



Issues for consideration at the 130th Session of the WHO Executive Board

Distinguished Members of the Executive Board of WHO,

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 WHO Executive Board. We hope that you may find time to read and consider these comments before the relevant discussions at the EB. 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.

However, WHO does not make it easy for civil society NGOs to contribute to its consideration of the issues coming before it.

It limits the number of organisations which have an official relationship with WHO and has recently restricted access to spaces in the Palais de Nations during the WHA. You may also know that civil society organisations have to submit their statements 24 hours before they are delivered. This rule often results in the statements getting censored, refused altogether, or, the least, rendering these interventions of little use for Member States, being written long before their deliberations.

Over the last week members of the PHM WHO liaison group have been working through the EB Agenda with the assistance of high level experts from a number of collaborating networks and NGOs. This workshop was part of our 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, and specifically for this EB meeting at: www.ghwatch.org/node/448)

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

PHM Comments on Various Agenda Items

5. WHO Reform

5.1 Programmes and priority setting

Secretariat Note

Document EB130/5 Add.1 covers the following elements: (a) current criteria and mechanisms for priority setting; (b) description of current activities carried out at headquarters, regional and country level; (c) description of the application of criteria and priorities to planning and the impact; (d) proposals for how criteria and priorities could be set and applied in the future; (e) detailed proposal, with a timeline, for the Member-State-driven process; and (f) proposals for a timeline for development of the programme budget and general programme of work for the period 2014 onwards.

PHM Comment

We are of the view that the EB should focus, at this point in time, on the process and mechanism of priority-setting rather than agreeing on specific priorities.

In paragraph 4 the document states that *“priority setting cannot be tackled in isolation”*; that *“priority setting is linked to resource allocation”*; and that *“resource allocation is also linked to funding modalities”*. This goes against the calls raised by several developing countries in the EBSS in November 2011, which noted that priority-setting should be informed by the mandate of the WHO and that financial constraints should not be the only thing that drives priority-setting.

The document places *“individual country needs”* as the starting point of the next general programme of work and programme budget (paragraphs 8 and 9), noting that this *“reflects a significant change from current practice”*. We welcome this approach, keeping in mind cost and practicality.

The concept of country groupings or *“typologies”* has been introduced, based on common priorities to be addressed. Paragraph 12 states that *“typologies or groupings of countries have been developed as a way of getting a better match between country needs and WHO’s collaboration”*. While we welcome this concept, we are of the view that the idea of grouping countries in just 5 proposed categories (Countdown countries; Small island developing States; Countries in fragile circumstances; Newly industrialized and middle-income countries; OECD market economies) is simplistic (as country circumstances change), and almost entirely based on economic variables. Priority-setting is neither *“free size”* nor *“one-size-fits-all”*.

Moreover, the concept of country groupings could be better applied within regions, rather than across regions. Small country aggregates can be identified, based on common concerns, within every single wider region. Empowering regional offices, and decreasing the level of centralisation in the WHO are prerequisites to these regional and sub-regional groupings.

It is worrisome to see the demand-led approach for priority-setting portrayed as a challenge, and that development agencies within governments, which are “major financiers of WHO’s work”, presented as the solution. Paragraph 13 mentions that they “express needs in terms of WHO’s support to furthering the objectives of their aid programmes in specific low-income countries”. This allows donor countries the opportunity to inordinately interfere in the sovereign domain of developing countries for health policy making and implementation. There is currently evidence of huge burden faced by developing countries in having to monitor, evaluate and report about funding to multiple donors in order to satisfy their requirements.

A more participatory process is needed, rather than immediately identifying fixed core priority areas to be applied to all Member States. The seven core areas of work (explained in paragraph 16) are quite broad and fairly comprehensive; however, the process of arriving at these priorities is not clear, and may not reflect the actual priorities of many Member countries.¹

There is currently a disconnect between priority setting and the allocation of resources, a fact recognised by paragraph 24:

“Clear Organization-wide priorities will promote better alignment between WHO’s objectives and voluntary funding. Furthermore, the transparency achieved through open pledging, as part of the proposed approach to increasing predictable financing (see document EB130/5 Add.5), should create a closer link between the responsibility for setting priorities and the responsibility for ensuring that they are adequately resourced.”

We are faced with the question of whether open pledging is the financing mechanism that will facilitate a better match between priority setting and resource allocation in future. The capacity of the donors to pick and choose which elements of the programme budget they will support remains unchanged. Moreover, the idea of country-driven priority setting is often neutralised by the multitude of vertical disease-focused programmes, driven by Global Public-Private Partnerships (GPPPs) which influence resource allocation within country offices. The success of any new mechanisms for prioritisation will depend upon addressing the distortions of resource allocation arising from tied donor funding.

The autonomy and independence of regional offices have to be emphasised, so that the WHO’s work is of more relevance to individual country needs and priorities. The ratio for resource allocation between the regions and the headquarters should be 70:30 (according to paragraph 26). In the resource allocation section, there are few positive elements related to increasing the autonomy of regional offices, and allocating resources to countries based on their individual needs rather than on regional allocations. But at the same time, member states need to examine whether the whole project of prioritisation is illusory, and whether the problem -- in larger measure -- is an issue of resource allocation for programmes being linked to donor driven priorities.

¹ Paragraph 16 states “An analysis of 140 country cooperation strategies and recent discussions of the needs of the different types of countries listed in paragraph 12, suggest that, taken together, country needs fall into a limited number of categories, in spite of the diversity presented by 194 Member States. Indeed, when country need is taken as the main driver of priority setting, the organizing structure for WHO’s work needs fewer categories – not more”.

5.3 WHO Governance (EB130/5 Add.3)

Secretariat Note

Document EB130/5 Add.3 is the first of two documents on governance reform, and it deals with the following four items from the decision EBSS2(2):

1) Revised terms of reference of the Programme, Budget and Administration Committee of the Executive Board; 2) Revised timelines for meetings of the governing bodies; 3) Linkages and alignment between Regional Committees, the Executive Board and the Health Assembly and harmonization of Regional Committees practices; and 4) Streamlined national reporting using modern tools.

PHM Comment

1. The Board is asked to approve the revised terms of reference of the Programme, Budget and Administration Committee (PBAC). The terms of reference of the PBAC listed in the Governance document are very general. Intergovernmental ownership of the PBAC's role is relatively weak, and the reform process would be a good opportunity for the body to be more open and transparent, and more engaged in a dialogue with the WHA, to which it addresses comments and recommendations. Is there any opportunity for WHA delegations to ask questions and raise issues to the PBAC on such key issues as programme planning, monitoring and evaluation; and about financial and administrative issues? The paper EB 130/5 Add. 3 does not seem to convey that such space for dialogue and interaction exists. Everything is filtered through the Executive Board.

An added concern is that discussions in the PBAC are not open to participation by civil society, thus closing access to a key area of WHO's functioning.

The WHA should approve the revised ToRs of the PBAC, only after the proposed new functions regarding monitoring and evaluation of programmatic and financial implementation at the three levels of the WHO are supported with a shared rationale, put in perspective, and better explained to ALL member states.

2. The paper provides information about dysfunctional timelines currently in place at the WHO. The delay with which documents are submitted to Member States is a major problem. This makes it almost impossible for delegations to read through the documents with any degree of in depth analysis, let alone consult with capitals if need be. If the quality of member states participation in the debates and negotiations in the WHO is to improve, for the enhancing of the agency's democratic exercise, it is necessary to set time frames that allow delegates to absorb the contents and proposals contained in the documents -- and hence the shift in timelines suggested needs to be supported.

3. Increasing linkages between regional committees and the global governing bodies and harmonization: There is a clear need to link, more effectively, the various organs of the WHO into a more functional and efficient body, across different level of the organization. However, increased harmonization across regional committees is insufficient without enhanced transparency on criteria for elections, participation, and the rules governing the meetings and

the decision making processes.

4. Streamlining national reporting: the paper provides background information related to the reporting requirements in the WHO constitution. A situation analysis would allow a better understanding of a possible deficient performance by member states, including the need for reporting to an increasing variety of actors present in countries and working on health issues. Reporting formats need to be user-friendly and easy to access.

5.4 Governance: promoting engagement with other stakeholders and involvement with and oversight of partnerships

Secretariat Note

The document (EB130/5 Add.4) provides a review of the different stakeholders with whom WHO engages and recommends a more detailed review defining more clearly the different kinds of stakeholders and developing more appropriate procedures for accepting organisations into official relations.

The paper recommends close attention to WHO's relationship with for-profit organisations, philanthropies and global public-private partnerships (GPPPs) with full consideration of conflict of interest provisions.

PHM Comment

While we welcome the timely review of WHO engagement with other stakeholders, we remain concerned about the following points:

1. Lack of a clear definition of the term “global health partnership”

There is a need to question whether the increasing number of partnerships with private actors, that the WHO is today involved in, addresses public interest.

We welcome the proposal of developing “*comprehensive policy frameworks to guide interaction with the private, for-profit sector as well as not-for-profit philanthropic organizations*”. However, we call for a clearer and binding definition, based primarily on public interest, of the term “global health partnership” that is becoming a common model of interaction between WHO and non-state actors.

Paragraph 12 states that “*No specific provisions exist in the Constitution that govern WHO’s relations with private for-profit organizations; not-for-profit philanthropies and public-private partnerships.*” PHM cautions against possible negative consequences of global health partnerships which often deprive the WHO of independently managing funding for public interest.

2. Civil society engagement at country level

In paragraph 14 (a), the document states that “*The review will consider widening and improving the modalities for the participation of nongovernmental organizations at regional and global governing body meetings*”. However, it fails to mention civil society engagement at country level which is critical for accountability and effectiveness.

3. Lack of distinction between PINGOs and BINGOs

The entire document does not mention any distinction between public-interest NGOs (PINGOs) and business-interest NGOs (BINGOs). Not recognizing the different natures of these organisations' interests raises concerns about the influence that widening engagement with other stakeholders can have on priority-setting and decision-making at the WHO.

4. A need for an explicit policy on institutional conflict of interest

The document does not effectively address issues related to the safeguarding and management of conflict of interest (paragraphs 5 and 14).

We call for setting up a comprehensive and detailed policy framework on conflict of interest, along with continuous institutionalised impact assessment of this framework, with the aim of securing the independence of the WHO.

5. A need for mapping and analysis of partnerships

Recognizing the important role of the EB in overseeing and guiding the dialogue on partnerships, we recommend that the next stage of this process should be a mapping and analysis of all partnerships. Such an exercise should be conducted with a focus on examining the purpose, strategy, and cost effectiveness of partnerships, as well as their compliance with the WHO Constitution and workplan. The result of this exercise should be made available to the public.

5.5 Managerial reform: making WHO's financing more predictable

Secretariat Note

Document EB130/5 Add.5 is a response to the request of the EBSS to develop a detailed proposal, for mechanisms to increase predictability of financing and flexibility of income, which supports priorities set by Member States.

PHM Comment

The paper recognises that an increase in assessed contributions is *'one way of addressing'* the mismatch between member state priorities and available resources, including earmarked resources but suggests that *"in the current economic environment' this is unlikely to happen"*. This is unconvincing. If a certain amount of funding is available through earmarked donations, the same amount could be available through untied payments, either donations or assessed contributions. The more fundamental problem is the insistence of the donor countries on using tied funding to control WHO generally and to impose their agenda on the Organisation.

The Secretariat paper seeks to improve predictability of funding of WHO by establishing a (1) rigorous priority setting process and programme budget; then proceeding to a (2) 'financing dialogue' with donors including a pledging conference, and then (3) stronger monitoring of results.

The pledging conference, it is proposed, will be open to all member states and NGOs in official relations. Donors will be urged to increase the flexibility of their donations either by untying their donations entirely or tying their donations to higher-level strategic components of

the programme budget. It is emphasised that the financing dialogue will take place after an inclusive process of member state driven priority setting and after the programme budget has been agreed upon. It is argued that this will be a more transparent process than the present practice of bilateral negotiations between donors and the WHO. However, we would like to point out that the **'pledging conference' model does not diminish the capacity of the donors to pick and choose the elements of the programme they would want to support.** The report's suggestion that showcasing the general trends will encourage donors to disburse funding to neglected areas remains to be proven. The model suggested, thus, while an advance over previous procedures is **not devoid of serious risks – principally that of entrenching donor control over the WHO.**

The present regime of earmarked funding has been widely acknowledged as being responsible, in large measure, for weakening WHO. **It is imperative that Member states work to build mechanisms that ensures adequate untied funding of WHO, including an increase in assessed contributions and the conversion of tied donor funds into untied donations.** It is unfortunate that the urgent need to move to a much higher proportion of completely untied funding, voluntary and assessed contributions, was not acknowledged by the EBSS Decisions.

The implications of donor budget control can be best understood in areas where the interests of the donor countries run counter to the health needs of people. For example, such a contradiction concerns intellectual property rights where the interests of donor governments are more closely aligned with the interests of transnational pharmaceutical companies than with the goals of access to medicines, innovation for priority needs and rational use of medicines.

The current regime of relying on cross subsidization to meet shortfalls in program support costs has grave implications for the already shrinking core budget. We are concerned about the lack of clarity in how the secretariat will conduct the targeted resource mobilization activities to fill the remaining gaps after the pledging conference.

5.7 Managerial reforms: clarifications on proposals for enhancing organizational effectiveness (EB130/5 Add.7)

Secretariat Note

Document EB130/5 Add.7 comes as a response to the EBSS request for clarification on the proposals with respect to: 1) enhancing networks and relationships between the WHO regional offices; and 2) enhancing the capacity for effective resource mobilisation at country level.

PHM Comment

In the first section, the document discusses different types of relationships and strategic groupings between countries across regions, primarily among developing countries. We welcome these initiatives, particularly as they enable South-South cooperation and exchange of knowledge and relevant experiences between developing countries. The Secretariat should provide some level of formality to these country groupings, and not necessarily stick to regional divisions.

Such Member States initiatives in creating country groups would substitute efforts required from the WHO Secretariat to find the most appropriate ways to appropriately pool countries together across regions. Member States should urge the Secretariat not to stick to the rigid

regional division of countries and encourage this flexibility of country pooling.

The second section reports on resource mobilisation. There is mention of the increasing opportunities for mobilisation of domestic philanthropic resources (paragraph 10.5), and of developing of a strategy to approach donors at country level. It has to be noted here that raising adequate funds at country level is not possible everywhere. It is very likely that seeking funding from the private sector could be the easy option, simply because in low-income countries this is where a sustainable flow of resources is better guaranteed. It is very common now to see heavily-funded campaigns against diseases being supported by pharmaceutical companies, often in collaboration with ministries of health. That said, we caution against undue influence of the corporate sector, particularly the pharmaceutical industry in developing countries.

It is surprising that the document does not refer to resource mobilisation at regional level, which is very relevant for some regions. Regions where there is a large variety in economic situations can benefit from flow of resources between its countries. We encourage Member States to explore this option.

5.8 WHO Evaluation Policy (EB130/5 Add.8)

PHM Comment

EB130/5Add.8 responds to the request by the SSEB in Nov 2011 to prepare a draft formal evaluation policy.

The draft evaluation policy submitted by the Secretariat is very disappointing. While stating that the purpose of the policy includes fostering a culture of evaluation across the Organisation, the evaluation paradigm described is top down and summative in orientation with an insistence that the evaluation function be owned by the Office of Internal Oversight Services.

The concept of formative evaluation - evaluation undertaken by program managers and implementers with a view to guiding implementation - is completely absent from this draft policy. This runs counter to the idea of embedding evaluation within the organisational culture. The image of the organisation implied in this policy is very hierarchical with evaluation results reported to the top and learnings from evaluations dictated downwards.

The draft evaluation policy set out principles and norms for evaluation, including principles of impartiality, independence, quality and transparency. It is important that a strong commitment be made that the evaluation plans, reports, management responses and follow up reports will be placed in public domain.

Principles and norms proposed in the report are silent as regards conflict of interest management. Conflict of interest issues also need to be addressed as regards evaluators who shall be contracted.

The policy refers to a global working group on evaluation however it is silent on the structure and composition of the working group. It is important that the policy spell out the composition and structure of the global working group.

5.9 Managerial reform: evaluation (EB130/5 Add.9)

Secretariat Note

PHM Comment

An important rationale for conducting an independent evaluation is that it would provide valuable inputs to the WHO's reform process. This was the reason why the EBSS had decided that the first stage of the evaluation would examine existing information with a focus on financing challenges for the organisation, staffing issues and internal governance of the WHO by member. However, the Secretariat has already proceeded with plans for the reform in all three areas without waiting for the outcome of the independent evaluation. We urge Member states to make sure that reform in the above areas awaits the findings of the independent evaluation.

The scope of the first stage evaluation is limited and is supposed to also propose a roadmap for the second stage of the review. Instead of leaving the scope of the second stage entirely undecided, it is important for Member countries to provide a broad direction regarding the scope of the second stage of independent evaluation. Inter alia, the second stage should examine WHO's programs, and analyse the impact of the involvement of different actors -- including the private sector, various partnerships, etc. The program and priority setting activities need to await the findings of the second stage of independent evaluation.

Till date, there is no consensus as regards the choice of agency that would carry out the independent evaluation. Three options are doing the rounds: the UN Joint Inspection Unit, WHO's External Auditor and an external consultant. An external consultant aligned to private sector interests should not be considered as an appropriate agency, given that this could create conflict of interest issues.

The evaluation exercise should be carried out in a transparent and participatory manner. An opportunity should be given to Member States and other interested entities to participate in the evaluation process. The inputs of Member States and others should be available in the public domain and a web based hearing can be organised in this regard.

The terms of reference for the first stage of evaluation is limited to examining whether available information is sufficient for Member States to assess WHO's financing challenges, staffing issues and internal governance. This is too narrow a mandate provided to the evaluator. It may be recalled that nowhere in the EBSS discussions was it decided that reliance would be placed only on existing information. It is important that the evaluating agency be allowed to ask for any information relevant to the three areas referred to them and conduct their independent analysis. They should not be constrained in their work by information provided by the Secretariat in a pre-decided set of documents.

All those documents necessary for the evaluation should be made available in public domain so that there is a wider and transparent ownership of the independent evaluation.

6.1 Prevention and control of noncommunicable diseases

Secretariat Note

Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (EB130/6)

Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan (EB130/7)

In document EB130/6 the Secretariat reports on the outcomes of the High-Level Meeting on Noncommunicable Diseases (NCDs) and suggest next steps for follow-up, while document 130/7 deals with the implementation of the 2008-2013 Action Plan.

PHM Comment

The outcome of the High-Level Meeting was extremely disappointing. Instead of the promised “action-oriented outcome document” in General Assembly resolution 65/238, the Political Declaration [1] is infused with elusive and vague terms. It lacks clear and measurable targets and relies on untested, voluntary solutions over binding regulations. Health was undermined by prioritising the interests of the food and beverage industries, as well as the pharmaceutical, technology, and treatment companies, over the public good. We have the following comments regarding the Secretariat’s proposed ‘next steps’ in their report to the EB (EB130/6):

Recommendations for a set of voluntary targets

The WHO Technical Working Group on NCD Targets has proposed targets to monitor progress in three areas: (1) outcomes, (2) exposure and (3) health systems. We regret that the second category does not include any targets on the social, economical or environmental determinants of health; for example the number of women using inefficient cooking stoves for indoor cooking [1 par28]. We further regret that the targets proposed under ‘health systems’ do not reflect a systems strengthening approach. Targets should include aspects that are identified as essential to innovative care for chronic conditions by WHO, such as the integrated management of chronic conditions in primary health care and the use of community health workers and peer-education programmes [2]. Equally important is to have targets to monitor the progress in accessibility and affordability of essential medicines and health care services.

We further request the inclusion of public-interest civil society organizations in the consultation process to discuss the working papers that will be prepared by the Secretariat.

Options for strengthening and facilitating multisectoral action through effective partnership

As emphasized by Dr. Chan in her opening speech for this EB we need to tackle the root causes of NCDs by a social determinants approach and whole-of-government action. We recall the 2008-2013 Action Plan in which the Secretariat promised to draw up a document *in support of policy coherence*, pointing out connections between the findings of the Commission on Social Determinants of Health and the prevention and control of noncommunicable diseases (Action Plan, objective 1). The summary of the evidence linking NCDs with socioeconomic development, poverty and the MDGs included in the Global status report mentioned by the Secretariat in EB130/7 does not serve this purpose sufficiently. WHO should provide guidance to Member States in promoting and strengthening health-in-all-policies approaches, as States have committed to do at the HLM [1 par36].

Such an approach should go beyond education, housing and agriculture to also address the structural determinants of health. We urge Member States in this regard to explicitly recognize the role of trade policies in the spread of noncommunicable disease risk factors and commit to ensure that future trade treaties do not increase such risks. [3]

We are concerned about how the terms ‘whole-of-government’ or ‘health-in-all-policies’-approach are used almost interchangeably with ‘multisectoral’ and ‘multistakeholder’ action in many of WHO’s documents; without proper distinction of their different meaning. We look forward to the results of the review and analysis of lessons learned from existing partnerships that the Secretariat will undertake. We urge to leave out the language ‘*through effective partnership*’ until this review has been performed and has proved that partnerships with the private sector are indeed serving the public interest.

We urge caution for conflict of interest when engaging with different ‘stakeholders’. Instead of establishing partnerships with industry, the UN and WHO need to put up firewalls between their policy making processes and industry [4]. There are numerous examples of the powerful sway that the tobacco, alcohol, and food industries have over international governments and how this impedes effective health policy [4,5], not to mention the NCD Summit. While the political declaration recognizes the fundamental conflict of interest between the tobacco industry and public health [1 par38], it remains silent on the interests of the food and beverage industries, as well as the pharmaceutical, technology, and treatment companies. We urge WHO to develop a code of conduct that sets out a clear ethical framework to identify and address conflicts of interest, eliminating those that are insurmountable and managing those regarded as acceptable after a thorough risk/benefit analysis, using Article 5.3 of the FCTC as example. This code of conduct and ethical framework should differentiate clearly between **no involvement in policy development and appropriate involvement in implementation**. We urge this code of conduct to be mandated at the international UN level [6].

To our regret, the declaration contains no references to international legislation surrounding the marketing and taxation of alcohol and we urge for the development of a global legal framework for alcohol, following the example of the FCTC.

Pharmaceutical companies are being viewed as active partners in the process of tackling NCDs. It is of paramount importance that conflict of interest issues be kept in mind while pursuing such an approach. It is in the interest of pharma companies to press for a medicalized approach to the tackling of NCDs. It is imperative that principles are put in place that promote the rational use of medicines, and the use of standard treatment protocols. The issue of access to treatment and Intellectual Property Rights need also to be addressed in a framework that allows the full use of TRIPS flexibilities as reiterated in the Doha Declaration of 2001.

An updated Action Plan for 2013-2018

Overall, we are deeply concerned about the way in which noncommunicable diseases are dealt with by the 2008-2013 Action Plan. The strategy of identifying risks and expecting individuals to change their behaviour to minimize their exposure has proved inadequate [7,8]. Genuine choice and an ability to modify risks depend on living conditions and access to resources. **Focusing only on four diseases risks increasing inefficient vertical disease programming, while there is an urgent need to strengthen health systems to deal with chronic conditions overall** [2].

We urge the WHO to develop a framework to guide countries in adopting a health-in-all-policies approach, addressing the social determinants of health instead of only four risk factors. Efforts should be made to look for synergies with other global health and development challenges, for example climate change [9,10]. Responses should be framed around health

systems strengthening for all chronic conditions (including the presently targeted NCDs, mental health, disability, HIV/AIDS and TB) instead of vertical programs targeting only 4 diseases².

References:

1. Political Declaration of the UNGA High-Level Meeting on NCDs. Available at: http://www.un.org/ga/search/view_doc.asp?symbol=A%2F66%2FL1&Lang=E
2. WHO (2002) Innovative Care for Chronic Conditions: Building Blocks for Action. Available at <http://www.who.int/diabetesactiononline/about/iccreport/en/index.html>
3. Labonté R *et al.* (2011). Framing international trade and chronic disease. *Globalization and Health* 7:21. <http://www.globalizationandhealth.com/content/7/1/21>
4. Cohen D (2011). Will industry derail UN-Summit? *BMJ*;343:d5328
5. Gilmore A and Fooks G (2012). Global Fund needs to address conflict of interest. *Bulletin of the World Health Organization*;90:71-72.
6. Lincoln P *et al* (2011). Conflicts of interest and the UN high-level meeting on non-communicable diseases. *Lancet* Volume 378, Issue 9804, Page 6.
7. Rasanathan K and Krech R (2011). Action on social determinants of health is essential to tackle noncommunicable diseases. *Bulletin of the World Health Organization*;89:775–776
8. Kickbush I (2006). Health and Wellbeing. In: *Constructive Conversations about Health* (ed. Marshall Marinker) Radcliffe 2006 pp31-40
9. WHO Health in the Green Economy Initiative, presented at the World Conference on the Social Determinants of Health, Rio, Brasil (2011) Available at: http://www.who.int/hia/dora_wcsdh_green_economy.pdf
10. The health benefits of tackling climate change: An Executive Summary for The Lancet Series. Available at: <http://www.thelancet.com/series/health-and-climate-change>

² For a more detailed analysis of the international policy response to NCDs, please consult the website of the WHO Watching project of the People’s Health Movement <http://www.ghwatch.org/who-watch/topics/ncd>

6.2 Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

Secretariat Note

The report in document EB130/9 is presented on the current global situation with regard to mental health, outlining the main challenges and priorities in this area and the possible approaches to meeting them. The report summarises the magnitude of the global health problem presented by mental health. It refers to the global burden of disease (GBD) associated with mental health diagnosis; the mortality risk including the risk of suicide; the particular risks associated with humanitarian emergencies; the inequalities in access to services; and the social impact of mental illness.

The document invites Member States to provide further strategic guidance.

PHM Comment

PHM has the following three points to highlight in response to this document:

1. The need for a broader perspective

The first chapter of the document summarises the magnitude of the global health problem presented by mental health; however, it is silent with respect to the social determinants of mental health. As other non-communicable diseases (NCDs), mental health is influenced by socio-economic inequalities. Indeed, the propensity for mental disorders reflects the interaction between genes and environment although the relative roles of these two factors differ across different situations.

2. Separation between medical and social sector

The report substantially reflects a medical, specifically a psychiatric, perspective with a focus on medical treatment of mental disorders and little attention is paid to the longer term rehabilitation and community support functions. The separation of psychiatric and social services could represent a huge risk in terms of policy making and could deeply undermine the effectiveness of mental health programmes. A comprehensive primary health care approach is therefore fundamental for people living with mental illnesses.

3. The increasing medicalisation of mental health

The document is also completely silent with respect to the increasing medicalisation of mental health. Numerous researchers argue that the pharmaceutical industry is emerging as one of the major “engine” driving medicalisation if we consider for example the aggressive marketing of psychotherapeutic drugs, especially for depression. The medicalisation of mental illness is having several negative consequences: a change in the public conceptions of mental illness, an increasing individualisation of social problems and a progressive dislocation of responsibility for social problems. This consequently creates a huge barrier to the development of social approaches to prevention and treatment of mental disorders.

6.3 Nutrition: Maternal, Infant and young child Nutrition: draft comprehensive implementation plan

Secretariat Note

The covering notes in document EB130/10 include the biennial report on the implementation of the International Code of Marketing of Breast Milk Substitutes. The Annex to the document gives a broad overview of the global nutrition situation, then proceeds to review the implementation of effective nutrition plans at the country level. The paper then sets out five draft targets for a comprehensive implementation plan to guide on-going monitoring and evaluation.

PHM Comment

From a PHM perspective the main weakness of this report lies in the careful and general language used to refer to some of the more contentious issues. Given the ongoing challenges of implementing the International Code on Breast Milk Substitutes it is likely that a more robust and more explicit approach to food trade, retail, marketing etc will be necessary.

In our view, the document is silent about the inappropriate promotion of baby foods (paragraph 37). A specific reference to paragraph 4 of WHA Resolution 63.23 on Infant and Young Child Nutrition should be added: “to end inappropriate promotion of food for infants and young children”.

While we view the enhancement of maternal education as important (paragraph 42), a warning should be included about food and beverage industry involvement. Corporate-sponsored nutrition education materials present an even more complex problem than straightforward advertising because they blur the boundaries between marketing and education. The Plan should refer to the WHO Recommendations on the Marketing of foods and Non-alcoholic Beverages to Children that restrict marketing, including in ‘settings where children gather’ (e.g. schools) and to ‘avoid conflicts of interest.’

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

Secretariat Note: Progress in the achievement of the health-related Millennium Development Goals and global health goals after 2015

The document (EB130/13) provides the annual report on the progress in achieving the health-related MDGs, supplemented by information on the reduction of perinatal and neonatal mortality and the prevention and treatment of pneumonia with further consideration of next steps towards goal-setting after 2015.

PHM Comment

The report indicates that some progress has been made over the last decade, but as correctly pointed out the current figures for most of the indicators continue to reflect a serious health crisis. While the specific interventions promoted to address the MDGs are important, it is also necessary to learn from the failure in many regions to achieve the targets that were set. Primarily this failure has its roots in the MDGs often being looked at as vertical targets, without adequate connections being drawn with underlying issues related to social and economic development and the functioning of health systems. For example, trade and intellectual

property policies influence the availability and affordability of medicines in developing countries, and accordingly have an adverse impact on maternal and child health.

Document EB130/13 also seeks to initiate the process of identifying global health goals after 2015. We urge Member States to identify, as priorities, not just targets but processes and determinants that need to change in order for targets for improved conditions of health to be achieved. Importantly, the focus has to be on building and sustaining integrated functioning health systems that can deliver the necessary interventions as part of their regular work and at reducing dependence on multiple funding and governance mechanisms for highly specific interventions.

6.6 Social Determinants of Health

PHM Comment

Document EB 130/15 reports on the World Conference on Social Determinants of Health held in Rio de Janeiro in October 2011. The conference was an opportunity to purposively build upon the valuable report of the Commission on Social Determinants of Health.

Unfortunately, in many ways, the Conference was an opportunity missed. The political Declaration does not break new ground and does not chart out a fresh approach to problems that are widely acknowledged as pervasive, acute and requiring urgent attention.

We urge Member Countries to consider the following as important imperatives while addressing the social determinants of health:

1. Building and strengthening of equity-based social protection systems and effective publicly provided and publicly financed health systems.
2. Use of progressive taxation, wealth taxes and the elimination of tax evasion to finance action on the social determinants of health.
3. Use of health impact assessments to document the ways in which unregulated and unaccountable transnational corporations and financial institutions on the one hand, and the global trading regime on the other, constitute barriers to Health for All.
4. Reconceptualisation of aid for health as an international obligation and reparation legitimately owed to developing countries under basic human rights principles.
5. Development and adoption of a code of conduct in relation to the management of institutional conflicts of interest in global health decision making.
6. Development of monitoring systems that provide disaggregated data on a range of social stratifiers as they relate to health outcomes.

6.9 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report on the work of the Advisory Group

Background

Document EB130/18 reports on the Pandemic Influenza Preparedness Framework Advisory Group, reflecting its deliberations during its first meeting in November 2011.

In May 2011, resolution WHA64.5 adopted the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits (PIP Framework). The PIP Framework aims at (1) to increase access to pandemic influenza vaccines and other pandemic influenza-related benefits; and (2) to ensure the continued sharing of viruses necessary for continuous global monitoring and assessment of risks for an influenza pandemic and for the development of safe and effective influenza vaccines.

This Advisory Group is mandated with monitoring and evaluating of the implementation of the PIP Framework, and provides evidence-based reporting, assessment and recommendations regarding its functioning.

PHM Comment

We would like to highlight the following points:

1. The appointment of the Advisory Group (para 3 of EB130/18)

The Advisory Group has been entrusted with a variety of important tasks including negotiating with the industry as to their contribution. Noting this, it is of utmost importance that the public as well as WHO membership have full trust in the neutrality and independence of the Advisory Group.

There is a need for full disclosure of information with regard to the membership of the Advisory Group. The WHO should be requested to make available publicly the complete CV as well as “WHO Declaration of Interests for WHO Experts” completed by the Advisory Group members, instead of the summary of declaration of interests (in APPENDIX 2), and simply stating that “no interests declared by the Advisory Group were deemed relevant as a conflict of interest matter to the work of the group in the meeting” (page 8 of EB130/18)

2. The work of the Advisory Group (paragraphs 11 and 12 of EB130/18)

(a) Transparency

It is important for WHO members to stress that the work of the Advisory Group be conducted with full transparency. For instance the process used by the Advisory Group to determine the partnership contribution should be publicly available; the methodology to be applied with the running costs of the network and how much each company will be paying bearing in mind the capacity of the company; and proposals submitted to the Advisory Group.

Member States should stress that the more transparent the discussions of the Advisory Group, the better it is for the operation of the PIP framework.

(b) Avoiding undue influence

According to paragraph 6.14.3, “The Director-General in consultation with the “Advisory Group” will further define the specific amounts to be contributed by each company as well as the

mechanism for implementation (see section 6.14.5 below). In so doing, the Director-General and the “Advisory Group” will collaborate with industry.”

However, paragraph 12 of EB 130/18 suggests that the manufacturers are the drivers behind the various proposals on partnership contributions, as it states that the manufacturers will be asked to update the Advisory Group on their proposals to define specific amounts to be contributed to the Partnership contribution of each company.

This approach is concerning because the issue of partnership contribution should be driven by the DG and the Advisory Group. They should emerge with specific proposals and then seek input from manufacturers as well as other interested members. Para 12 suggests the strong likelihood of undue influence of manufacturers on the decisions to be taken by the DG and the Advisory Group.

The Secretariat and the Advisory Group should ensure that the process it employs to determine the partnership contribution is free of any undue influence and that the process is fair, transparent and inclusive (i.e. Inviting input not only from manufacturers but also other stakeholders).

(c) *Involving Other Stakeholders*

Para 11 of EB 130/18 states that the Advisory Group will take into account input from the industry and stakeholders. It should be stressed during the EB that “stakeholders” must include public interest civil society organisations and that these organisations should be consulted at all stages of discussions by the Advisory Group.

3. Papers to be prepared by the Secretariat

It is clear that the Secretariat will preparing papers for the Advisory Group in advance of its next meeting (paragraph 13 of EB 130/18). Thus it is important during the EB to inform the Secretariat to make these papers also publicly available.

4. Other Issues

Presently the viruses are being shared without the SMTAs being signed. What we are told by the Secretariat is that the companies are being put on notice about SMTA2. It is not clear what this means. Some clarification should be sought during the EB as to whether these companies that have taken hold of the virus sample will then be required to enter into SMTA2.

The WHO should obtain some concrete commitments on benefit sharing (i.e. What the company will commit to) before sharing the virus samples with companies. It is not entirely clear what WHO is waiting for since the Framework had been finalised sometime ago i.e. in May 2011. Member states should insist that as a general practise, WHO only share virus samples with companies that have entered into SMTA2.

WHO member states should insist on full transparency with regard to the SMTAs. In particular it should be stressed during the EB that all SMTA2 executed with companies should be publicly available. It is just fair that there is full disclosure of information with regard to the type of terms and conditions that govern the third parties. Many of these terms have not been settled as such. Further information on benefit sharing arrangements with companies should also be publicly available.

6.11 Elimination of schistosomiasis

Secretariat Note: Elimination of Schistosomiasis: Report by the Secretariat

The report contained in document EB130/20 states that resolution WHA54.19 on schistosomiasis and soil-transmitted helminth infections has not attained its goal of a minimum target of regular administration of chemotherapy of at least 75% and up to 100% of all school-age children at risk of morbidity in endemic areas by 2010. The report notes progress in expanding schistosomiasis control, particularly through large-scale schistosomiasis treatment carried out in endemic countries. The Secretariat invites the EB Members to consider the text of a draft resolution.

PHM Comment

The proposed resolution does not set out a comprehensive short, medium and long-term plan for the elimination of schistosomiasis. It is focused, almost entirely, on scaling up preventive mass praziquantel treatment as a strategy for controlling schistosomiasis, and the need to mobilise more funds to ensure supply and delivery of praziquantel.

Strategies should include, and go beyond, resource mobilisation for mass preventive treatment. While mass praziquantel treatment is effective in controlling the burden of morbidity from schistosomiasis, elimination of the disease calls for a more broad-based strategy.

The disease-focused approach should not obscure the need for basic water supply and sanitation. Strong intersectoral collaboration is needed to ensure that such projects are planned with full consideration of the implications for all soil transmitted infections.

6.12 Draft global vaccine action plan: update

Secretariat Note

Document EB130/21 summarizes progress in the development of the global vaccine action plan. The Board is invited to review progress in developing the Decade of Vaccines draft action plan, including the draft vision statement, and details of the four work streams in the action plan, in preparation for a substantive review by the Sixty-fifth World Health Assembly.

PHM Comment

There are four main issues which raise our concern in this document:

1. WHO's limited role in setting vaccine policies

The collaborative process to develop a global vaccine action plan runs under the umbrella of the Decade of Vaccine Collaboration, which is a public-private partnership including the Bill and Melinda Gates Foundation, UNICEF, GAVI Alliance, and Sabin Vaccine Institute, among others.

As the WHO is just one actor in this venture, it prevents the organisation from fully playing its leading role in global public health and independently guiding the establishment of fair and effective vaccine policies.

2. Conflict of interest

In paragraph 16, the document states that *"the establishment of a vaccine access forum could improve communication among countries, public sector organisations and vaccine*

manufacturers". We are concerned about the way in which conflict of interests will be dealt with if this forum will include stakeholders with commercial interests that can be in conflict with public health goals.

3. Public health assessment of immunisation programmes

The document fails to provide strong evidence and robust data on the impact of introducing new antigens and, in general, immunisation programs on reducing the mortality and in decreasing the incidence of vaccine-preventable diseases. The introduction of new vaccines should be subjected to detailed needs assessment studies, cost-benefit analysis and public health impact assessment which recognize the specific circumstances of each country. Immunisation programmes should not be seen as a substitute to a range of public health measures, such as preventive measures (other than vaccination), primary healthcare, access to safe drinking water and sanitation, etc.

4. Access to vaccines across different countries

Paragraph 25 states that *"success relies on countries embracing the outcomes, setting country-specific targets, developing country-specific plans that are guided by the global vaccine action plan, and mobilizing resources in order to achieve those targets. Success further relies on robust decision-making"*. However, not all governments, especially in low-income countries, might be able to define immunisation as a priority within the health system due to technical, infrastructural and financial constraints. In these circumstances, it is important to guarantee an equitable access to vaccines that have been demonstrated to be effective in reducing the negative impact of infectious disease at population level.

Advance market commitments (AMC) should not be the guiding mechanism to secure equitable access to vaccines. AMCs can perpetuate monopoly over vaccine manufacturing technology and persistence of high monopoly pricing. Instead, the WHO should take lead in promoting alternative mechanisms such as transfer of vaccine technology.

6.13 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States

Secretariat Note

Document EB130/22 focuses on three main elements: 1) reaffirming the role of the WHO in SSFFC; 2) strengthening of regulatory capacity; and 3) suggested mechanism and terms of reference for the consideration of the WHA.

PHM Comment

In 2008 several developing country Member States (MS), expressed strong criticism over the drifting of the WHO towards intellectual property (IP) enforcement when addressing compromised medicines, rather than ensuring their Quality, Safety and Efficacy (QSE). The use of the term "counterfeit" to describe medicines of compromised quality was one main reason behind this, because it is a specialised term which refers to trademark violation under the TRIPS

Agreement (Agreement on Trade-related Aspects of Intellectual Property Rights). For this reason, a combined terminology has been agreed to refer to these medicines: “Substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

WHO has come under criticism on two issues. First, on the use of the term “counterfeit” to refer to medicines with compromised quality, safety and efficacy (QSE). Second, the WHO was particularly criticised for its association with the International Medical Product Anti-Counterfeit Taskforce (IMPACT), which is mandated with IP enforcement and comprises other agencies such as the Interpol and also closely associated with pharmaceutical industry. It is important to stress the need for WHO to drop the term “counterfeit” and also to disassociate from IP enforcement initiatives such as IMPACT.

The OEWG was established in this context with the aim of finding ways to ensure QSE of medicines and make them available. It met from 25 to 28 October 2011, and submitted a report to the EB (contained in document EB130/22). The OEWG decided to establish a new mechanism for international collaboration among Member States from a public health perspective. According to the terms of reference the new State Mechanism it is to examine to collaborate with and contribute to the work of other areas of WHO that address access to quality, safe, efficacious and affordable medical products.

Hence the mandate of the new mechanism includes the issues affects access to medicines other than intellectual property. This is an opportunity to also address the functioning of the Department of Essential Medicine and Pharmaceutical Policies. This department is currently under crisis due to underfunding.

“Strengthening of the WHO’s activities” in ensuring QSE of medicines (p.3) should be envisaged by MS in ways they identify, and see the most appropriate means this could be achieved in light of their national needs and technical inadequacies. Member States are encouraged to engage in the design and planning of such activities in a way that matches their regulatory priorities.

Technical expertise is key to the success of the proposed mechanism. This should be based on previous work done by the WHO expert bodies and committees, or published in comprehensive guidelines in the past. Member States should pay attention as to not to reinvent the wheel, when setting mechanisms for future work. Duplication of work done in the past should be avoided, particularly that there is a tendency to set up new entities under the proposed mechanism (under structure on p. 9 the mechanism suggests the establishment of subsidiary working groups).