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Open Letter to the Distinguished Delegates to the 66th World Health Assembly, May 2013

from the People's Health Movement

Distinguished Delegates,

On behalf of the People's Health Movement and a number of affiliated networks we submit the comments and suggestions included below regarding some of the items appearing on the agenda of the 66th World Health assembly. We hope that you may find time to read and consider these comments before the relevant discussions at the WHA. We hope that you find them useful.

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

PHM is committed to a stronger WHO, adequately funded, with appropriate powers and playing the leading role in global health governance. PHM follows closely the work of the WHO, through the governing bodies and the secretariat. Across our networks we have technical experts and grass roots organisations with close interests in many of the issues coming before you over the next week.

Over the last week members of the PHM WHO liaison group have been working through the 66th WHA Agenda with the assistance of high level experts from a number of collaborating networks and NGOs. This workshop was part of our Democratising Global Health Governance Initiative which involves both watching and advocacy. In the course of these discussions we have prepared the following comments on some of the key issues coming before you. (You can follow the analysis in detail at www.ghwatch.org/who-watch and specifically for this WHA meeting at: http://www.ghwatch.org/who-watch/wha66.

Members of the PHM WHO liaison group will be following the discussion at the WHA over the next week and would be keen to discuss these comments with you during this week.

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PHM Comments on Various Agenda Items

11 & 12 (and 21. and 22) WHO Reform and Programme and Budget Matters (and Financial Matters and Audit matters in Committee B)

Background to agenda item(s)

The following papers are part of this agenda, for consideration by WHA66 and EB133.

- **WHA 66/4** (**WHO Reform: High level implementation plan and report) --** provides an overview of progress up to the end of the first quarter of 2013 in the three broad areas of WHO reform: programmes & priority setting, governance, and management. The report is structured around the 12 elements of reform that were identified in the monitoring and implementation framework that was discussed at the Sixty-fifth World Health Assembly. It provides information on action taken in each area, and a status update on the outputs and key deliverables.

- **WHA 66/5 (Implementation of Programme budget 2012–2013: interim report) --**presents a mid-term review of Implementation of Programme Budget 2012–2013.

- **WHA 66/6 (Draft twelfth general programme of work)** -- provides a strategic vision for the work of WHO for the period 2014-2019.

- **WHA 66/7 (Proposed programme budget 2014/2015) --** first of three biennial budgets to be formulated within the draft twelfth general programme of work for the period 2014–2019. It presents the Organization's expected deliverables and budget requirements for the 2014–2015 biennium within the broader context of the programme of reform.

- **WHA 66/48** (**WHO Reform. Financing of WHO) --** provides information on: (i) the implications for the 2014–2015 programme budget resolution and for WHO's Financial Regulations and Financial Rules of the World Health Assembly's approval of the proposed programme budget in its entirety; (ii) the form and format of the financing dialogue; (iii) the strategic allocation of WHO's resources; and (iv) the role of WHO's governing bodies in the different phases of the financing cycle of WHO's programme budget.

- **EB 133/3 (WHO reform -- Governance: options for criteria for inclusion, exclusion or deferral of items on the provisional agenda of the Executive Board) --** The 132nd session the Executive Board requested that the Director-General prepare options for criteria for inclusion, exclusion or deferral of items on the provisional agenda of the Executive Board. The document contains two options for the Board consideration.

- **A66/35 (Report of the Internal Auditor) --** This is the annual report produced by the Office of Internal Oversight Services for the calendar year 2012 on its activities, their orientation and scope, and on the implementation status of recommendations.

PHM comments

Comments on documents WHA 66/4

A. In relation to the proposals for **streamlining the work of governing body (A66/4 and EB133/3),** PHM has concern around the following issues:

1. While appreciating the need for more discipline in managing the submission of resolutions, there remains a concern about the **negative consequences of curtailing the right of Member States to propose resolutions on matters they consider important.** Moreover, para 7 of Document EB133/3 states that the five criteria established by the WHA in 2012 "*are difficult to apply operationally in order to recommend inclusion, deferral or exclusion of proposals".* It is not clear why the criteria which have been used for setting the priorities and the categories of work of WHO cannot be used to effectively manage the agenda of the EB.

2. Concerning the five criteria that should guide the assessment of the added value of proposals for the agenda of the Board (para 4 of EB133/3), we are concerned about the implications of the fifth criteria (*"comparative advantages of WHO"*). A strict application of this criteria **would favour the adoption of 'technical' positions while neglecting WHO's mandated political role in matters of global health.**

3. The proposal entitling the Officers of the Board to evaluate supplementary agenda items referred directly to the WHA (para 9, EB133/3), might entail the risk of **reducing the plurality and the democratic nature of the organization.**

4. In Doc 66/4 (output 2.3.2) it is proposed that "*Governing bodies make better use of the Chairman's summaries, reported in the official record, with the understanding that they do not replace formal resolutions".* The **Chairman's summaries** have no legal status and are not binding documents. They are not decisions, and do not capture the diverse opinions, of the meetings they summarise.

B. Engagement with Non-Governmental Organizations (NGOs):

1. The EB132 was asked "*to submit, for the consideration of the Executive Board at its 133rd session in May 2013, overarching principles for WHO's engagement with non-State actors, defining separate operational procedures for both non governmental organizations and private commercial entities".* (Doc A66/4 par.10) However, **this document is still missing** from the official documentation of EB133;

2. There is still no clear position articulated by the Secretariat regarding the **differentiation of non governmental organizations** between those that have a commercial interest and those that do not. WHO should take a clear position on this issue because it cannot be tackled on a case-by-case basis as proposed by some countries during the last EB. Procedures and criteria need to be established to address this issue so as to clearly address **conflict of interest issues**;

3. The proposal to **limit the accreditation of NGOs** to individual meetings of governing bodies, **could lead to fragmentation** of contributions by NGOs and prevent civil society from fully participating and contributing to the broad debates within WHO;

4. The "**24 hours rule**" on NGO's statements (where NGOs have to present proposed statements for approval 24 hours prior to the agenda item) seriously restricts participation by NGOs in discussions in governing bodies of WHO and we therefore urge member states to consider amending this rule;

5. **References to policies aimed at dealing with the "private not-for-profit sector" are no longer present** in the documents on WHO reform. The increasing influence of the philanthropic foundations in the funding of WHO is an undeniable trend and should be a primary source of concern.

6. Finally, we urge that WHO **re-launch the 2001 Civil Society Initiative** with a view to deepening dialogue and cooperation with public interest NGOs at all levels of WHO's work.

C. Under the heading, **"support for all Member States",** the Secretariat articulated a commitment to strengthening technical and policy support for all member states. PHM commends this commitment, but would like to highlight that the **outcome indicators** 3.1 in Doc A66/4 are very **weak** and are not really measuring what they should. This is quite a simplification compared to the analysis of weaknesses of WHO work at country level made in previous documents (EBSS/2/2).

D. Under the heading **"human resources"** the Secretariat reported on a number of initiatives designed to promote improved staff performance, and a more flexible mobile workforce. PHM already noted that WHO works in a complex and shifting environment and developing clear staffing policies is of critical importance for the organisation. However, there are clear risks associated with the current move to short term contracts and greater mobility. Moreover, the proposed **outcome indicator 3.2 seems very weak.**

E. Concerning the **independent evaluation of WHO,** PHM would like to reiterate that:

1. **It runs counter to common sense to have the evaluation as "one input running in parallel to other aspects of the reform".** The paradox is that now we are in a situation where Member States are deciding on the future of WHO before the evaluators' recommendations are presented on issues of essential value for the implementation of a meaningful reform.

2. In the first stage of the evaluation process, the External Evaluator failed to abide by the terms of reference. The Evaluator was asked to review the existing information with respect to finance, staffing and internal governance, but this was not done. Instead the team presented a very positive evaluation of the WHO Reform Program as implemented at that point on time. Therefore it would be extremely important to **monitor, in this second stage, the adherence of the evaluators to the established terms of reference.**

3. Another concern is that, by focusing on "WHO's readiness to take the reform forward", the second stage will mis-direct the original purpose of the evaluation, leaving out a number of crucial information for developing a Constitution-based vision of WHO's future role. We strongly believe that the independent evaluation of WHO should produce a comprehensive analysis of WHO's current positioning on the overcrowded stage of actors influencing global health.

4. Finally, as regards the **selection of the evaluation team** for the second stage of the evaluation, it is important to guarantee the transparency of the process, by making publicly available the applied criteria.

Comments on Document A66/48 (WHO Reform -- Financing of WHO)

Document A66/48 contains a description of the form and format of the financing dialogue (par.10 onward). We reiterate that **the proposed financing dialogue presumes the continued freeze on increases in assessed contributions.** Indeed, par. 8 of the document A66/48 states that the WHA should *"Encourage Member States and other contributors to support, on a voluntary basis, the financing of the voluntary contribution part of the programme budget."* It is important to explicitly recognize that this freeze in assessed contributions is disabling WHO. Therefore PHM urges Member States to **re-open consideration of a substantial increase in assessed contributions** as was proposed in the extraordinary meeting of the PBAC in December 2012 (Doc EB132/3).

PHM supports the stated objective of *"enhanc[ing] the alignment of resources with outputs agreed by Member States"* (Par.10). It is important to ensure that funding follows priorities duly established by decision-making bodies, not vice versa. However, it is not clear how the proposed approach (through the medium of the financing dialogue) will contribute to this objective.

In our opinion the proposed **financing dialogue** is in essence a **pledging conference**, despite claims regarding enhanced transparency and improved mechanisms to fund the entire budget. Member states are urged to consider the possible implications of providing a formal space to non-state actors in the WHO's decision making structures, by institutionalising a mechanism such as the financing dialogue.

Further, the dialogue could lead to a further institutionalization of what is called **"multi-bi financing" --** the practice of donors choosing to route non-core funding earmarked through multilateral agencies. It reflects a desire by participating governments, and others, to control international agencies more tightly. Multi-bi financing leads to an increased competition between WHO and other global health actors for funding to implement short-term, cost-effective, targeted programs. Short-term funding will erode the knowledge capacity of the WHO, which has been build-up over the last decades.

However, in spite of its obvious shortcomings, if the financing dialogue mechanism is endorsed by the WHA, we propose some mechanisms that could contribute to shifting influence and accountability from individual funders to the EB and WHA. These include:

1. Establishing transparent and clear criteria, keeping in mind considerations related to conflict of interest and to the possible promotion of commercial interests by potential funders, as regards participation of donors in the financing dialogue.

2. Requesting donors to provide a significant percentage (at least 20%) of every grant as flexible funding.

3. Allocating costs for corporate services and enabling functions to individual programmes pro rata with their share in total budget.

4. Flexible resources can be allocated more strategically by deferring decisions on the allocation of assessed contributions after the availability and distribution of tied funding has been determined, and not (as proposed) at the second meeting of the financing dialogue. This would allow such funding to be allocated according to the gap between organizational priorities and committed funding.

5. Consideration should also be given to allocating assessed contributions to areas and activities where voluntary funding would give rise to risks of conflicts of interest (e.g. with donors' commercial interests) and a risk of skewing policies or priorities, for example in relation to pharmaceuticals, intellectual property, etc.

6. Vulnerability to anticipated funding not materializing is of particular interest in light of increasing financial pressures on some donor countries and associated uncertainties regarding funding. Consideration should therefore be given to seeking contingency funding lines, in case anticipated/pledged funding does not materialize, in addition to conventional programme funding.

7. Finally we suggest the WHA to install **a working group** to explore *if* and *how* a mechanism to increase WHO's core budget can be implemented. This could be via an increase in assessed contributions, and perhaps also via innovative financing mechanisms, such as a financial transaction tax or other taxation regimes. An increase in core, predictable, funding is crucial to secure WHO's essential functions in the long term.

Comments on the Draft twelfth general programme of work (A66/6)

The purpose of the document is to provide a strategic vision for the work of WHO for the period 2014-2019. PHM would like to highlight the following issues:

The first chapter of the document provides an analysis of the changing political, economic and institutional context in which WHO is working. However, this is more in the form of a description rather than an analysis of the situation. A causal analysis would have brought out a number of issues that deal with Global Health and that should be taken into account by WHO.

We appreciate the introduction, among the strategic priorities, of the social determinants of health conceived as a means of reducing health inequities. However, **the whole exercise of priority setting is not sufficient alone to solve the problem of budget allocation if it is not associated with a discussion on new sustainable financial mechanisms.** The success of any new mechanisms for prioritisation will depend upon addressing the distortions of resource allocation arising from tied donor funding.
Moreover, the proposed mechanism to connect the priorities with the budget allocation is insufficient and would not prevent **distortions of resource allocation arising from donor interests.** There is no clear explanation offered of **how the remaining financial gaps will be filled.** There is thus a clear risk that certain key areas of WHO's work which do not attract donor funding will continue to be poorly financed.

Finally, despite the fact that several Member States had asked for an increase in assessed contributions during the last WHA and this is also one of the outcome of the extraordinary PBAC meeting held last December, this issue is not addressed in the present document.

Comments on the Proposed programme budget 2014/2015 (A66/7)

The budget for ***corporate services and enabling functions*** (broadly overall organizational management and support services) is increased by 10.0% to $684m. **Excluding the increase for corporate services and enabling functions, the overall budget declines by 1.3% and this is a matter of concern as the real availability of funds would be much less if inflation is factored in.**

The proposed budget for the 2014-15 biennium shows a marked shift from communicable to non-communicable diseases, with a reduction of 7.9% in the former compared with 2012-13, while the latter is increased by 20.5%.

However, the communicable diseases budget excludes **polio eradication**, which is classified separately under emergencies. This is increased by 17.4%, and is nearly as large as the Communicable Diseases budget itself. Combining this with the Communicable Diseases budget indicates an increase of 2.1% in the overall budget for communicable diseases, but also an increase in the share of polio in the total from 39.5% to 45.4%. Polio eradication accounts for more than one-fifth (21.2%) of WHO's total programmatic budget.

The budget reflects a gross mismatch between stated priorities of the WHO and financial allocations. For example, the budget for social determinants of health is remarkably small, given the weight accorded to this in several of the WHA documents. Overall, it amounts to $30m, or 0.7% of the total budget.

Assessed contributions account for only 23% of the programme budget, while the remaining 77% is to be financed through voluntary contributions. There is a considerable variation in the level of voluntary funding between programme areas which appears partly to drive variations in overall budgets. The strongest areas for voluntary funding are emergencies and disasters (95.2% of funding coming from voluntary sources), communicable diseases (93.7%) and HIV/AIDS, tuberculosis and malaria (88.8%). Taken together, these three areas account for 69% of all voluntary funding (communicable diseases alone amounting to 45.4%). WHO needs to conduct a deeper analysis of the impact of tied funding being the main source of finances for several important programme areas, especially as regards whether this distorts internal programme priorities and coherence.

Finally, during the extraordinary PBAC meeting it was proposed to *"continue to explore avenues to broaden WHO's donor base to reduce the financial risks for WHO"*. We would like more clarification on what this does imply.
(Tables in Annexure provide details of budget allocations described above)

Comments on Report of the Internal Auditor (A66/35)

PHM would like to raise the following points related to the issue of conflict of interest as highlighted by the audit report:

- Para 16 of the Internal Auditor's report suggests serious shortcomings in WHO

practice in the matter of conflicts of interest, even in relation to WHO's very limited concept of this issue (that is, in relation to the contracting of consultants and membership of advisory committees, and not, for example, in sources of funding). The reference to *"large variations… in the level of compliance"* with conflict of interest procedures clearly indicates major deficiencies in some technical units at headquarters. Explicit reference is made to cases in which the same staff member responsible for implementation is also responsible for assessing potential conflicts of interest. This is clearly inappropriate.

- Para 18 of the same document highlights what appears to be a particularly serious case, relating to the Health Metrics Network, where it is stated unequivocally that *"controls were not adequate to mitigate… major risks";* that *"the selection and the contractual arrangements of the consultant… did not fully comply with WHO procedures and gave rise to a conflict of interest"* (by implication an actual, not only a potential, conflict of interest); and that *"there was no systematic evidence that the deliverables listed in the service contracts had been technically and financially cleared before payment to the service providers".*

These paragraphs **indicate extremely serious shortcomings in WHO's practice in relation to conflicts of interest, and the need for urgent action to rectify this situation.**

13. Noncommunicable diseases

13.1 and 13.2. NCDs

Background to agenda item(s)

A66/8 (Draft comprehensive global monitoring framework and targets for the prevention and control of non-communicable diseases): In response to decision EB132(1) adopted by the Executive Board, in which it decided to endorse the comprehensive global monitoring framework including indicators, and a set of voluntary global targets for the prevention and control of non-communicable diseases, the Health Assembly is invited to adopt the comprehensive global monitoring framework. Member States are also urged to consider the development of national targets and indicators based on national situations. The Director-General is requested to submit interim reports on the progress achieved in attaining the voluntary global targets to the Sixty-eighth and Seventy-third World Health Assemblies and to submit a final report to the Seventy-eighth World Health Assembly in 2025, through the Executive Board.

A66/9 (Draft action plan for the prevention and control of non-communicable diseases 2013–2020): In response to resolution EB130.R7 and resolution WHA64.11, the Secretariat developed a draft action plan taking into account the outcomes of discussions at the 132nd session of the Executive Board, the results of the plenary meeting on 28 November 2012 at the United Nations General Assembly, and four rounds of informal consultations with Member States, organizations of the United Nations as well as relevant nongovernmental organizations and selected private sector entities.

The Health Assembly is invited to endorse the global action plan for the prevention and control of non-communicable diseases 2013–2020, to urge Member Stares to implement policies options for Member States and request the Director-General to implement the actions for the Secretariat included in the global action plan and to submit reports on progress achieved in implementing the action plan to the Sixty-eighth, Seventy-first and Seventy-third World Health Assemblies through the Executive Board.

PHM Comments

A stated premise of the ongoing discussions on non-communicable diseases (NCDs) is that NCDs constitutes a major public health challenge that undermines social and economic development throughout the world. Such a premise views the action plan as an investment to safeguard the health and productivity of populations and economies, within a debate that perceives health as an input for economic growth rather than a common good, and above all, a fundamental human right.

The main focus of this action plan is on four types of NCDs (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes). Though the importance of an integration of NCDs programmes is mentioned, the narrow focus on specific diseases would contribute to a vertical approach rather than a more broadly integrated primary care approach. The strategy could create an artificial fragmentation in approach towards NCDs.

Further, the action plan focuses on four behavioural risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol) often perceived as harmful individual choices. Such a 'victim-blaming' approach disregards the influence of socio-economic circumstances on risk and vulnerability to NCDs and the impact of health-damaging policies. The "four diseases and the four risk factors"- framework diverts attention from the root causes of ill-health and does not address conditions in which people live, that are shaped by political, social, environmental and economic determinants of health.

Reducing modifiable risk factors for NCDs needs to be clearly linked to the activities of the alcohol, tobacco and food industries. These industries have a high degree of concentration, and the top firms wield enormous power that they use to promote behaviours and lifestyles associated with NCDs. The action plan explicitly calls for the involvement of the private sector as one of the international 'partners' and there is no mention of an effective management of potential conflict of interests arising from the engagement with corporations representing agribusiness, food, beverage and pharmaceutical industries. We are also concerned about the influence that the pharmaceutical industry might have in shaping the research agenda and the public health strategies. In this regard it is fundamental for Member State to carry out independent analyses and evaluations of the efficacy, safety, cost-effectiveness and feasibility of public health measures – including pharmaceutical interventions - in their own contexts.

The proposed action plan bypasses the recommendation of the CEWG on R&D: financing and coordination. The action plan should explicitly include work to promote

health R&D that addresses access to essential health technologies for non-communicable diseases, particularly in developing countries.

The comprehensive global monitoring framework mirrors the narrow approach to NCDs of the action plan. NCD targets must explicitly address global and local social determinants and corporate behaviour, including potentially damaging marketing practices.

The targets, in the framework proposed, focus on the individualised causes and could lock in interventions within a behavioural risk factor paradigm that has been challenged by evidence on the importance of societal factors.

To address diet-related NCDs, interventions (and targets) must tackle the systemic problems that generate poor nutrition in all its forms and reflect how our food systems are making people sick. The accumulating international evidence highlights that there are structural issues that affect the availability, affordability, and acceptability of food, which, along with everyday living conditions, affect what people eat. This is seen through food price speculation, land grabs, and the longer-standing issues of liberalised trade and foreign direct investment.

The comprehensive global monitoring framework recommends only voluntary global targets and indicators. It is imperative that the WHO take the lead in building a global consensus on developing statutory norms, to be followed in across the globe. Such norms need to include measures directing at curbing the activities of the food and beverage industries, in addition to the alcohol and tobacco industries. More research needs to inform strategies for containing NCDs, including those that link social determinants with NCDs. For example there is clear evidence that poor nutrition early in life is known to predispose to diabetes and cardiovascular diseases. Poorer populations in many countries are often more prone to obesity as they depend on low-cost high trans-fat packaged foods.

13.3. Draft Mental Health Action Plan

Background to agenda item(s)

The WHA65 adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. In addition to urging Member States to develop and strengthen comprehensive policies and strategies around mental health, the WHA65 requested that the Director-General develop a comprehensive mental health action plan covering services, policies, legislation, plans, strategies and programmes.

The Director-General developed a "zero draft"of the Draft Mental Health Action Plan 2013-2020 which has guided consultation with Member States civil society and international partners. The EB132 approved the draft for finalization. The WHA66 is asked to note the report by the secretariat, **A66/10 Rev.1**, and provide further guidance on preparation of the final draft.

PHM Comment

The work done by the WHO to address mental health at the country level is an important step forward in addressing the growing burden of poor mental health across the globe. The focus on expansion of "cost-effective and feasible mental interventions" (A66/10, para. 18) is welcome. Further, integrating mental health care at the primary level in community-based settings addresses the large disparity between the provision of and access to mental health care and physical health care. Finally, the report calls attention to discrimination and stigmatization toward people with mental illness and highlights the necessity of a human rights perspective in the approach to mental health which is critical.

While the determinants discussed in this document make mention of social, cultural, economic, political and environmental determinants of mental health (para. 9) there is little detail provided on these and no mention of or action recommended on determinants that give rise to mental illness such as post-traumatic stress in relation to conflict, domestic violence, economic insecurity, withdrawal of states from providing comprehensive healthcare schemes and the general reliance on the market to respond to the demand for mental health services, among others.

Issues related to medications for mental health are not sufficiently developed in the draft. First, more attention should be given to non-pharmacological approaches to mental illness as the medicalization of mental health and the misuse of psychotropic medications in treating mental illness, unfortunately, adds to the burden of mental health problems.

The document relies on a biomedical explanation for mental health. While the document notes, at para. 70, that a wide range of social and economic determinants influence mental health, it needs also be recognized that these determinants, along with structural determinants, transform along with society. Deteriorating conditions of work, insecure conditions of living due to economic and social deprivation, all contribute to poor mental health and need societal solutions.

With regards to data collection, there is an additional need for sub-national data, including sociological data, to get a better perspective on local challenges with regard to mental health.

The document does not recognize the cultural aspect of mental health. Mental health definitions are culturally bound, but there is an assumption that universal norms of defining mental health can be applied. Such definitions may exclude those who could benefit from mental health care but do not see themselves as having such need. Identifying "social and emotional well-being" as a key element in the mental health action plan will work to ensure that those who need mental health attention are not excluded.

Communities at risk need to be involved in the decision-making processes to promote prevention, including, as a mentioned earlier, outreach to those who may not recognize themselves requiring care. The documents notes that civil society is only loosely organized around mental health, but a plan to seek a more central role for civl society is not articulated.

13.4. Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019

Background to agenda item(s)

A66/11 (Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019) -- The Executive Board at its 132nd session considered an earlier version of this report, and adopted resolution EB132.R1 in which it recommended a resolution "towards universal eye health: a global action plan 2014–2019" for adoption by the Health Assembly. The draft action plan has been updated in the light of comments made during the Board's discussion.

PHM Comments

Innovations in the institutional management and surgical treatment of avoidable blindness have vastly improved cost-effectiveness and accessibility for patients during the last 35 years, particularly for cataract surgery.

While the Draft Action Plan (A66/11) identifies cataract as the major reason of avoidable blindness, it does not pay due importance to actions to address refractive errors -- the other major cause of visual impairment in most countries.
Nor is importance paid to measures such as glaucoma diagnosis through mobile routine tonometry.

The Global Action Plan 2014 -2019 needs to go beyond generalities and too narrow a focus on two pathologies and include comprehensive proposals on a range of conditions that contribute to visual impairment. The Global Action Plan 2014 -2019 needs to include a 'road-map' for action in the different WHO regions, in order to harness adequately globally available technological know-how.

13.5. Disability

Background to agenda item(s)

A66/12 discusses findings and recommendations from the *World Report on Disability*. It also lists activities of the Secretariat around disability. The WHA66 is invited to adopt the draft resolution EB132.R5, which endorses the recommendations of the *World Report on Disability*.

PHM Comments

Document A66/12 was updated following EB132; no material changes were made. Disability issues remain marginalized in all health care and right to health discussions. There is limited engagement of primary health care and community health practitioners in this area.

PHM supports disability being a cross-cutting issue in the post-2015 agenda. WHO should further engage with stakeholders to articulate why and how disability-inclusive development should be reflected in the post-2015 agenda.

14. Promoting health through the life course

14.1. Monitoring the achievement of the health-related Millennium Development Goals

Background to agenda item(s)

WHA66/13: In response to requests in resolutions WHA63.15, WHA63.24 and WHA58.3, this report summarizes the latest trends in progress towards achievement of the health-related Millennium Development goals and specific targets. It also describes progress towards reducing child mortality through the prevention and treatment of pneumonia, as requested in resolution WHA63.24; reducing perinatal and neonatal mortality; and achieving universal coverage of maternal, newborn and child health interventions, as requested in resolution WHA58.31. The Executive Board at its 132nd session considered an earlier version of this report.

WHA66/47 (Health in the post 2015 development agenda) -- This report updates the report considered by the Executive Board at its 132nd session in January 2013. It summarizes processes that have been established in response to both mandates, focusing on the several streams of work taking place in the lead up to a final review of the current Goals at a high-level meeting during the sixty-eighth United Nations General Assembly, due to be held in September 2013. It also outlines an emerging narrative in relation to health, showing how health in the post-2015 environment can provide a link between concerns for sustainable development and poverty reduction – meeting the needs of people and the planet.

PHM Comments

PHM is concerned that WHA66/47 does not outline any lessons learned from the Millennium Development Goals (MDGs) process. PHM believes that identifying key lessons is a critical step towards ensuring that the post-2015 framework does not replicate the identified shortcomings of the MDGs. For the purpose of informing the post-2015 agenda, the PHM urges that Member States ask for a section on 'lessons learned from the MDG process' be included in the next report. Experience from the Millennium Development Goals taught us that isolating targets from their context does not work.

The document fails to address the need to reform the global economic and political architecture. The current drive for global economic integration makes it increasingly difficult for nation states to achieve sustainable development and universal social protection.

In particular, it is important to point out how and why the MDGs failed to address inequity in health in order to plan realistically for the post 2015 Development Agenda. Inequities in health continue to persist and were sharpened during the period that the MDGs were implemented. The growing gap between poor and rich between and within countries has a negative impact on health for the majority of people. Health outcomes will not improve through an increase of per capita income without concrete policies aimed at balancing distribution of power and resources. The new development agenda

must include the achievement of equity within countries and between countries as a top priority.

The MDG process was top down in its construction and execution. It is important that the process of agenda-setting be designed in such a way that recognized the capacity of people to control and steer their own development rather than imposing a top down development framework.

The MDGs presumed that development could be achieved through international aid, without addressing power imbalances between countries and within countries. PHM urges Member States to consider replacing the 'charity' model of MDGs with a model that starts by working to change the balance of power relations embedded in the structure of global governance.

14.2. Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health

Background to agenda item(s)

The report (**A66/14**) was prepared in response to WHA65.7 which requested an annual report to the Assembly on progress in the follow-up of the recommendations of the Commission on Information and Accountability for Women's and Children's Health. The WHA66 is invited to adopt the draft resolution EB132.R4 urging Member States to put into practice the implementation plan on life-saving commodities for women and children.

PHM Comments

PHM welcomes and supports this initiative to strengthen monitoring capacity and accountability for women's and children's health that focuses on the 75 high burden countries. In addition we support the UN Commission that is focusing on 13 commodities that are deemed essential for saving women's and children's lives, but which are often overlooked or not readily available. Similarly, we welcome the role of WHO in implementing recommendations to strengthen the quality of products, for ensuring regulatory efficiency and for scaling up access to emergency contraception.

PHM is, however, surprised that nowhere in this report is there mention of the bottleneck to the delivery of already existing effective commodities for maternal and child health and survival, namely human resources for health. A recent Lancet series on pneumonia and diarrhea, respectively the first and second causes of young child death globally, lamented the extremely poor coverage of antibiotic treatment for pneumonia and oral rehydration therapy for diarrhea management. It is clear that the obstacles to delivery of these commodities are not primarily due to their poor 'quality', but to weak health systems, in particular in respect of health personnel. Indeed, this situation is even more extreme in relation to maternal health, where coverage of safe delivery and postnatal care is severely constrained by a critical shortage of skilled human resources. Despite successive statements since 2006 when the World Health Report focused on this issue, and notwithstanding a Code of Conduct regarding recruitment of health personnel from LMICs, little progress has been achieved in addressing Africa's health human resource crisis.

Accordingly, PHM urges WHO to include in the mandate of the Commission on Information and Accountability for Women's and Children's Health a specific focus on human resources for health and report to Member States on progress in this regard.

14.3. Social determinants of health

Background to agenda item(s)

This report **(A66/15)** describes the progress in implementing resolution WHA65.8, including the support provided to Member States in implementing the Rio Political Declaration on Social Determinants of Health and advocacy, research, capacity building and direct technical support provided along with other organizations in the United Nations system. The Health Assembly is invited to note the report.

PHM Comments

Member States have expressed their commitment to SDH and have identified it as a priority area for WHO's work. It is of concern that the report presented to the Health Assembly is limited to a list of activities without qualitative assessment of the impacts of these activities. The report constitutes a shallow engagement and understanding of social determination of health. It is necessary that the WHO give itself the means to undertake credible studies and research into the root causes of social determinants of health. It is worrying that the budget for social economic and environmental determinants taken together only comes to 0.7% of the WHO budget.

The approach to social determination of health should encompass much more than classic risk factors and individual lifestyles. Behind risk factors and effects, such as smoking, sedentary behavior and poor nutrition, lies a social construct and structures including global structural determinants such as commercialization of life, unequal economic relations, inequity and power imbalance . Today austerity measures are driving the privatization of health systems and the dismantling of the welfare state. The report also fails to identify the causes of health inequities and avoids suggesting future actions and policies to address such inequities. Such an approach contributes to the concept of social determinants of health to becoming reduced merely to individual behaviors.

The work on SDH should delve deeper into structural determinants such as the impact of trade and financial liberalization policies and global power imbalances.

While measurement and evaluation are necessary, unless the indicators adopted are disaggregated using meaningful stratifiers, progress on the SDH cannot be meaningfully measured.

We call upon WHO and Member States to adopt SDH as a cross cutting framework in the development and the implementation of current and future health strategies. The opportunity to address the post 2015 development agenda in facing health inequities through actions on their root causes cannot be wasted.

15. Preparedness, surveillance and response

15.1 Implementation of the International Health Regulations (2005)

Background to agenda item(s)

This report **(A66/16)** provides an update on progress made in taking forward the recommendations of the *Review Committee on the Functioning of the International Health Regulations (2005)*(see A64/10) in relation to Pandemic (H1N1) 2009, as requested in resolution WHA64.1. This report also takes into account information provided by States Parties on the implementation of the Regulations and describes the Secretariat's related support activities, in line with the annual reporting mechanism established under resolution WHA61.2(p3). In addition, it contains sections on the proposed monitoring of national core capacities and the development of criteria for future extensions (of time for fulfilment of the obligations under the IHRs), as requested in resolution WHA65.23(p39).

The International Health Regulations (IHRs) date back to the Sanitary Conferences of the 19th century dealing with disease notification, vaccination for travel, quarantine etc. They were under review in the 1990s but this review was greatly accelerated by the SARS epidemic (severe acute respiratory syndrome) in 2003. The new version of the IHRs from 2005 included explicit obligations on member states. However, some member states had not put in place all of the resources and systems required for the full implementation of the IHRs by the deadline of end 2012 and required extensions of time to fulfil their obligations. Some of these states may apply for a further extension beyond 2014. This paper sets out the current status with respect to member state implementation of the 13 elements being monitored. It also sets forth possible criteria for further extensions of time for implementation in 2014.

Following the H1N1 pandemic in 2009 there was some controversy over the application of the IHRs and the Review Committee was set up to report to the Assembly about the application of the IHRs in this context. This paper reports on progress in the implementation of the 15 recommendations of this committee also.

PHM Comment

The IHRs are an important institution for global public health protection. They impose binding obligations on states in order to ensure the protection of people in different countries. It is proper that states should be obligated to implement these regulations. The Secretariat is doing a good job in strengthening the systems of surveillance and monitoring upon which these regulations depend.
There is a stark contrast between the use of a binding instrument to contain the risks of pandemic communicable disease and the opposition to any such obligations in relation to the international marketing of breast milk substitutes and cheap junk food. In fact, investment protection provisions in new trade agreements are deliberately designed to protect transnational corporations from any such regulatory obligations.

The integrity of WHO requires that vested interests should not be allowed to prevent the implementation of public health provisions needed to protect the health of millions of people.

15.3 Polio (A66/18)

Background to agenda item(s)

In 2012, the Sixty-fifth World Health Assembly in resolution WHA65.5(p10) declared the completion of poliovirus eradication a programmatic emergency for global public health and requested the Director-General, inter alia, to undertake the development and rapid finalization of a comprehensive polio eradication and endgame strategy to the end of 2018.

The present report gives details of progress made, and challenges experienced, in implementing the global and national emergency action plans against poliomyelitis; explains new challenges and risks, particularly in the area of security; summarizes the new six-year polio eradication and endgame strategic plan 2013–2018 (see), including its implications for the 144 Member States using oral poliovirus vaccine; and, outlines the planning process for securing the broader legacy of the Global Polio Eradication Initiative.

The Assembly is invited to note the report.

Emergency action on polio is focused on the three remaining endemic countries: Afghanistan, Nigeria and Pakistan. Action is complicated by the need to ensure the security of health personnel in conflict areas.

The strategy for polio eradication involves the withdrawal of oral poliovaccine (OPV) especially the type 2 component because of the risk of infection and illness from vaccine derived polio virus and replacement of the OPV with inactivated virus.

Legacy planning involves mainstreaming of polio specific resources and ensuring that the lessons of the polio eradication campaign are transferred into mainstream public health.

PHM Comment

The eradication of polio is an important goal and it appears to be achievable.
In the polio eradication initiative, WHO appears to be focused solely on immunisation, delivered largely through dedicated vertical programs. There is no mention in this paper of the need for clean water and improved sanitation. There is no mention in this paper of the need for comprehensive primary health care as a secure platform for sustainable immunisation programs.

The importance of economic development, equity and conflict resolution as preconditions for health improvement is underlined by the experience of the polio campaign, including the murder of health workers and disruptions to immunisation programs.

In the legacy process it will be useful to review the historical debates around inactivated versus attenuated virus. In retrospect it appears that the adoption of the OPV was unfortunate.

16. Communicable diseases

16.1 Global Vaccine Action Plan (A66/19)

Background to agenda item(s)

The report outlines the status of progress towards operationalising of the Global Vaccine Action Plan, and the process and the content of the proposed Monitoring and Accountability Framework for the Global Vaccine Action Plan. The Health Assembly is invited to note the report, including the proposed Framework.

PHM Comment

We are concerned that the core of the action plan seems to be the promotion of immunization as an aim in itself, while ideally the focus should be on decreasing the burden of disease and ensuring disease control. Immunization is one of the strategies for disease control. However efficacy and cost effectiveness of vaccines and immunization campaigns have to be evaluated case by case in the specific country context.

The introduction of new vaccines cannot be seen as goal in itself as the document appears to propose. Many new vaccines target only specific strains of the causative pathogen and their use is limited by the ability of pathogens to mutate and take up the space ceded by strains that are sensitive to vaccines. . Evaluation of cost-effectiveness of new vaccines is essential and has to be conducted through a transparent process that avoids conflicts of interests. National strategies for vaccine should respond to priorities and needs of local populations.

On the other hand, introduction of new technologies should be accompanied by transfers of technology in order to ensure sovereign control over population health needs. This aspect does not find a mention in the report.

The Action Plan does not refer to the role of health systems and the necessity to strengthen them in order to ensure delivery of immunization services. Similarly, the role of underlying social, economic and environmental determinants of health in ensuring higher efficacy of immunization campaigns is not addressed.

16.2 Neglected Tropical Diseases: Prevention, control, eradication and elimination.

Background to agenda item(s)

The report (**(A66/20)** updates the Health Assembly on the adoption of resolution EB132.R7, which reaffirms the commitment of Member States and WHO in prevention, control, elimination and eradication of Neglected tropical diseases (NTDs), and is invited to adopt the resolution.

PHM Comment

While recognising that NTDs are closely related to poverty and exclusion, the report fails to highlight the structural dimensions that shape the distribution of NTDs and the root causes of ill-health.

The document identifies five fundamental public health interventions: preventive chemotherapy; intensified case-management; effective vector control; the provision of safe drinking-water, basic sanitation and hygiene; and involvement of veterinary public health. Given that NTDs are rooted in poverty, no action will be entirely effective without addressing the structural determinants of health.
.
The main vehicle of implementation of activities around NTDs is through partnerships, with a major role for pharmaceutical transnational corporations without any safeguards on managing conflict of interest. Safeguards need to be built into the NTD initiative to prevent TNCs from using it to extend their corporate interests.

Further, the draft resolution does not provide a clear mechanism to encourage and incentivise research and development for neglected tropical diseases. The report of the Consultative Expert Working Group on Research and Development recommended a global coordinating mechanism – linking priorities, financing, and access. We urge member states to integrate recommendations from the report of the CEWG in the draft resolution on NTDs.

16.3. Malaria

Background to agenda item(s)

The 64th WHA endorsed resolution WHA64.17 on malaria. The secretariat submitted the progress report EB132/42 Add.1 on the implementation of this resolution to the 132nd EB session. The EB noted the report but referred the subject as a technical issue to for the consideration of the 66th WHA.
The secretariat has provided a more detailed report A66/21 for the consideration of the current Assembly.

PHM comments

The report highlights indicators of success in the combat of malaria as represented by significant decline in related mortality but also notes that the burden of disease is still very high, especially in Sub-Saharan Africa. Among other barriers to the universal access to malaria interventions, the report emphasizes the shortage in funding, drug (Artemisinin) resistance, vector resistance and weakness of surveillance systems.

The report does not contain an analysis of the experience of pursuing a vertical approach in the combat of malaria. Evidence suggests that such an approach led to the fragmentation of health systems in a number of countries.

The report fails to emphasize the importance of addressing the social and environmental determinants of malaria including the effect of global warming, living conditions, sanitation, housing conditions, nutrition, access to healthcare and medicine, etc.

Actions to deal with drug resistance should include:
- rational use of drugs which need efficient health system at national level and enforcement of regulations at national and global levels;
- integrated global and local strategies for R&D on new drug development;
- a portion of available resources should be invested in strengthening health system and malaria control programs should be integrated within a comprehensive primary health care approach.

17. Health systems

17.1. Substandard / spurious / falsely-labelled / falsified / counterfeit medical products (A66/22)

Background to agenda item(s)

The first meeting of the new Member State mechanism on Substandard/spurious/falsely-labelled/falsified/counterfeit medical products was held on19–21 November 2012, in Buenos Aires, Argentina. The Member state mechanism (hereafter MSM) was adopted by the WHA resolution 65.19in 2012 following the recommendation of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/ Falsified/Counterfeit Medical Products in 2011 (which itself was established by decision WHA63 in 2010). The Director-General will transmit the report of the meeting to the Health Assembly. As per 18 May 2013, the secretariat had not published the report.

PHM Comments

We welcome the establishment of a Member State mechanism to address the issue of quality, safety and efficacy (QSE) of medical products, from a public health perspective and excluding trade and IP considerations. We urge Member States to request the WHO to dissociate itself from IMPACT, which was an attempt at delegitimizing generic drug use by conflating trade mark infringement with issues of QSE. Trade mark infringement is an IP issue, not a health issue. We also urge Member States to consider requesting that WHO to dissociate itself from the terminology of counterfeit, which has been misused. In addition, baseless data has been quoted as originating from the WHO on the issue of QSE and trade mark infringement. WHO should be requested to clarify its position.

The commitment by the WHO to provide assistance to member states in developing regulatory capacity is welcome. However, it is essential that funding for the MSM should be drawn from the regular budget, and not from tied contribution, so as to guard against conflict of interest.

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

Background to agenda item(s)

The document **(A66/23)** is a follow-up of the report of the Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination. The documents includes: 1) the report of the open-ended meeting of Member States that was held from November 26th-28th, 2012 in Geneva, and 2) a draft resolution that was agreed upon during the open-ended meeting. The Assembly is invited to consider the adoption of the draft resolution.

PHM Comments

Despite some valuable elements contained in the draft resolution, PHM would like to raise some concerns:
1. The draft resolution doesn't reflect several CEWG recommendations. The resolution does not propose a binding agreement on a global R&D treaty. A firm global commitment to a new system for R&D is required to ensure that LMICs are equipped with the knowledge needed to improve health outcomes. We urge Member States to urgently consider the feasibility of developing a global fund for R&D, located within WHO.

2. Though the current work plan provides an essential outline of various activities, the commitments that are made are too limited and unclear. Greater clarity must be provided on several areas if the health research needs of developing countries are to be adequately addresed within an appropriate timeframe. Indeed the resolution postpones discussion of an R&D Convention at the WHO (Par. 4(7)), thus delaying urgently needed actions.

3. More clarity is necessary on the underlying principles that would guide the proposed demonstration projects in order to assure that they are predicated upon the principles outlined in the CEWG report and in order to avoid the engagement with private sectors without any safeguards.

We recommend that the Assembly strengthen this critical work plan by:

- Making clear the role of Member States in the work of the R&D Observatory that will be established within the WHO Secretariat (Par. 4(3))
- Noting appropriate principles of engagement between various private and public stakeholders for the implementation of the demonstration projects (Par. 4(4))
- Reconsidering the postponement of another open-ended meeting of Member States (Par. 4(7)), as this delays further action on outstanding issues

17.3. Universal Health Coverage

Background to agenda item(s)

The 66th WHA is invited to note document **A66/26**. This is an updated version of a report on universal health coverage that was reviewed during Executive Board's 132nd

session. The original version was edited to incorporate 1) the concerns of Member States, and 2) the results of the ministerial meeting on universal health coverage that was held in February 2013. The report outlines the major components of UHC, and charts relevant progress, challenges, and continued and future efforts of the WHO to provide technical support to Member States for financing for universal coverage.

PHM Comments

PHM welcomes the continued interest and enthusiasm for UHC. However, we wish to convey our unease with the term universal health "coverage" as opposed to universal health "care" throughout document A66/24 and previous WHO reports.

While para 7 accurately states that health coverage is "not about achieving a fixed minimum package", the document consistently discusses UHC as if it is entirely an insurance-based approach to providing health service delivery. Para 17 in particular indicates an emphasis on financing for "even a minimum set of health services". PHM is concerned that this focus will perpetuate the principles of selective primary care that replaced the principles of Alma Ata.

PHM urges Member States to reconsider this current vision of UHC, which could lead to the dismantling or further weakening of public health systems while providing increased space for the commercial, for-profit sector. We suggest the return to the term "care", to be achieved through organized and accountable systems of high quality public provision of comprehensive primary health care. Indeed, access to quality services, though important, must be understood as one strategy embedded within a broader health systems framework that attends to the structural social, economic, and environmental determinants of health.

We urge Member States to envision UHC beyond financing for universal coverage, executed as a comprehensive primary health care strategy driven by community participation.

17.4 The health workforce: advances in responding to shortages in migration, and in preparing for emerging needs (A66/25)

Background to agenda item(s)

The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted in 2010 at the 63rd Health Assembly. In 2011 two resolutions were adopted, on health workforce strengthening (WHA64.6) and on strengthening nursing and midwifery (WHA64.7). This report gives an overview of the current situation in relation to health workforce migration, and delineates challenges for the future. The Health Assembly is requested to take note of this report.

PHM Comments

We are concerned with the apparent lack of country ownership of the WHO Global Code of Practice on the International Recruitment of Health Personnel adopted in 2010 in the context of the health workforce crisis faced globally and most strongly in developing countries. The language on *collaboration* between source countries and receiving countries was an unfortunate watering down of the legitimate demand for

compensating source countries for their lost investment in the training of this staff. This is most legitimate in contexts where the health workforce is educated in the public sector, and supported by public spending.

Many source countries of migration have not yet taken advantage of the Code and its provisions. Source countries could benefit from developing stronger leadership for implementation of the Code, as it could support their efforts in health workforce development and retention.

The implementation of the Code and necessary monitoring involved demands commitment, leadership and adequate resources, including monetary resources. It is unfortunate that the budget allocated for "human resources for health" at the WHO global secretariat has been reduced after the Code was adopted, while this is when it should have been increased.

This is unfortunate, as 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 standard setting and regulation. This links the technical issue of Code implementation with the overall issue of WHO reform and the role of WHO in global health governance.

We support the statement in the Secretariats report that there is a lack of coordinated and comprehensive data. In this regard, we are concerned that the reports on Code implementation received using the national reporting instruments are not publicly available. This hinders both data analysis and accountability.

Finally, it has to be recognized that migration of health workers is currently a market driven process. The orientation of education of the health workforce towards the export of health professionals can lead to the transformation of health workforce education in developing countries to suit the needs of developed countries. Further, we urge Member States to oppose the idea of global planning of health workforce, as health workforce planning ought to be part of national strategies.

17.5 eHealth and health Internet domain names

Background to agenda item(s)

This document describes trends and progress in eHealth and gives an update on the *.health* internet domain. The WHA66 is invited to take note of the report and consider the draft resolution recommended in EB132.R8.

PHM Comments

eHealth for health systems and services as well as eLearning for capacity building and networks can play an important role in public health.

WHO has done well to provide technical support to Member States in developing eHealth and health information systems through tools such as *The National eHealth Strategy Toolkit*. However, in addition to technical support, investment in infrastructure

is critical for developing a functional eHealth system, requiring the need for financial support in developing countries.

As noted in the document, interoperability is essential to achieve the full potential of information and communication technologies. WHO should ensure formulation of data standards between countries to ensure interoperability as work in eHealth continues.

The document notes the WHO's engagement with ICANN in securing of the *.health* domain name. Five applications have been submitted to ICANN for the domain name, but none belong to the health community. PHM support's WHO's efforts to secure the *.health* domain name for the public interest and urges Member States to acknowledge the damaging consequences of the takeover of .health domains by commercial interests.

20. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (A66/28)

Background to agenda item(s)

The secretariat report A66/28 was requested from the Director-General by the resolution WHA65.9 adopted in 2011. It provides an overview of the health situation in Palestine and highlights the progress in relation to key areas of WHO support in the Palestinian Ministry of Health.

PHM Comments

The secretariat report fails to recognize the occupation and the continuous aggression of the occupation forces as major threats to people's lives, physical and mental health, dignity and livelihoods.

While WHO is mainstreaming the approach of social and economic determinates of health across its work, the report fails to recognize the impact of the blockage imposed by the occupation forces on people's lives and health in Palestine (West Bank and Gaza) and Golan.

The report does not mention the attacks on health personnel, the conditions of political activists in the prisons of the occupying forces. The report does not report the number of deaths and the much larger numbers of handicapped people – all a consequence of the conflict arising out of the occupation of the region.

The report does not acknowledge the huge difficulties that face UNRWA including the need to have permission from the occupying forces to access the refugees' camps. The report and the related resolution fail to request the immediate end of the occupation, and immediate sanctions against all forms of violence.

Finally, it is unacceptable that the report has chosen to name the apartheid wall in Palestine as a 'security wall' which clearly reflects the perspective of the occupying forces and not the Palestinian people. We urge Member States to press for a correction in this regard.

23. Staffing matters

PHM Comments

Since the WHO Reform and a major policy renewal in the newly formulated Global Health programs such as NCDs and the Global Vaccination Decade will result in an intensified workload, the statement by WHO staff representatives to the EB in January 2013 gives proper emphasis to an enabling working environment, to carry out the WHO leadership mandate in the Global Health arena.

The 10 WHO Staff Associations raised major concerns in 2012 at the Global Staff Management Council in this respect with regard to meaningful prior consultation on proposed changes to Staff Rules on appointment policies.

The right to a reassignment process was changed from 5 years of continuing service to 10 years for all future and many current staff as of February 2013, despite repeated indications from management that existing staff would not be affected. Staff Associations noted that evidence-based justification or alternative scenarios were lacking. Such management proposals focus narrowly on reductions in staffing costs, without considering the implications for attracting and retaining the best global talent and providing minimal social protection for current staff.

It is likely that the 10-year continuous service rule will negatively impact on WHO's commitment to the UN-system-wide Gender Action Plan (to achieve gender parity by 2019 on all positions above P4), simply because women tend to interrupt service more often than men for family reasons.

Overall, there is major concern that WHO's medium- and long-term workforce model is not commensurate with the Organization's activities and priorities to improve Global Health; and without response to the well-known, massive departure of experienced current professional staff.

In this context, attention is drawn to a reduction in payroll costs of US$ 7 million per month since March 2012, signifying a staff reduction of 11.3 % across major offices, while current projections show that 2102 staff (32 % of total workforce) will retire in the next 10 years, of which 41.6 % are professional or higher categories.

A lack of cost-effectiveness analysis concerning the increased transaction costs incurred by the change of Staff Rules, and thus associated with the frequent re-establishment of contracts as well as the connection with stress and insecurity among staff raise further concerns regarding the achievement of stated outputs and outcomes during the Reform Process.

Annexure. WHO Programme budget utilization - Year ended 31 December 2012					
	$million			percent	
	assessed	voluntary	total	assessed	voluntary
Communicable diseases	38.5	575.5	614.0	6.3	93.7
HIV/AIDS, TB and Malaria	20.3	161.4	181.7	11.2	88.8
Chronic noncommunicable conditions	18.5	28.9	47.4	39.0	61.0
Child, adolescent, maternal, sexual and reproductive health, and ageing	22.6	75.1	97.7	23.1	76.9
Emergencies and disasters	6.9	137.2	144.1	4.8	95.2
Risk factors for health	14.1	30.7	44.8	31.5	68.5
Social and economic determinants of health	9.2	7.7	16.9	54.4	45.6
Healthier environment	16.1	22.7	38.8	41.5	58.5
Nutrition, food safety and food security	9.8	17.3	27.1	36.2	63.8
Health systems and services	59.5	75.3	134.8	44.1	55.9
Medical products and technologies	12.8	49.1	61.9	20.7	79.3
WHO leadership, governance and partnerships	101.3	23.0	124.3	81.5	18.5
Enabling and support functions	97.6	62.4	160.0	61.0	39.0
Total	***427.2***	***1266.3***	***1693.5***	***25.2***	***74.8***

	Distribution (%) of WHO Funding	
	Assessed	Voluntary
Communicable diseases	9.0	45.4
HIV/AIDS, TB and Malaria	4.8	12.7
Chronic noncommunicable conditions	4.3	2.3
Child, adolescent, maternal, sexual and reproductive health, and ageing	5.3	5.9
Emergencies and disasters	1.6	10.8
Risk factors for health	3.3	2.4
Social and economic determinants of health	2.2	0.6
Healthier environment	3.8	1.8
Nutrition, food safety and food security	2.3	1.4
Health systems and services	13.9	5.9
Medical products and technologies	3.0	3.9
WHO leadership, governance and partnerships	23.7	1.8
Enabling and support functions	22.8	4.9