Background

The EB is invited to review progress with respect to implementation and financing of PB14-15 as reported in [EB136/33](#).

PHM Comments

[EB136/33](#) provides some useful information on the implementation of the PB14-15 but **there are many important questions which it does not answer**, including:

- how effectively are the resources flowing to country cooperation?
- how effective are the arrangements for the 'mainstreaming' of gender, equity and human rights, including accountability arrangements?
- how effectively is WHO engaging with other sectoral interests (trade, migration, security, IP, etc) in promoting health and health equity?
- **how effectively is WHO addressing the six leadership priorities** (Para 60, Box 2 of the [GPW12](#)), in particular addressing the social, economic and environmental determinants of health?
- how effective has WHO been in positioning health in relation to global governance issues listed in para 119 to 123 of [GPW12](#)?
- are the post occupancy charges being paid?
- **what is the cost of the financing dialogue?** (no data provided).

The weaknesses in WHO's evaluation practices (see [our comments under Item 13.1](#)) mean that MSs are not able to make judgements regarding important questions about how well the limited resources are being used.

However, the more basic issue is the inadequacy in absolute terms of the Programme Budget. The **freeze on assessed contributions** and the continuing **donor dependence** are profound disabilities in relation to WHO's operations, both regarding priorities, effectiveness and efficiency. The Funding Dialogue doesn't seem to be a lasting solution.

11.2 Proposed programme budget 2016–2017

Background

A revised draft of the Proposed programme budget 2016–2017 has been prepared, following review and discussion by the regional committees, for consideration by the Board ([EB136/34](#)).

PHM Comments

The Secretariat has presented three **budget scenarios** for the EB to consider (paras 20-22; tables 1-3). PHM urges MSs to support **scenario 3** rather than 2 or 1.

Evaluating the budget shifts

The Secretariat is proposing some reductions and some increases against the approved PB14-15. Like for the PB 14-15, PHM thinks the key issue for the PB 16-17 is the **underfunding of WHO** which is a more serious constraint on WHO's ability to fulfill its mandate than arguable misallocations of an inadequate total across programmes, regions and levels.

Policy coherence: trade and health

The **lack of any explicit reference to policy coherence across trade and health** under Outcome 3.4 (from page 56) is disappointing. New trade agreements with serious implications for public health policy are being introduced at a rapid pace. Investor state dispute provisions threaten to seriously curtail the capacity of countries to regulate for public health, including in relation to NCDs. [Resolution WHA59.26](#) gives the Secretariat a clear mandate to engage robustly in intersectoral dialogue at all levels around these issues.

Monitoring and evaluation

PB16-17 does not discuss Impacts (ultimate health outcomes). These are seen as being followed across the whole period of the GPW12. The draft PB16-17 includes proposed Outcome indicators ('increased access to health services and/or reduction in risk factors') and Output indicators ('delivery of products and services' by the Secretariat). However, **the indicators proposed for Outcomes and Outputs are in many cases loosely defined and present huge challenges** (and costs) in terms of valid and reliable measurement. It does not appear that: a) provision is made for following the extraneous influences which interact with WHO's Activities and Outputs in generating Outcomes; b) robust means will be available for drawing conclusions about the contribution that Activities and Outputs have made to Outcomes; c) the data being collected will enable programme and office leaders to evaluate the strategic assumptions underpinning the distribution of Inputs (money and staff) across programmes and offices.

The movement of oversight of the Secretariat's Evaluation function from the Office of Internal Oversight to the DG's Office (described in [EB136/38](#)) is a step forward. Hopefully the new unit will allocate **increased attention to measurement across the results chain**.

11.3 Strategic budget space allocation

Background

[EB136/35](#) conveys the report of the Working Group (WG) in which a revised version of the strategic budget space allocation methodology is outlined.

PHM Comments

The WG's report is clearly a step forward from non-transparent and historically based allocation practices. However, there are some significant issues which still need to be resolved.

Concerning **Segment 1**, it is not clear whether the country specific allocations for this segment will be determined within the regional office or will involve HQ. PHM urges firm involvement of HQ.

Concerning **Segment 2**, one reading of the WG's report is that budget space in this segment will be the aggregation of expenditure needs of a series of projects, based largely on governing body resolutions. However, these projects also have an organisational reality; they are carried by the clusters, departments, units and regions. Ultimately budgeting is about funding organisational entities. There is nothing in the WG's report about how 'program budgeting' based on 'the project management approach' will mesh with the funding of organisational units in HQ and regions.

It is not clear how the WG conceives the management of the global revolving fund and of the regional emergency funds, given that Table 1 'allocates' almost all of the emergency money to the country level. Table 1 establishes the foundation for the new methodology in terms of 'planned costs' in which case it makes sense that most of the money will be spent at the country level. However, 'allocation' does imply something about who will be holding the funds.

The idea of regional emergency funds will need further attention in view of the fact that the Afro fund has been completely unfunded and the African Development Bank appears to have refused to assist in its management (see [AFR/RC64/7](#)).

The WG provides **no guidance regarding budget space allocation between segments**. This is an important missing component. There was no discussion of how 'segments' map onto the 'categories' which form the basis of the [GPW12](#).

The report does not touch upon the relationships between regions and directorates and how these will work together in developing and evaluating expenditure proposals.

In view of the gross underfunding of WHO, the debate on the 'strategic budget space allocation' needs to take into account that **the elephant in the room is the small budget in aggregate which is a consequence of the freeze on assessed contributions**. With the freeze on assessed contributions comes donor

dependence and with donor funding comes competition between clusters, departments and regions for donor attention. **The dependence of the WHO on (tied) donors' contributions remains the central issue.** MSs should increase their voluntary contributions, but these should be untied.

12.1 Draft financial strategy for WHO and 12.2 Scale of assessments for 2016–2017

Background

In its report on financing of administrative and management costs ([A67/7](#)) noted by the Sixty-seventh World Health Assembly, the Secretariat proposed to present a report ([EB136/36](#)) linking the various reform initiatives in the financing domain and mapping out the broad strategic directions for the financing of WHO. [EB136/37](#) contains a report on scale of assessments 2016-17.

PHM Comments

The freeze on assessed contributions and the dependence of WHO on tied donor funding are doing serious damage to the Organisation:

- The total resources available to WHO are completely inadequate for it to properly do its job. Consider the Ebola crisis.
- The dependence on donor funding has created a competition for visibility and donor attention that is completely inimical to organisational coherence and collaboration. See the comments of the Independent Expert Oversight Advisory Committee (see [PBAC21/2](#), and the corresponding [PHM note](#)).
- The freeze **undermines WHO's integrity and credibility.**
- The preferences of the donors, *not to fund certain functions*, means that certain decisions and policies adopted by the Assembly are not funded. Furthermore the implicit threat from the donors, that funding is contingent on approved behaviour, distorts the decision making of the governing bodies.
- The transaction costs associated with the funding dialogue and funds mobilisation are huge and detract from the real purposes of WHO. PHM urges that the metrics referred to in para 24 ([EB136/37](#)) include reporting on the costs of resource mobilisation, including the funding dialogue and the management of budget space.

13.1 Evaluation

Background

The report ([EB136/38](#)) provides an update on progress made in implementing the Organization's evaluation policy.

PHM Comments

PHM has been critical of the treatment of evaluation by the Secretariat for several years. Programmatic evaluation has been weak or non-existent. Organisational evaluation has been weak with meaningless indicators proffered to demonstrate organisational effectiveness. The evaluation policy has been overly influenced by the audit perspective and the accountability function and has neglected formative evaluation, 'learning whilst doing'. The disciplines of plausible attribution have been generally ignored. Validity and reliability are expensive but indicators which are not valid or reliable can be very misleading.

There has been talk of developing an evaluation culture and creating a learning organisation but these objectives require the Organisation to move beyond the audit and accountability paradigm. (See discussion of WHO evaluation policy and practices under [Item 6.1 at EB135](#).)

[EB136/38](#) makes no reference to the 'results chain' and 'theory of change' issues identified by the IET (above).

The weaknesses in the monitoring of the 'results chain' is reflected in the draft 2016-17 programme budget ([EB136/34](#)). Many of the Organisation Wide Expected Results, through which implementation of the PB16/17 is supposed to be monitored, are far from valid and reliable. The determination of the level of achievement appears to be self-assessed and highly subjective. The indicators will not identify how WHO has contributed to the changes which are reported.

PHM applauds the move of evaluation oversight to the DG's office. We hope that this leads to more substantive progress towards WHO as a learning organisation. However, it might be time for the EB to consider the possibility of following the World Bank precedent of creating an independent evaluation unit which reports directly to the EB. The World Bank's [Independent Evaluation Group](#) is charged with evaluating the activities of all of the organisations within the World Bank Group and the Director-General of IEG reports directly to the World Bank Group's Board of Directors. The IEG's evaluation reports are sometimes quite robust.

14.4 Human resources: update

Background

The report ([EB136/45](#)) provides an update on the implementation of the Organization-wide human resources strategy.

PHM Comments

The Secretariat faces significant challenges on the HR front and is taking a systematic approach to dealing with them. This is to be applauded. However, the potential obstacles to implementation are significant and close monitoring, adjustment and reinforcement will be critical. In this context the validity and reliability of the proposed **performance indicators** will be critical. We have commented under Item 13.1 on inadequacies in WHO's selection of performance measures in relation to the achievement of organisational goals. The comments of the Independent Evaluation Team (see [EB134/39](#)) regarding having a theory of change and following the results chain remain relevant.

There is nothing in the Strategy or this report about dissolving the walls of the **silos**, recently highlighted in the report of the Independent External Oversight Advisory Committee (PBAC21/2).

Neither the Strategy nor the report mentions **interns** nor **junior professional officers** ([here](#)). Both of these categories represent very promising pathways towards recruitment to formal employment. However, in both cases, these pathways effectively exclude young people from low and middle income countries. Access to internships requires independent funding. Access to JPO opportunities appears to be completely restricted to Europeans. Given the commitment to 'diversity' in the Strategy this exclusion is not appropriate. PHM urges the inclusion in the HR Strategy provision for scholarships to support young people from L&MICs to access intern and JPO opportunities.

There is no reference in either the Strategy or the report to the issue of **secondments** to the staff of WHO from governments, universities and corporations. Given the importance that this issue has attracted in relation to the Framework for Engagement with Non-State Actors it is surprising that the HR report is silent on the issue.

Commenting on the abolition of continuing appointments the staff associations' report to EB135 ([EB135/INF/1](#)) highlighted the need to balance managerial flexibility with technical depth and institutional memory. There is nothing in the Strategy or EB136/45 which shows how the Secretariat proposes to manage this balance.

In commenting on the emphasis on staff mobility in the revised Strategy, the staff associations report to EB135 ([EB135/INF/1](#)) commented on the need to find an

appropriate balance between building cohesion and multi-skilling versus building and maintaining technical depth. There is nothing in the Strategy or EB136/45 which shows how the Secretariat proposes to manage this balance.

According to Para 3 of the [HR Strategy](#), it seems that the abolition of continuing appointments and the increasing pressures on staff to be more mobile are necessary strategies for adapting to the financial crisis and the uncertainties of donor dependence. The arguments which are offered in the Strategy for these provisions are clearly predicated upon the need to adapt to the financial crisis. The warnings of the staff associations may foreshadow a new set of organisational failings for which the member states must take responsibility.