



Open Letter to the Distinguished Delegates to the 65th Session of the WHO Regional Committee for the Western Pacific Region

Manila
13 October, 2014

Dear delegates,

The following comments, prepared by the People's Health Movement, are presented as a contribution to the deliberations of the Western Pacific Regional Committee meeting from Monday 13 October 2014 (in more detail at: <http://www.ghwatch.org/who/watch/wpr/2014>).

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 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 through 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 65th Session of the Western Pacific Regional Committee.

PHM is part of a wider network of organisations committed to democratising global health governance and working through the WHO Watch project. More about WHO Watch at: www.ghwatch.org.

PHM observers attending the Regional Committee meeting will be pleased to discuss with you the issues explored below.

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8. Programme Budget 2012–2013: Budget Performance (final report)

Key documents

- [WPR/RC65/3](#) (Programme Budget 2012-2013 Budget Performance final report)

Commentary

Donor control

The power of the donors to determine WHO's effective agenda is clearly reflected in [WPR/RC65/3](#). The trivial allocation to addressing the social and environmental determinants of health illustrates how donor control shapes what WHO including WPRO can do.

Over 60% of donor funds go to only three strategic objectives: communicable diseases (30% of total Voluntary Contributions (VCs)), HIV/AIDS, TB and Malaria (18% of total VCs) and Health Systems and Services (14% of total VCs). Voluntary contributions made up 91.5% of communicable disease funding and 95.4% of HIV/AIDS, malaria and TB funding.

In view of the continuing freeze on assessed contributions the Organisation is not in a position to make up for the refusal of the donors to untie their contributions.

Evaluation

Many of the indicators through which implementation of the PB12/13 was supposed to be monitored and the scale of achievement ('fully', 'partially' and 'not' achieved) are not very meaningful.

The narrative comment on the achievement of the 13 SOs does not seek to clearly identify how WHO has contributed to the changes which are reported. They are not contextualised within any program logic linking WHO activities to the wider context and the strategy linking the activities to the expected outcomes.

The evaluation practices of WHO attracted substantive criticism from the Stage II Reform Evaluation consultants ([EB134/39](#)), including weak attribution of improvements to WHO activities. In their report to the WHA67 the PBAC ([A67/55](#)) made similar criticisms.

9. Proposed programme budget 2016–2017

Key documents

- [WPR/RC65/4](#) (Draft Proposed Programme Budget 2016-2017)
- [EB134/39](#)

Commentary

Program logic and monitoring

Many of the outcome and output indicators defined in this draft PB are highly problematic. The comments of the Independent Evaluation Team (IET) on the GPW12 are very relevant (see [EB134/39](#) p40).

The ‘theory of change’ linking outcomes, deliverables and outputs remains poorly defined.

In large degree the outcomes, budget space and responsibilities associated with the ‘leadership priorities’ (UHC; MDGs; NCDs; IHRs, access to medical products, and SDH) are dispersed across a range of different ‘categories’ and ‘programmes’ which makes appraisal of the planning for these priorities difficult.

The output indicators are weak. They do not appear to reflect a strategic focus on WHO’s role in the corresponding ‘theory of change’ and are in most cases not clearly attributable to the foreshadowed deliverables. Indeed despite the criticisms of the IET regarding indicators such as *‘net primary education enrolment rate’* and *‘number of slum dwellers with significant improvement in their living conditions’* these continue to be cited in this PB (p48).

Throughout the document there are output indicators which take the form of ‘the number of countries which have generated a document’ or some similar structure. The supposition that generating the document will drive change or that WHO’s job is completed once the document is generated stretches comprehension.

For instance OP indicator 6.1.1 (p88) is ‘Level of satisfaction of stakeholders with WHO’s leading role in global health issues’. It is unclear which stakeholders are to be surveyed and how their ‘satisfaction’ will provide any guide to the achievement of Outcome 6.1.

The indicators for Outcome 6.1 are likewise problematic: “Proportion of WHO leadership priorities reflected in major intergovernmental and international processes (including those relating to: (i) the BRICS grouping of Brazil, Russian Federation, India, China and South Africa; (ii) the post-2015 development agenda; (iii) the United Nations General Assembly; and (iv) ASEAN)”.

There are some striking absences from this list, including the major donors supporting ‘development assistance for health’. One of the reasons WHO is advocating around UHC

is the fragmenting and burdensome effects of vertical disease based 'development assistance'. From this perspective the test as to WHO's leadership role will be a significant shift in the practices of development assistance donors, moving their funding away from vertical disease programs and towards health system development and action on the social determinants of health.

The IET also highlighted the accountabilities of Member States as well as those of the Secretariat. This comment does not appear to have been considered in the development of this draft PB.

10. Mental Health

Key documents

- [WP/RC65/5](#) (Mental Health draft Regional Agenda)
- [WPR/RC65/5 Corr. 1](#)
- [Mental Health Action Plan 2013-2020](#)

• Commentary

PHM welcomes the proposed Regional Agenda and congratulates the Secretariat. In particular we welcome the three approaches (health systems, whole of government and social movement) and the three implementation packages: core, expanded and comprehensive.

We appreciate the several references to whole of society approaches for mental health and well-being, however, we believe that as a whole this document can be strengthened. In particular, there is little practical guidance in the draft Agenda regarding the 'cross cutting' policy influence of the social determinants of health, as promised in the draft PB 2016-17.

The way that employment is organised, for instance, is not conducive to good mental health. The drive for economic integration through so-called 'free' trade agreements exposes communities to intense competition for jobs and markets and many communities are unable to compete. Some of the consequences include displaced farmers, urban slums and high levels of youth unemployment. These developments bring with them alcohol and drug use, violence, suicide and stress. In many ways these signs of mental illness are like canaries, warning of the mental health costs of an economic system that benefits the rich and exploits the poor.

The individualisation of mental health disorders contributes to the dominance of individualised clinical services, the misuse of psychotropics, and the failure of policy leadership with respect to wider cultural and political environment.

PHM calls for a quantum leap in research and advocacy around the social, political and cultural conditions for a good society in which people can live a good life. The policy should have three focuses; ensuring that we have a society with economic arrangements which are supportive of good mental health and low rates of mental illness, b) argue for the development of good mental health care for those who get sick and which builds on integrated primary health care services and institutional services, and c) campaigns to reduce the stigma associated with mental illness. Such research and advocacy, undertaken in association with the communities who have most to gain, should take a core place in the implementation packages at all levels from core to comprehensive.

In passing we urge deeper reflection on the unfortunate dichotomy between ‘serious’ and ‘less severe’ mental health conditions. Of course many people cope with mild depression or anxiety without recourse to specialised services. However, such conditions can impact on parenting with intergenerational consequences; can contribute to alcohol and drug use and to domestic violence including homicide.

11. Tobacco free Initiative

Key documents

- [WPR/RC65/6](#) (Tobacco free Initiative: Regional Action Plan 2015-2019)
- [A59.26](#)

Commentary

PHM believes that the structure and broad approach of this draft Regional Action Plan is reasonably comprehensive. However, we urge the Committee to give particular attention to the following issues.

Delays in implementing the commitments in the FCTC

PHM notes and regrets that a substantial proportion of WPRO countries are yet to meet several obligations under the FCTC, in particular Article 11 (on health warnings) & 13 (a comprehensive ban on advertising, promotion and sponsorship) for which deadlines have been well exceeded. This is extremely important as these measures are amongst the most cost-effective and require little resources to enforce. We appreciate that this is acknowledged in the draft Regional Action Plan.

Tobacco industry interference on health policy-making

The acknowledgement of tobacco industry interference on health policy-making is welcomed by PHM. The industry’s efforts to obscure, divert and delay must be exposed wherever possible, as well as its continued efforts to diversify its deadly products and market them to (often young) audiences when the evidence of their harm is stark and

indisputable. From Baseline 2014 (page 59) it is apparent that not enough countries have a policy to address tobacco industry interference.

Trade and investment agreements which give tobacco companies the power to intimidate governments

The use of investor protection provisions in trade and investment agreements, in particular investor state dispute settlement (ISDS) is acknowledged in general terms in this draft. However, the action plan does not go far enough in acknowledging ISDS as a powerful weapon in the hands of tobacco companies and other corporations whose products and services are damaging to health.

We urge the Committee to include in the Regional Action plan provision for WHO to provide advice to governments about the dangers to public health of accepting ISDS provisions in trade and investment agreements. This would be fully consistent with Resolution [A59.26](#) on Trade and Health adopted by the Assembly in 2006.

Raising taxes

Raising taxes on tobacco products is known as the most effective tobacco control intervention and it is welcomed due to its impact on reducing tobacco use prevalence and therefore the deaths and diseases caused by tobacco. However, there is room for stronger encouragement to appropriate such taxes to tobacco control and health.

PHM urges the adoption as a regional target: “70% of Western Pacific Region countries are working towards utilizing tobacco tax revenues for health promotion and NCD prevention, including tobacco control”

Women youth and marginalised groups

PHM appreciates the attention drawn to tobacco use among women, youth and marginalised groups. Tobacco use prevalence also remains stubbornly high in many marginalised populations countries throughout the world (including countries renowned for tobacco control such as Australia e.g. in the Indigenous Australian population).

The practical actions suggested are largely about reducing tobacco use in these groups without addressing the dynamics of powerlessness, alienation and exclusion.

WHO has committed to addressing the social determinants of health as a ‘cross cutting’ issue. This means naming and addressing the political, cultural and economic roots of marginalisation; not just discouraging poor people from smoking. The draft Regional Action Plan should certainly be strengthened in this respect.

Cost-effectiveness of pharmacological intervention

The cost-effectiveness of pharmacological intervention is debatable for developing countries with weaker health systems, as the costs imposed by the pharmaceutical companies are significant and the proportion of people who quit tobacco using such products is fairly small (most quit without assistance). PHM is wary that this may divert

scarce resources from other possibly more effective components of tobacco control and/or health.

Cessation through physician counselling and advice has potential wherever smokers interact with the health care system.

12. Antimicrobial Resistance

Key documents

- [WPR/RC/7](#) (Draft Action Agenda for Antimicrobial Resistance in the Western Pacific Region)
- [WPR/RC62.R3](#) (WPR resolution on Antimicrobial Resistance)
- [WHA67.25](#) (WHA resolution on Antimicrobial Resistance)

Commentary

The Action Agenda projects three priority actions and a number of implementation steps for each priority action. There is much in this Action Agenda which we applaud. The following areas need to be strengthened.

Animal husbandry

The use of antibiotics as growth promoters in animal husbandry needs to be phased out and tight controls placed on 'prophylactic' and 'therapeutic' use. This should include restricting the group medication of animals for disease prevention and shifting away from livestock production practices known to drive antibiotic use such as early weaning, inadequate sanitation, or inappropriate diets.

Hospitals should take a leadership role in procuring food produced without routine use of antibiotics, as part of building awareness and market pressure, for food to be produced without the routine use of antibiotics. Likewise, meat and fish products should be labelled so that consumers can choose to give preference to products which do not involve the irresponsible use of antibiotics.

Waste water treatment

The pollution of the environment via livestock waste, sewage, industrial meat processing waste, and hospital disposal needs to be monitored and controlled. Hot spots for horizontal resistance gene transfer such as in wastewater treatment facilities need to be controlled. Health ministers should work with their colleagues in infrastructure and local government to ensure a clean water supply.

Monitoring and surveillance

OP1 (10) of WHA67/25 urges MSs to (10) to develop antimicrobial resistance surveillance systems in three separate sectors: (i) inpatients in hospitals; (ii) outpatients in all other health care settings and the community; and (iii) animals and non-human usage of antimicrobials (including aquaculture).

In many respects surveillance information (in particular on drug sales) is collected but not available publicly. Prescribing and drug sales data collected by commercial organisations should be made public.

Medicines procurement, regulation and reimbursement

Medicines regulation, including tighter controls over antibiotic prescribing and sales, is critical. Commercial promotion of antibiotic use to physicians and veterinarians should be banned. Likewise over the counter sales and direct to consumer advertising should be banned. This needs to be supported by adequately funded independent educational programs for both clinicians and for the public.

We appreciate the reference in Priority Action 3(1) to ‘Strengthen financing and procurement mechanisms’. In accordance with WHO’s commitment to UHC this should include public provision or reimbursement mechanisms to cover the cost of medicines, arranged in ways which do not include perverse incentives to over prescribe, nor perverse disincentives which discourage manufacturers from selling essential medicines.

Research and development

New antibiotics and new diagnostics are needed; likewise new ways of funding research and development. The challenge of AMR adds weight to the proposed R&D Treaty as well as other initiatives such as the proposed Antibiotics Innovation Funding Mechanism (AIMF) which combines the advantages of supporting innovation, eliminating incentives to overuse, and supporting transfer of technologies to insure access to medicines for low income countries (full text at <http://keionline.org/node/1832>).

The need to encourage the development of novel diagnostics and antimicrobial medicines, including through new collaborative and financing models, was recognised in OP1(8) of [WHA67.25](#), but appears to have been omitted from this Action Agenda.

Avoid investor state dispute settlement (ISDS) in trade agreements

In accordance with Assembly resolution [A59.26 on trade and health](#) (2006), the regional office should play an active role in advising Member States to avoid trade agreements which include ISDS provisions because of the risk of action to regulate antibiotic use being challenged under such agreements.

Collaboration with civil society including professional groups, organic farmers, the consumer movement and the environment movement

There are several references in the Action Agenda to public education and key stakeholders but the document does not explicitly recognise civil society networks as partners in the struggle towards a more ecological approach to bacteria.

13. Expanded Programme on Immunization

Key Documents:

- [WPR/RC65/8](#) and [updated](#) (draft Regional Framework for Implementation of the Global Vaccine Action Plan in the Western Pacific)
- [Global Vaccine Action Plan 2011–2020](#) (May 2012).
- [WPRO EPI page](#)

PHM Comment

The Draft Regional Framework for Implementation of the Global Vaccine Action Plan in the Western Pacific is comprehensive and constructive. PHM congratulates the Secretariat and various stakeholders who have contributed to the Framework.

Nonetheless, there are at least three areas that PHM would like to see given particular attention.

First, PHM believes in a stronger integration of immunisation within primary health care (PHC) and greater emphasis on systematic programs of disease prevention and control.

Functioning systems of comprehensive primary health care with appropriate programmatic support from more specialised units can play a critical role in delivering health care and addressing the social and environmental determinants of health. The PHC model envisions primary care practitioners, agencies, and their communities to advocate for health needs and take direct action in addressing community concerns. Multi-sectoral mobilisation is essential in developing comprehensive primary health care, with benefits across a broad range of health needs, including immunisation.

Building effective PHC systems also provides a platform for promoting healthier domestic environments and for implementing comprehensive disease control programs, including safe delivery (with implications for hepatitis B and neonatal tetanus).

Second, PHM calls for an assessment of the need and scope for the development of domestic vaccine production technology and technology transfer in the region.

The development of domestic vaccine manufacturing lead to less price pressures, more secure supply chains, higher quality standards, and greater flexibility as regards emergency response.

PHM urges WPRO to work with Member States in exploring strategies for such development, including but not limited to technology transfer, and to evaluate the economics of such initiatives.

Third, there is a need for capacity building regarding the methodologies and information needs involved in decision-making as to the introduction of new vaccines.

PHM appreciates the emphasis on taking local conditions into account in determining whether new vaccines should be introduced, including epidemiology, delivery capacity, and opportunity costs.

These are complex decisions that require capacity building, adequate information and technologies, and effective health governance.

14. Emergencies and Disasters

Key Documents

- [WPR/RC65/9](#) (Western Pacific Regional Framework for Action for Disaster Risk Management for Health)
- [WHA64.10](#) (WHA Resolution)

PHM Comment

PHM congratulates the Secretariat and the various experts who have contributed to the development of the draft Western Pacific Regional Framework for Action for Disaster Risk Management for Health. It is comprehensive and practical.

The region is prone to health threats from emergencies and disasters. The rising occurrences of typhoons, earthquakes, tsunamis, and floods have resulted in enormous loss of life, with serious health, social, and economic consequences.

In reference to resources under Section 6.4, the discussion does not convey the urgency of ensuring that adequate resources (finance, people, supplies and logistics) are available when needed. This is certainly not the case in the Secretariat of WHO.

According to the [final report of 2012-2013 Programme budget](#), income on Emergencies and Disasters for the WPR was USD 6.7 million, USD 1.8 million less, or a 26.9% decline,

compared to the allocated for the biennium. The issue appears to be the lack of assessed contributions for this item as the USD 1.1 million represents only 12.9% of the allocated funds. The rest was secured from voluntary contributions.

WHO reports that it did not meet the objective RER 05.001.WP01: Establishment and implementation of national health emergency risk management plans and WHO readiness plans (p66), as “*Limited resource allocation in disaster risk management for health at both national and international levels was a major constraint...*” Yet, it is worth noting that USD 22.5 million of the allocated voluntary contributions was not spent in the 12/13 biennium.

PHM also believes that recent experience with the responses to the devastation wrought by Typhoon Haiyan may provide key lessons in the operational practicability of the framework. The adequacy of the immediate response needs to be reflected in the status of the affected populations. Almost a year after Typhoon Haiyan, there are still many affected communities living in temporary shelters like tents and remain vulnerable to subsequent disasters that visit them.

Lastly, PHM urges Member States to commit to lifting the freeze on assessed contributions and to untie earmarked donations. At the same time, PHM calls on Member States to ensure transparency in the use of such funds so as to insulate these from local political interests.

15.2 Tuberculosis

Key Documents

- [Regional Strategy to Stop Tuberculosis in the Western Pacific \(2011–2015\)](#)
- [WPR/RC6510](#) (Secretariat reports on progress on TB)
- [WHA67.1](#)
- [Stop TB website](#)

PHM Comment

PHM commends the laudable progress in the prevention, care, and control of tuberculosis beyond 2015. The Global Strategy has allowed Member States to address various aspects of TB, from access to medication to surveillance, from multi-drug resistant and extremely-drug resistant TB to the multi-sectoral and comprehensive approach.

In the regional context, PHM calls for the Regional Strategy to promote substantial changes, especially as regards the social determinants of health. The Regional Strategy can provide Member States the opportunity to creatively approach TB through

integration: coordinated health systems that simultaneously involve multiple programs, stakeholders, and initiatives in a continuum of concerns.

PHM also calls on the WHO to:

- Ensure that the implementation of the Regional Strategy is anchored in a Primary Health Care-oriented approach, with inter-sectoral and participatory processes;
- Strengthen the use of human rights instruments to ensure the right to health, including the right to diagnosis, treatment, and care, and to promote accountability measures that will prevent barriers to access and treatment;
- Include measures that will address the social and political context whereby vulnerable groups like migrants, indigenous peoples, and refugees are exposed to TB and are able to access prevention and treatment; and
- Promote innovative mechanisms for funding of research and development of diagnostic and therapeutic products

The [draft programme budget 2016-2017](#) (p3) suggests a scaling down of activities at country level. TB will see a decrease in financing of 10% from the approved 2014/2015 budget to 117.2 million (p10). As PHM believes that TB programmes should be fully in the public sector, such scaling down may be detrimental to inroads and initial success gained.

See [PHM note on Item 12.1](#) from WHA67 where this was discussed.

15.4 Noncommunicable diseases

Key Documents

- [WPR/RC65/10](#) (Progress report on Noncommunicable diseases, p9)
- [WPR/RC64.R6](#) (WPR resolution on Noncommunicable diseases 2013)
- [Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases \(2014–2020\)](#)
- [RC report to EB134](#)

Comment

The progress report (Item 15.4) reveals action across a range of fronts. The Secretariat and partners and Member States are to be congratulated for progress achieved although we agree that 'efforts to combat noncommunicable diseases (NCDs) have been insufficient to curb the epidemic'.

We wish to draw the attention of the Committee to four key issues which need continuing attention.

Conflict of interest

Widespread concern regarding the influence of big pharma, big food and big beverage on WHO and UN policy making around NCDs points to the importance of ongoing attention to conflict of interest and managing the risk of improper influence in relation to NCDs policy making and implementation.

Trade and health policy coherence: dangers of ISDS

Among the proposed functions of the Global Coordinating Mechanism is “Advancing multisectoral action: Advance multisectoral action by identifying and promoting sustained actions across sectors that can contribute to and support the implementation of the WHO Global NCD Action Plan 2013–2020”.

In this context we congratulate the Pacific Islands Forum for bringing together economic and health ministers in July this year to consider amongst other things the challenges of NCDs.

PHM urges that particular attention be paid to the dangers of investor state dispute settlement provisions (ISDS) in new trade agreements such as the Trans Pacific Partnership (TPP) which several members of this Committee are currently negotiating. These provisions provide a powerful weapon in the hands of transnational corporations to intimidate governments, including when they are contemplating regulatory or fiscal action to control NCDs.

Rheumatic heart disease

Rheumatic heart disease (RHD) is a neglected NCD of the Pacific. The burden of RHD in the Pacific has been increasingly well documented over the last decade, and is comparable only to rates in Sub-Saharan Africa. Register based control programs have been seeded by philanthropic and development funding (AusAID and NZAID) in Fiji, Samoa, Tonga, Nauru, Kiribati, Papua New Guinea and the Solomon Islands. The burden of advanced disease throughout the Pacific is considerable.

There has been a number of engagements by WHO at a regional level, leading to the development of a Pacific RHD White Paper in collaboration with WHO South Pacific Office, World Heart Federation, and academic centres. The document will review all 21 Pacific Island countries and territories (PICTS), and look at successes, challenges and gaps in RHD control and prevention. The Pacific RHD white paper will present recommendations for integrated management of RHD as a model guide, with a focus on NCD programs and include recommendations for integration with other regional and national strategies such as child and reproductive health, infectious diseases and integration of RHD activities through WHO NCD Package for Essential Interventions (NCD PEN). The white paper will provide a platform for ongoing engagement with key regional and international stakeholders to advocate for the prioritisation of RHD.

We call on member states to amplify efforts in rheumatic heart disease (RHD) prevention and control. RHD is a neglected NCD of the Pacific. We emphasise the importance of primary health care in relation to RHD prevention and control throughout the region.

Health system strengthening

PHM urges continuing attention to the crucial importance of strong health systems based on comprehensive PHC for the treatment and control of NCDs.

15.7 Nutrition: The double burden of malnutrition in the Western Pacific Region

Key Documents

- [WPR/RC65/10](#) (Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region 2015–2020)
- [WPR/RC63.R2](#) (Scaling up Nutrition in Western Pacific Region)
- [Trade, Trade Agreements and Non-Communicable Diseases in the Pacific Islands: Intersections, Lessons Learned, Challenges and Way Forward](#)
- [WPRO media release](#), [IDLO note](#), and Sydney Law School [report](#) (April 2014 consultation on overweight, obesity, diabetes and law).

PHM Comment

It is clear that the WPRO has taken its mandate seriously in this area and has undertaken a range of projects and activities directed to addressing the double burden of malnutrition.

The Action Plan presents a balanced and comprehensive approach to the double burden. The six guiding principles and approaches and the five objectives provide a strong platform for the countries of the region and the regional office.

Implementing the actions proposed under the five objectives will require resources, expertise, persistence and political will. Some of the actions will be opposed by powerful stakeholders.

PHM calls upon ministries of health, professional associations, and civil society organisations to commit actively to the success of the Plan.

15.8 Universal Health Coverage

Key Documents

- [WP RC65/10](#) (Progress Report on UHC)
- [World Health Report of 2010](#).
- [Resolution 64.9](#) (WHA Resolution 2011)
- [Health systems financing: the path to UHC: Plan of Action](#)
- [A66/24](#) (Secretariat Report 2013)

PHM Comment

The focus of WHO documents on universal health coverage (UHC) has been on removing financial barriers to access and in preventing illness-induced poverty by reducing catastrophic health expenditure. Various WHO documents have emphasised the abolition of user fees, funds pooling, single payer, quality of care, efficiency, and Primary Health Care in the drive for UHC.

However, WHO has refrained from providing clarity as regards the institutional mechanisms through which universal cover is to be achieved. Conspicuously absent is the debate between advocates of publicly-funded and publicly-delivered health care and those of the stratified public-private models supported by the World Bank and USAID.

The continued freeze on assessed contributions to WHO has forced the Secretariat into dependency on its donors, such that the WHO welcomed greater cooperation with the WB in the 67th WHA. The WB is known to promote health initiatives with greater private sector involvement and scaling-up of health insurance schemes, often at the expense of public interest.

Hence, while Member States exert effort to fulfil UHC goals, the UHC mantra should not be used as a rationale for the greater privatisation of health care and vertical fragmentation of health systems. Like the WHO, developing countries with limited resources should be insulated from having to subscribe to policy directions of donor institutions.

PHM's position is very clear. The [People's Charter for Health](#) (2000) demands "that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access". More recently Amit Sengupta has critically reviewed the debates around UHC ([here](#)).

See [statement delivered to WHA66 \(2013\) on UHC](#) on behalf of MMI and PHM.

16. Coordination of the work of the World Health Assembly, the Executive Board and the Regional Committee

16A. Strategic Budget Space Allocation

Key documents

- [WPR/RC65/11](#)

Commentary

The Committee proposes a further shake up with respect to terminology. Under GPW11 resources were allocated by ‘strategic objectives’. Under GPW12, WHO moved to ‘categories’ and ‘programmes’ and now the Committee proposes moving to ‘segments’ which do not map easily onto ‘categories’. The transaction costs of these kinds of changes are considerable and would require some confidence that they carried real benefits.

At this stage, the methodology used by the Secretariat for PB16-17 appears more practical than the very limited proposal now being considered.

Overshadowing the challenge of budgeting methodology is the overwhelming problem of donor dependence associated with the freeze on assessed contributions. With this comes competition between clusters, departments and regions for donor attention. The funding dialogue, and the strategy of treating line items in the budget as a fixed ceiling regardless of donor willingness, will not solve the divisive effects of competition for donors since clusters and regions still face the possibility of budgeted line items being under-funded.

PHM urges the Regional Committee to be cautious in encouraging the PBAC process which could lead to more churning but less progress.

We urge the Member States to commit to a significant increase over the current level of assessed contributions. We urge the donor states to untie their voluntary contributions.

16B. Framework of engagement with non-State actors

Key documents

- [WPR/RC65/11](#)
- [A67/6](#)

Commentary

PHM shares the concerns of many Member States raised at WH67 (as reported in [WPR/RC65/11](#) from p41). However, we particularly wish to draw Member States attention to the following issues.

Operational practicability

The proposed procedures are extraordinarily complex. There are four specific policies in [A67/6](#) that deal with four types of non-State actor, which detail specific policy provisions for each type of interaction. The challenge of monitoring the compliance of WHO staff with the provisions of these policies is even more complex.

The complexity of these procedures has implications for their operational practicability and the transaction costs involved in their implementation.

Learning from the past: the role of judgement and culture as opposed to bureaucratic protocols

There have been several incidents of real or perceived improper influence in recent years, including for example: the International Medicines Product Anti-Counterfeiting Taskforce (IMPACT) debate (see Third World Network report [here](#)), Paul Herrling and the Expert Working Group on Financing and Coordination (see Third World Network report [here](#)), virus sharing in the context of PIP, the management of the H1N1 outbreak (see [A64/10](#)) and the case of psoriasis at EB133 (see WHO Watch report [here](#)).

These provide real life cases for testing the comprehensiveness and practicability of the Secretariat's proposed policy package. It is hard to see the complex bureaucratic protocols envisaged in A67/6 protecting WHO from the risks arising from any of these episodes.

In all of these cases the risks to WHO were self-evident. What was missing was the culture of integrity and the assurance of organisational support for officials who might resist the pressures to place the Organisation at risk.

The accountability of Member States for protecting WHO's integrity

The proposed protocols say nothing about the accountability of the Member States for protecting WHO's integrity. However, in several of the above cases particular Member States were involved in initiatives which created risks for the integrity and decision making of the Organisation.

In a situation where departments and units depend on voluntary donations for their survival and regions and clusters depend on voluntary donations for their effectiveness, there are powerful incentives on WHO staff to overlook the risks to the Organisation as a whole arising from particular initiatives, if those initiatives promise much needed resources for those groups.

We urge the Regional Committee to explore ways of strengthening the accountability of individual Member States in terms of defending the integrity of WHO.

We urge the Regional Committee to adopt a strong position regarding the need to increase assessed contributions and untie earmarked voluntary donations.

'Patient groups' funded by pharmaceutical companies

It is unclear how the Secretariat plans to handle 'patient groups' funded by pharmaceutical companies. The draft framework appears to deal with this by stating that NGOs can be considered as private sector entities if the "level and funding are such that the non-state actor can no longer be considered as independent of funding private sector entities".

Member states asked for explicit process and criteria - the revised framework, however, does not make it clear how WHO will determine an NGO "independent" or unduly influenced by private sector funding sources, nor criteria it will apply, or whether this process of assessment will be transparent.

Entities with which WHO will not deal

Paragraph 13 (p43) should also include: manufacturers of unhealthy foods and beverages, which are increasingly being linked to obesity and NCDs; violators of the International Code of Marketing of Breastmilk Substitutes; agri-chemical industries whose products have been implicated in diseases like cancers, and industries involved in labour law violations and environmental damage.