People's Health Movement



Health for ALL NOW!!

Items for consideration during the 64th WHA

Distinguished delegate to the 64th World Health Assembly,

On behalf of the People's Health Movement and affiliated networks we submit the following comments and suggestions regarding some of the items appearing on the agenda of the 64th World Health Assembly (WHA). We hope that you may find time to read and consider these comments before the relevant discussions at the assembly.

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 owning the leading role in global health governance. PHM follows closely the work of WHO, through the initiative '<u>Democratizing Global Health Governance</u>' which was launched by the PHM and several international civil society networks in May 2010. The collaborating networks includes: the <u>Third World Network</u> (TWN), <u>Health Action International</u> (HAI), <u>Medicus Mundi International Network</u> (MMI) and <u>Medico International</u> (MI).

Within the framework of this initiative, the PHM has established a 'WHO Watch'. The watch aims primarily at building capacity in supporting the WHO to regain its leadership role in global health governance according to its Constitution. WHO Watch mobilises a large number of health activists, civil society networks and academics to provide resources and evidence-based critiques related to the secretariat reports, draft resolutions, and other materials during the preparations to the WHO governance meetings especially the Executive Board (EB) meetings and the Assemblies. Kindly refer to the section 'WHO Watch' on the PHM's 'Global Health Watch' (GHW) website at http://www.ghwatch.org.

Over the last week, 30 members of the 'WHO Watch' group from over 20 countries have been working through the 64th WHA Agenda with the assistance of high level experts from a number of collaborating networks and NGOs. During the workshop, the following comments on some of the agenda items of the 64th WHA were drafted for your kind consideration. Members of the PHM WHO liaison group will be following the discussion at the 64th WHA over the next week and would be keen to discuss these comments with you during this week.

We hope that our comments on the agenda items coming before you over the next few days will be useful in your important deliberations.

We would be keen to chat further with you regarding any of the topics or our comments if you felt that might be useful. You can contact me on hserag@phmovement.org or +41 76 706 97 66.

Yours sincerely,

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Item 11. The future of financing for WHO

We are particularly concerned regarding the Director General's (DG) report "The Future of Financing for WHO: Reforms for a Healthy Future" (Doc. A64/4).

The WHO is facing a financial crisis: programs, projects and staffing face the prospect of being disbanded; the dominance of tied donor funding is having a terrible effect on administration. The WHO is also suffering from a crisis of identity and legitimacy; its role and mandate have been diluted and usurped by the proliferation of new actors in the field of global health. Inefficiencies within the organisational processes remain unresolved.

These crises have been building over several decades. They also reflect questions about the role of the UN, the sovereignty of nation states and the democratic deficit that exists at the global level of governance more generally.

The driver of the reforms foreshadowed in the DG's report is the financial crisis in which the WHO finds itself. In accordance with the demands of the donors, the report simply addresses issues of effectiveness, efficiency, responsiveness, objectivity, transparency and accountability (A64/4, p.6). However, while the report sets out broad directions for the WHO, it has few concrete recommendations and inadequate analysis of the financial crisis. Most worryingly, the key document – the "detailed development plan for the program of reform" (A64/4, p.6, footnote 2) – was not posted until a few days before the Assembly. Calling for endorsement of a general plan without detail is asking member states to sign a blank cheque.

Core business

The focus on "core business" could turn out to be a narrowing of the mandate projected by the Constitution of the WHO. The DG has previously stated that certain key areas of work of the WHO, including action on the social determinants of health, human rights and gender, are to be 'mainstreamed'. Mainstreaming is a euphemism and will lead to reduced focus, analytic capacity and drive. There are powerful interests that would like to see WHO restricted to a technocratic role on communicable disease control and 'health security', and distanced from issues such as economic development, justice and peace, despite the fact that these are critical determinants of health and are wholly encompassed in the WHO Constitution.

Organisational effectiveness

There is a need for greater coherence between the country, regional and global levels of the WHO. But there is nothing in the report about the concrete changes required. The issues of accountability, coordination and management are complex and difficult. But it's time to stop talking about organisational effectiveness and to start drawing up an agenda and implementing real reform.

Management and accountability

The WHO has not escaped from the new religion of performance-based funding. Of course, the WHO should have clear plans and be capable of self-evaluation and impact monitoring, but subjecting itself to a narrow form of performance management could undermine its mandate, authority and independence. Much of what the WHO does (convening, facilitating, leading, advocating, coordinating and persuading) cannot be measured through simplistic performance-related results and indicators. Management and accountability in the WHO call for leadership and diverse methods of evaluation.

As the directing and coordinating authority on international health work, the WHO should take the lead in promoting accountability and transparency in global health governance. This should include transparent and participatory audit of WHO's progress towards achieving the 'highest attainable standard of health for every human being', including provision for the 'right to information' for its constituents.

Human Resources (HR)

The goals of reform should precede changes to HR policies, planning and management. However, the need to downsize is preceding and informing the process of reform. It is a direct response to the WHO's financial crisis, and not to a rational and evidence-based determination of staffing needs for the fulfilment of its mandate. Of course there are many improvements that need to be made to the WHO's systems of recruitment and HR management but the evidence and logic to support reducing the number of core staff and supplementing them with temporary staff and sub-contractees has not been presented.

Financing and communication

To fulfil its mandate the WHO needs a budget that is adequate, predictable and untied. WHO's state of financing is untenable; only 18% of WHO's funding comes from core, assessed contributions. The rest is cobbled together from multiple streams of voluntary donations, grants and in-kind support, much of which is conditional. A high proportion of voluntary contributions by member states undermines the organisation's independence and results in huge inefficiencies. Increasing dependence on private philanthropies and corporates carries serious risks of further distorting WHO's priorities.

It is time that the assessed contributions formula for countries is reviewed and revised; and it is time for a fair and adequate system of public financing for the WHO. We propose that member states collectively commit to increasing assessed funding so that it reaches 50% of the overall budget over the next five years.

The report calls for the WHO to widen its resource base by drawing on the private and commercial sector but it makes no mention of how its independence will be protected, nor does it say anything about the management of institutional conflicts of interest. WHO should set a cap on the amount of tied funding received from the corporate sector. Independent monitoring of public-corporate relationships are required to prevent unsafe or inappropriate relationships from forming. The funding of WHO programs by corporates and other donors should be explicitly identified on the website. These safeguards to prevent the privatisation of the WHO and the corporate capture of policy making should be spelled out before setting off a revitalised program of private and corporate fundraising.

WHO's effectiveness at country level

Effectiveness at the country level should be "a key outcome of reform and an immediate priority in the agenda for organisational alignment". WHO does have a role in promoting inter-agency cooperation but its unique role is supporting access to evidence, information and best practice in the fields of social determinants, intersectoral collaboration, primary health care, health system strengthening, health care financing, rational use of medicine and other critical areas. Whether this is carried out through country representatives or regional offices, WHO should be accountable at the global, regional and country level for the effectiveness of these functions and for the protection of people's health.

Global health governance

It is essential that the reform of the WHO be framed around the health needs of people instead of being centred upon the financial crisis. Health policy making over the last 30 years has been distorted by the pressure of odious debt, the defence of intellectual property and the rationalisation of an unjust global economy. WHO should speak truth to power.

The proposed World Health Forum has the potential to promote the interest of the private sector at the expense of a member states' driven process. The rationale and need for such a forum is not made clear; and there is no discussion about how such a proposal would avoid undermining or duplicating the role and mandate of the WHO. WHO must not pursue public-private partnerships

without ensuring safeguards against corporate influence over policy making and pernicious conflicts of interest. We urge you to consider the risks of this proposal and hope you will not endorse it in its current form.

The WHO Secretariat should not promote a gathering that has a potential to create a parallel structure for shaping global health decisions outside the WHA. We question the involvement of corporates and private foundations in decision shaping. The first represent their share holders while the latter represent their founders – none represent legitimate constituencies for global health decision-making.

Item 13.01 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

The H5N1 and H1N1 crises have shown the need for a transparent and equitable mechanism for pandemic preparedness that puts public health as a top priority. Towards this end it was a necessity to have a framework with contractual agreements to oblige recipients of biological material to share reasonable benefits to facilitate pandemic preparedness and response particularly in low and middle income countries.

In this regard, we view the recently agreed Framework and the Standard Material Transfer Agreements (SMTA) for sharing of influenza viruses and access to vaccines and other benefits as a positive step forward as it puts in place terms and conditions to govern the sharing of influenza viruses of pandemic potential and obliges the recipients of influenza biological materials to engage in benefit sharing.

However, we believe that the Framework has some shortcomings. The monetary contribution required from industry is too low given its profit levels. The benefit sharing option (manufacturers setting aside 10% of their production of vaccines and antivirals) is not sufficient for the 80% of the world's population who live in low and middle income countries.

The granting of non-exclusive licenses (on an affordable basis or royalty-free) to produce vaccines and other products in the event of a pandemic is only a voluntary benefit sharing option under the SMTA. This should instead have been listed as a stand-alone mandatory benefit to facilitate the sharing of knowledge, technology, and know-how, which low and middle income countries need to prepare themselves to counter an influenza pandemic.

We are disappointed that developed countries have placed the interests of the industry (and their profits and intellectual property) and national export earnings ahead of the interests of global public health, throughout the negotiations on Pandemic Influenza Preparedness, resulting in weak components in the Framework including diluted benefit sharing obligations.

We note with concern the efforts made by some Member States to undermine the relevance of the Convention of Biological Diversity (CBD) and the Nagoya Protocol on Access and Benefit Sharing in the context of PIP discussions.

We call on the WHO Member States and the Director General to ensure that the Framework and the SMTAs are implemented in a manner that protects and promotes public health and is consistent with the objectives of the CBD and the Nagoya Protocol.

Item 13.04 Health system strengthening

The two reports (A64/12 and A64/13) provided by the Secretariat deal with the role of WHO in supporting national work towards health system strengthening.

These reports provide an overview over the current challenges and policy directions for health system strengthening. The reports are however insufficient in addressing the political and socioeconomic conditions that shape health systems. They are written largely from a technocratic and donor perspective, focused on alignment, harmonisation and effectiveness. However, the importance of democratic participation of people's movements at local, national and global level as crucial to shape people's centred health systems is not acknowledged. It seems that the principles of Alma-Ata are being forgotten.

The reports acknowledge that health care reform is fundamentally a political process but the focus on the rational logic of 'best practice' does not offer any guidance with respect to the politics of health care reform in the unique circumstances of each country. In particular there is no mention of the advocacy, accountability and participatory role of civil society in driving health system reform. Historically, strong health systems have emerged from the demands of political and social movements including the labour movement and public interest organisations. This dynamic goes beyond a technical construction of health sector reform, addressing the real needs of the people as part of a wider social protection strategy.

There is no mention in these reports of the policies of the World Bank which since 1993 have promoted the horizontal stratification of health systems (private for the rich, social insurance for the middle and minimal safety net packages for the poor), nor is there any explicit analysis of the contribution of the disease specific funding bodies in promoting vertical fragmentation and internal brain drain. There is no mention of IMF restrictions on 'fiscal space' in allocating public financial and human resources which may be available at national level.

Strong democratic participation in health policy dialogue is critical in resisting these fragmenting and constricting tendencies and a strong commitment to Primary Health Care as the basis of strong and integrated health systems, as stated on the World Health Report of 2008, needs to be continuously reaffirmed.

We recognise the importance of an appropriate skill mix of health care workers. Nevertheless, we are concerned by the current trend of task shifting of health service provision from formally employed health personnel to informal and unpaid community health workers. This approach is being promoted by and based on the <u>Marginal Budgeting for Bottlenecks (MBB)</u> approach developed by the World Bank and UNICEF. We see this as a quick and cheap fix to provide basic care services by poorly remunerated, protected and trained community health workers.

We caution against relying solely on health insurance currently being promoted for L&MICs as a sufficient strategy for health system strengthening. Health insurance addresses financial barriers to access but such schemes tend to be essentially curative, not addressing promotive, preventive, and rehabilitative care. Health financing mechanisms should address resource development, regulatory capacity and service provision issues as well as access barriers. Social protection funds should not be used to strengthen the private sector in countries while at the same time weakening the public health care institutions.

The Secretariat Report on <u>Trends and Challenges</u> endorses the integrated service delivery model as the basis for health system strengthening. This is explained in terms of "networks of primary care providers – public, private or mixed – backed up by hospitals and specialized services. Such networks are responsible for the health of a defined population, offering health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care." The call to integrate private sector providers within district health systems is clearly linked with the

promotion of demand side funding through health insurance. There is a certain logic to the call to recognise the reality of private sector providers but effective regulation of private providers is not simple and the coordination of public and private providers in 'integrated health care delivery' has proved to be very difficult, even in high income countries. We urge member states to keep health care delivery in the public domain. It is highly irresponsible of WHO to be arguing for public subsidy to private providers as a blanket policy prescription in view of these complexities and difficulties.

One of the most critical elements of health system strengthening involves the rational use of medicines. Surprisingly there is no mention of this in either of the Secretariat reports. It seems that under continuing pressure from the pharmaceutical industry and subject to the funding preferences of large donors effective action on rational use of medicines has been relegated to the back burner. The widespread irrational use of medicines in the private sector in high income countries illustrates the challenge of effective regulation under the 'integrated service delivery' model.

The development of a national public or not-for-profit sector pharmaceuticals production capacity has potential to reduce expenditure on drugs including foreign exchange. This should be a core element of the health system strengthening program.

Harmonisation and alignment of agencies and countries on health systems' financing are laudable goals as the International Health Partnership initiative and Joint Assessment of National Strategies framework demonstrate. But alignment does not prevent volatility of international health financing associated with changing economic conditions and domestic policies. Despite that G8 leaders pledged for sustained investments to reach the MDGs, there remains a large gap in the funds required to finance universal health coverage. Moreover, these finances are prone to fluctuation and receiving countries cannot rely on it for sustained support for their health sector budget.

We appreciate the references to a multisectoral approach to prevention and the need for 'health in all policies'. However, the reports lack guidance on leadership of the process to have concrete action on the social determinants of health being integrated into health system strengthening.

Item 13.05 Global immunisation vision and strategy

Although immunisation coverage did increase during the period 2000-2009, ideal coverage of 90% has not yet been achieved. Instead of simply considering technical issues as possible cause of this lack of coverage, WHO must recognise the important role social determinants of health play in achieving immunisation outcomes. Immunisation programs need to be locally responsive and include actions on structural determinants of health.

Immunisation should be delivered in the context of proper infant and child nutrition and food security. The absence of evidence on the efficacy of immunisation in malnourished populations is worrying. WHO as a knowledge institution in health has the responsibility to make sure such essential questions are answered and the answers inform policy.

The strategy mentions monitoring and surveillance of immunisation but should also include reference to the monitoring of adverse events in the use of vaccines. Likewise, issues as the promotion of safe injection, proper storage of vaccines and ensuring appropriate compensation mechanisms for adverse events should also be included into the strategy.

It is positive that the necessity to design specific approaches for the increased vaccination of other target groups than infants (pre-school children, adolescents, health care workers) is being highlighted. Still, it must not be forgotten that the promotion of vaccination on target populations other than infants also represents an appealing opportunity for the industry to increase its sales and profits. A 'one-size-fits-all' approach in the introduction of new vaccines must be avoided. National priorities are not everywhere the same. The introduction of new vaccines should be subject to detailed needs assessment studies, cost-benefit analyses and public health impact assessments which recognise the specific circumstances of each member state. WHO should assist member states

in undertaking such studies where appropriate. Similar to the vaccination of other people than infants, the introduction of new vaccines cannot be a strategy for increasing industrial margin, but must be a complementary, responsive and locally adequate tool to improve public health.

It is recognised that effective and efficient vaccine delivery requires and should be mediated through well functioning health systems. It is less widely recognised that a over emphasis on immunisation delivery can disrupt health care delivery with serious negative consequences. WHO must ensure that immunisation campaigns do not decrease the availability and quality of primary health care.

While Global Alliance on Vaccines and Immunisations (GAVI) may subsidise the cost of new vaccines for a few years, the capacity of member states to carry those costs in the longer term needs to be considered. The projected cost of a full course of vaccination (paragraph 25) underlines the importance of affordability.

The strategy also lacks adequate reference to the contribution of community health workers, a functioning primary health care system and the active inclusion of communities in the process.

There is also no mention made about the importance of enhancing local capacities, strengthening the vaccine delivery system and promoting scientific research. Creating new knowledge is not a western privilege. Building research and manufacturing capacity in the public sector is needed so governments are not over-reliant on the private vaccine and biotech industries.

Sustainability is a key criterion in the financing of immunisation programs. Member states should be given technical assistance with respect to using the flexibilities provided under the Trade Related aspects of Intellectual Property Rights (TRIPS) Agreement to ensure affordability of vaccines.

Item 13.06 Draft WHO HIV strategy 2011–2015 and Item 13.17J Progress Report (A64/26, page 18) on the Implementation by WHO of the recommendations of the Global Task Team on improving AIDS coordination among multilateral institutions and international donors

The Draft HIV/AIDS strategy should inform AIDS coordination and vice versa, with clear links established between the two. The two items should not be considered in isolation from one another.

The health financing element of the draft strategy calls for efforts to minimise out-of-pocket expenditure, but places the mobilisation of donations as the principal element, further reinforcing a vertical donor-centred approach, which is unsustainable. The immediate interpretation of such approach is that it seeks to avoid negotiating the cost of diagnostics and treatment and not challenging the commercial interests of the pharmaceutical industry. We believe that mainstreaming a policy that prioritises both cost reduction and funds mobilisation would be more sustainable. In many settings a shift to generic products would significantly reduce costs. (For second line drugs this would require compulsory licensing.)

The vertical approach is unsustainable because it does not develop integrated health systems. It is important to strengthen national capacity, in particular, health regulatory and legislative capacities. Investing in local pharmaceutical manufacturing capacity, where available, is also a long term solution which should be considered.

On containing costs, the Strategy highlights the need for an "open, competitive market", referring to the use of the TRIPS flexibilities "as needed", and suggesting the options of "patent pooling and voluntary licence agreements between patent holders and generic manufacturers". This paragraph is very conservative in terms of genuine cost containment. We believe the full use of the flexibilities contained in the TRIPS Agreement, and further emphasised by the Doha Declaration, is a legitimate and certain way of ensuring access to affordable medicines. For example, compulsory licensing and government use options have been of tremendous benefit to several low and middle income countries in terms of providing affordable ARVs. Hence, the use of TRIPS flexibilities should be

encouraged. While voluntary licensing and patent pools are useful short term solutions, it is also important to be investing in long term options which help develop local research and development, and manufacturing capacities in low and middle income countries.

The strategy document appears to equate use of TRIPS flexibilities with use of voluntary license and patent pool for ensuring access to medicines. These measures can contribute to access to medicines but should not be regarded as equivalent to the use of TRIPS flexibilities. Experience to date of voluntary licenses sometimes include restrictive conditions on generic manufactures and are therefore not a preferred option. It is important for Member States to ensure primacy of the use of TRIPS flexibility to ensure availability of medicines and to maximise the potential of these flexibilities in their patent law.

It is recognised in the Strategy that access to affordable HIV-related medicines is hampered by the failure of countries to use safeguards available in the TRIPS agreement. However, there is no reference to the <u>Doha Declaration on the TRIPS Agreement and Public Health</u> which emphasises that private intellectual property rights should not be allowed to prejudice public health interests. Paragraph 6 of the Doha Declaration allows least developed countries with no pharmaceutical manufacturing capacity to issue compulsory licenses for medicines they need through another country with manufacturing capacity. That said, we note that paragraph 6 is subject to a current review process at the TRIPS Council, because of the lengthy and complicated procedure its implementation entails. The WHO, as the UN organisation mandated with health matters, should take a leading position in moving this review process towards tangible results.

Health-related intellectual property issues are increasingly being discussed in other international fora (WIPO, WTO and other plurilateral fora). The WHO should take the lead on such health-related discussions. There is also a need for more information about specific ways in which the WHO will contribute, particularly to the content of technical assistance programs provided by some organisations to low and middle income countries to ensure that public health interests are placed above private rights.

HIV/AIDS is poverty-related and very much dependent on socio-economic context, hence it must be addressed in its broader social contexts where it is prevalent. While social determinants of health are mentioned, among many others, under "maximising synergies across other program areas" (A64/15 para. 115), we noticed the inadequate coverage of how this aspect will be mainstreamed in HIV response throughout the document. That said, we emphasise the importance of a holistic approach that goes beyond the formal health systems to community level engagement.

Strategies related to reaching out to vulnerable population groups (such as men who have sex with men and transgender people) should take into consideration differences in cultural and religious norms between regions and often between countries within the same region. However, WHO's mandate to ensure access to treatment should not be compromised by cultural tensions over life choices. It also has to be acknowledged that implementation strategies in this regard would vary to suit the country-specific nature and needs of people living HIV.

The progress report on Implementation by WHO of the recommendations of the Global Task Team on improving AIDS coordination among multilateral institutions and international donors (resolution WHA59.12) (Document A64/26) notes that the full engagement of WHO in Joint United Nations Teams on AIDS and joint programs of support at country level, is dependent on the presence in countries of WHO HIV program staff.

We are concerned to know that such necessary engagement with other UN organisations at country level is hindered by lack of WHO HIV staff. HIV/AIDS needs a multi-stakeholder response and the role of other UN organisations remains important for facilitating that of the WHO.

Reasons for lack of WHO HIV staff in certain countries were not provided in the rather short progress report. There are two issues to which we would like to draw attention: 1) in the interests of cost

saving, there is a need for a mechanism that allows HIV staff at regional offices to cover for work at national level where there is no WHO HIV staff representation, rather than losing this important element of response; 2) the sustainability of HIV response at national level depends on engaging national actors and developing their capacities to independently respond to HIV in ways which fulfil their country-specific context and needs. Investing in developing human capacities in HIV response at national level should guarantee the sustainability of the WHO's contribution, should there be no WHO staff representation.

Similarly, developing the capacity of monitoring and evaluation at national level should also be covered by technical support activities, since this is a crucial element for the sustainability of HIV response.

Item 13.07 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

There is an urgent need to ensure access to medicines with quality, safety and efficacy (QSE) at an affordable price. The first step in this direction is to ensure availability of medicines at affordable price. This would eliminate the incentive for the business of QSE-compromised medicines. Towards this end Member States need to undertake various legal and policy measures. The role of WHO is to provide information and technical assistance to facilitate access to medicines. However, the performance of WHO in this respect has been far below expectation including pushing countries in the opposite direction especially through WHO 's work program to combat counterfeit medicines.

WHO's counterfeit work program and its partnership on counterfeit known as International Medical Products Anti-Counterfeit Taskforce (IMPACT) are clear examples of influence of pharmaceutical multi national corporations along with their host states. For almost 20 years this complex of vested interested groups has conflated quality, safety and efficacy issues with issues of intellectual property enforcement. This was made possible by using the term 'counterfeit' to describe QSE-compromised medicines and hushing up the fact that the term counterfeit is a legal term with very specific meanings in the domain of trademark infringement. Thus WHO has promoted IP enforcement measures instead of addressing the root causes for the circulation of QSE compromised medicines such as high prices and lack of effective national regulation. There is an urgent need to reconsider the continuance of WHO's work program on counterfeit medicines.

We urge Member States to demand the disengagement of WHO from IMPACT, which has not been approved by any governing body of WHO. Member States should also reject WHO's suggestion of replacing the term 'counterfeit' with 'falsified medicines' without clarifying the distinction between trade mark violation and QSE-compromised medicinal products.

Item 13.09 Cholera

We are aligned with the content of the resolution and the report. They include all important aspects of cholera prevention and management. However, we emphasise the importance of equitable and appropriate provision of water and sanitation; not only beneficial for cholera but for many other diseases as well.

Item 13.10 Malaria

This report (A64/19) reviews the prevention and control of malaria with regard to sustaining the gains made so far, as well as reducing transmission. The report also charts a course for sustaining and expanding these gains from 2011–2015 while taking into account potential threats to success and new opportunities for action. The document includes a resolution (EB128.R13) for consideration.

The resolution calls for the use of the expansion of interventions for malaria prevention and control as an entry point for strengthening health systems, it does not include actions around rational use of

medicines and strengthening national drug regulatory services. Especially as the report indicates that only 34% of malaria-endemic countries are complying with WHO recommendations to routinely monitor the efficacy of first- and second-line anti-malarial medicines.

The report mentions the low usage of long lasting insecticide treated nets in many malarious countries, it does not acknowledge that people still have to pay part of the cost of bed nets and this reduces their utilisation. Recent studies have found no evidence that cost-sharing reduces wastage. Studies show that women who received free ITNs are not less likely to use them than those who pay part of the cost. There is no evidence that cost-sharing helps in selection of women who need the net more. On the contrary, cost-sharing dampens the use of bed-nets.

There has been progress is some areas, there is the need to emphasise on improved surveillance and better estimates of malaria deaths. For instance, a recent Lancet study (Dhingra, Jha et al. 2010), show there are 13 times more malaria deaths in India than the WHO estimates. The authors conclude that malaria kills more than 200,000 people each year in India.

Global efforts and recommendations against malaria should develop a more holistic approach by promoting better living conditions, sanitation, housing conditions, nutrition, access to healthcare and medication among others.

Whilst there has been increased spending on malaria over the past decade, there is need for sustainable commitment to reduce cost of artemisinin based combined therapy and improve access. Also, whilst the Affordable Medicine Facility – malaria (AMFm) may be contributing to increasing access in selected countries, it doesn't address technology transfer and building of long-term access to drugs.

Item 13.11 Eradication of dracunculiasis

The Assembly will consider <u>Document A64/20</u>, a report from the Secretariat on the eradication of dracunculiasis (Guinea worm). PHM calls on affected Member States to implement the actions in the resolution, in particular:

- 1. work towards improving the living conditions in some of the forgotten places where Guinea worm still spreads;
- 2. work towards the provision of universal access to health care especially in Guinea worm endemic communities;
- 3. motivate health workers to deal effectively with Guinea worm;
- 4. focus attention on sustaining gains in communities that have managed to eradicate Guinea worm so as to prevent re-emergence.

Item 13.12 Prevention and control of non-communicable diseases

The United Nations General Assembly decided to convene a high-level meeting on NCDs in 2011 in resolution <u>A/RES/64/265</u> which requires the Assembly to hold consultations on the scope, modalities, format and organisation of the high-level meeting and requests the Secretary General to submit a report to the General Assembly at its Sixty-fifth session on the global status of NCDs.

Under this item on the WHA agenda the Assembly considers a report by the Secretariat on WHO's role in the preparation, implementation and follow up to the High Level Meeting of United Nations General Assembly in September 2011. The First Global Ministerial Conference on Healthy Lifestyles and NCDs held in Moscow April 2011 aimed to support member states in developing policies for promotion of healthy lifestyles and prevention of NCDs. The <u>outcomes document</u> covered the current situation of NCDs and recommendations for action at national and international levels.

The report by the secretariat neglects mental health as an NCD which is estimated to be one of the leading causes of burden of disease by the year 2030. Currently the scope of NCDs is limited to four

diseases but there is a need to widen the scope of coverage of NCDs to include various other diseases especially mental ill-health.

The focus on life-style and behaviour in the Moscow meeting returns to an older 'victim blaming' approach rather than addressing the core determinants. It is extraordinary that there is no reference to the work of the Commission on Social Determinants and Health (CSDH) in the annex summarising previous events leading up to this meeting. Unhealthy behaviours do play an important role in determining NCDs however as the report by CSDH has indicated there are structural determinants like marketing pressure, education, income, gender and ethnicity which are underlying causes of NCDs and their contribution to behavioural risk factors needs to be tackled. The CSDH emphasised the importance of looking at the equity dimensions as well as the disease process. Clearly there are important equity dimensions to the incidence and prevalence of NCDs and these variations are closely linked to the social and environmental factors; not just individual behaviours. Therefore if the UN General Assembly is to provide an action-oriented outcome document preventive measures for social and environmental factors must be included.

The focus of the NCD initiative has been on the prevention of NCDs rather than treatment. While prevention is important we also urge member states to address access to affordable treatment for NCDs. Hence it is important that WHO initiate law and policy measures to ensure access to affordable diagnostic tools and treatment, in particular the full use of the flexibilities of TRIPS.

The development of new diagnostic tools and medicines is crucial for early detection, and also for the people living with NCDs. However the usage of these products requires further attention (guidelines, education & regulation) in order to avoid over consumption that will burden the health systems. Therefore rational use of medicines and diagnostic tools must be vigorously promoted.

We appreciate the role of WHO in tobacco control but it is also important to curb the practices of other industries which contribute to the prevalence of NCDs such as food and agricultural corporations. Therefore it is important that the proposed resolution incorporate a call to develop a code of conduct to regulate their advertisement and promotion of products.

The Secretariat report is very weak on the health systems implications of NCDs. The challenge of chronic disease management underpins the management of the four specific diseases highlighted in this initiative as well as many other chronic conditions, including psychiatric disorders and emotional problems. Chronic disease management calls for on-going follow up and monitoring and clinical audit based on comprehensive primary health care. The need to strengthen comprehensive PHC as the basis for managing chronic disease is not recognised in this report.

The drive to give more prominence to NCDs includes some distinguished civil society networks which bring together much professional expertise and commitment. This drive is also strongly supported by some very large transnational drug companies who have clear interests in terms of marketing and profits in the progress and direction of the NCD initiative. WHO needs to have a rigorous set of protocols in place to identify and protect against conflict of interest at the institutional level. At this time WHO has protocols in operation which deal with potential conflicts of interest involving contracted experts but there are no such provisions with respect to institutional conflict of interest.

Item 13.13 Infant and young child nutrition: implementation plan

Both under-nutrition and obesity are linked to the increasing dependence of poor countries on the high income countries for their food security; a process that has been accelerated by trade agreements, climate change, and use of cereals for biofuels. It is imperative that nutrition strategies address not only the immediate nutritional needs of children (i.e. their right to nutrition), but also the complex socioeconomic and political determinants of malnutrition. If these root causes are not addressed, the global food crisis will continue to be a threat to the livelihoods of poor and marginalized groups across the developing world. At the same time, country governments and

international bodies such as the WHO must actively advocate for policies and measures to enforce a regulation of trade and marketing of unhealthy foodstuffs in order to protect the health of populations, and of children in particular, from aggressive corporate influence.

There is a concern that the focus within WHO has shifted on nutrition in general, to the detriment of breastfeeding and complementary feeding. Breastfeeding is a major safeguard against early child malnutrition and needs to be protected, promoted and supported within the broad social, economic and environmental context and as part of comprehensive primary health care. Support has to be at all levels. Making it easy for mothers to breastfeed also requires provisions such as laws governing workplace practice, statutory paid time off work and a general acceptance of breastfeeding including in public places. IBFAN's reports on the ongoing violations of the International Code of Marketing of Breast-milk Substitutes are strong indicators that the battle for breastfeeding still needs to be fought.

In order to prevent the later consequences of inadequate nutrition in early childhood, the control of marketing practices should be strongly enforced, especially in schools and other areas where children and adolescents gather. Binding regulations in the public interest are necessary and crucial, as voluntary agreements by corporations are inadequate and often disregarded when manufacturers feel free, especially in the South. The envisaged industry participation in the development and implementation of the plan is therefore of concern. The WHO report suggests their involvement in regional and national consultations from the very outset, without any mention of guidance on the management of conflicts of interest. Any consultation process should be made transparent through publication on the website of all submissions, including those coming from the private sector. All actors involved should be clearly identified and all conflict of interest, including institutional ones, should be disclosed. WHO topic and program websites should disclose donors.

The implementation plan must be aligned with the wider health systems, that should be based on primary health care with strong community participation. This is crucial to make nutritional interventions sustainable in local contexts. The use of ready-to-use therapeutic foods (RUTF) should be restricted to the treatment of severe acute malnutrition and should not be employed for use in chronic under-nutrition or prevention. Local production of RUTF should be accelerated, together with a focus on sustainability of such interventions by promoting awareness of the basic ingredients of such packaged products, in order that users may cultivate or purchase such constituent foods in the future. In addition, technical interventions to fight malnutrition have to be balanced with decentralised social interventions that allow for community control and address the underlying determinants of nutritional problems. These strategies need to be comprehensive and in line with broader socioeconomic objectives, and not be based on centralised, top-down solutions.

The long-term and definitive elimination of malnutrition rests on consistent action to tackle its structural determinants. Any short-term strategy must, at the minimum, ensure that it does not postpone acting on the long-term goals of peace, right to nutrition, social justice and disparity reduction. The WHO must insist that food security and sovereignty are essential for good nutrition, and that measures to promote such food sovereignty are supported also by other sectors and institutions.

Item 13.14 Child injury prevention

The report by the Secretariat covers the causes of the child injuries while also drawing attention on some key issues like gender differentials and inequitable distribution of them. However the report has no reference to the child injuries and deaths incurred during wars and conflicts and due to political instability and other forms of violence like sexual abuse of children which also causes long term mental injuries.

The resolution adopted by the Executive Board calls for action based on intersectoral coordination, multisectoral policy making, raising awareness and health literacy on child safety. The report covers

child labour as a cause for injuries and calls for action but the other situations mentioned above are neglected. WHO should recognise the contribution of these factors to child ill-health, injury and death.

Item 13.15 Strategies for the safe management of drinking-water for human consumption

As stated in the report A64/24, the quality of drinking-water is a powerful determinant of health. However, a large part of humanity still has to rely on unsafe water due to limitations in access. Significant reasons are the high cost and the loss of community ownership and control over this vital public good.

The aggressive privatisation of both of water supplies and water resource is on-going globally and is contributing to increasing costs. The continued promotion of bottled water instead of reticulated clean water supplies is a global challenge.

Access to safe drinking water cannot be tackled only with a technical approach on water management. It requires WHO to monitor and generate clear and systematic knowledge on the implications and extent of privatisation, as well as advocacy for public ownership of natural vital resources, speaking up regardless the interests of none else but the people.

Item 13.16 Youth and health risks

The Secretariat Paper provides a useful summary of the various conditions which are of particular relevance to young people and some of the economic, social and cultural determinants and some general directions by way of response.

The paper identifies some of the ways in which gender inequalities contribute to the health risks of young women. It is not so strong in terms of how structured gender inequality is to be addressed. The paper does not refer to some of the other axes of inequality which affect young people including racism, caste and disability.

The Secretariat has correctly identified decent employment as a critical determinant of youth health and life chances. It does not refer to the structured imbalances in the global economy which deny many million young people access to such employment.

The paper makes reference to the involvement of young people in recognising and addressing many of the problems and causes which it identifies. It does not refer to comprehensive primary health care as a health care model which is designed to provide openings for affected populations and communities to work with health care practitioners towards better health.

Addressing the structural determinants of health involves politics, community action and social movements. It is not enough for WHO to conceive its engagement in this area solely in terms of suggestions to ministries of health.

Item 13. Progress Reports

Item 13.17A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)

We recognise that great achievement has been accomplished, millions of personal catastrophes have been prevented by the global efforts to eradicate polio. However, the lower prevalence of polio has altered the context of the fight against this disease. Eradication remains a worthy objective, but given this phase of diminishing returns WHO must not allow a single minded pursuit to compromise primary health care and health system strengthening. A case study of this danger is provided by the experience of the Pulse Polio campaign in India.

Item 13.17B. Onchocerciasis control through ivermectin distribution (resolution WHA47.32)

The progress report quantifies the results of ivermectin utilisation and epidemiological surveying and mentions efforts made to strengthen health systems, improve stakeholder coordination and identifies sustainable funding as primary difficulty. PHM applauds resolution WHA 47.32: Onchocerciasis control through ivermectin distribution. The resolution recognises the importance of NGO participation, free provision of ivermectin and international technical cooperation.

Item 13.17C. Climate change and health (resolutions WHA61.19 and EB124.R5)

The climate change in the next few decades will become the biggest global threat for life and well-being of the humankind and therefore the priority into the global public health agenda. The effect of climate change will have a negative impact especially on the health of the most vulnerable, those who are less responsible for greenhouse gas emission and less capable to adapt to its effects.

Aiming to protect the health of people, a powerful voice to strongly support an equal global strategy is urged. WHO should not limit its role to technical interventions in advocating, creating knowledge and building capacity with respect to adaptation. It should use knowledge and scientific evidence for actively advocate for mitigation measures.

WHO should not be fearful in indicating that the current situation has been caused by a system of development based on overconsumption and rapid depletion of natural resources. We ask WHO to be example of a different model, minimizing greenhouse gas emissions in all its projects and activities and creating a code of conduct and good practices in mitigation measures.

Starting from the acceptance of the historical role played by developed countries in generating more than the 80% of the greenhouse gas emission, we ask the WHO to support technology transfer and the financing for clean and sustainable development of the countries of the South.

Item 13.17D. Improvement of health through sound management of obsolete pesticides and other obsolete chemicals (resolution WHA63.26)

The Assembly is invited to consider the Progress Report (<u>WHA13.17D</u>, page 7) on the Improvement of health through sound management of obsolete pesticides and other obsolete chemicals (Resolution <u>WHA63.26</u>, page 55). This resolution and its progress report deal with a highly specific issue; namely the management of obsolete chemicals. However, this should not be considered in isolation from the broader issues of chemicals safety which are described in the more comprehensive document <u>A63/10</u> (Strategic Approach to International Chemicals Management).

The Strategic Approach is an important resource and its implementation should be pursued vigorously. However, there are some issues which are not adequately addressed in A63/10 which must be followed up.

It is important to have national and international regulation regarding the introduction of chemicals into the human environment. However, these regulatory structures do not address the commercial motivations which drive the conditions for wider use of chemicals. These include the seed companies which use increasingly restrictive intellectual property laws to trap and lock farmers into pesticide dependence.

Regulations need policing and nowhere more so than in the illegal dumping of waste in Third World countries. The protection of Union Carbide managers after the Bhopal tragedy speaks to the role of money and corruption in driving the chemicals juggernaut and avoiding corporate accountability.

These are issues where technical assessment and bureaucratic regulation must engage with democratic politics and popular struggle. WHO's engagement in these areas must prioritise the education of occupational health practitioners and primary health care practitioners. In view of the

influence of corporate interests on governments it is essential that community organisations and environmental and health activists are supported with high quality and easily accessible technical and regulatory information. Environmental and health activism is critical in stiffening the political will to take effective action on these issues.

Item 13.17E. Improvement of health through safe and environmentally sound waste management (resolution WHA63.25)

This is a follow up of <u>WHA63.25</u> which itself arose out of the consideration at WHA63 of the Secretariat's Strategic Approach report (A63/21).

A63/21 provides a introduction to the broad field of chemicals regulation. Out of this two specific resolutions were passed at WHA63.26 (obsolete chemicals) and WHA63.25 (waste management). Doc A64/26 provides progress reports on both resolutions.

WHA63.25 urges Member States to apply health impact assessment as one of their tools for managing waste. Among the actions requested of the DG are improving controls over the illegal shipment of waste, raising awareness, strengthening subregional and regional cooperation on waste and health issues by promoting human and appropriate technical capacities at national, regional and international levels; and technology transfer needed for waste management.

The main focus of the Progress Report in Doc 164/26 is on health care waste. This is a very narrow reading of resolution WHA63.25.

In view of the financial power of those who generate chemical pollution and their influence on governments it is essential that WHO reach out to community organisations and environmental and health activists with high quality and easily accessible technical and regulatory information. Environmental and health activism is critical in stiffening the political will to take effective action on these issues.

Item 13.17F. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)

The Assembly will consider the Secretariat's report on progress towards universal reproductive, maternal, newborn and child health interventions as per resolution WHA 58.31.

The report details the grim situation that many women and children currently face, underlining the need for prompt and decisive action. WHA 58.31 recognises the need to involve civil society and community organisations in wider access to life saving interventions.

As well as the need for health system strengthening, the resolution recognises the need for global mobilisation, and the adoption by member states of legal and regulatory frameworks to promote gender equality and protect the rights of women and children. Maternal and child health is political as well as technical. For example, addressing the role of patriarchy in denying women access to care requires the full recognition of civil society organisations and social movements in driving change in political and cultural environments. Unfortunately progress regarding these goals is not reported upon.

Item 13.17G. Female genital mutilation (resolution WHA61.16). Stop the cutting now!

Female genital mutilation (FGM) comprises procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997). Despite previous efforts approximately 3 million girls per year are at risk of this harmful practice.

Of concern is the medicalisation of this practice (where it is undertaken by registered practitioners in licensed facilities).

There has been inadequate attention to changing the social representation of FGM; changes in the way the society perceives FGM particularly in areas with a high prevalence rate.

There is also a need for psychosocial rehabilitation for girls/ women that have gone through his act.

The adoption of new laws and declarations does not always immediately transform local cultures. Egypt which still has one of the highest incidence rates has had a law against FGM since 2008. It is still a framework which demands from institutions, communities and individuals the transformation of ideas and the initiation of new practices. Hence, while it is crucial for Member States to adopt appropriate laws as one of the tools in fighting FGM there is also a need for more media coverage on the issue particularly in conjunction with key people such as traditional senior people in communities since FGM is a deeply entrenched cultural practice. The media should also make more emphasis on the harmful effects of FGM, to include for example transmission of HIV and hepatitis among others. It is also very important to engage health professionals to support the abandonment of FGM and reiterate that they should never perform it. It breeches their medical professionalism and ethical responsibilities.

It would also be useful to provide National protocols, manuals and guidelines to guide healthcare workers and also to adopt the global strategy against the medicalisation of FGM.

Item 13.17H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)

Gender analysis helps to promote equality between men and women as an essential component of sustainable development, economic stability, social justice, peace and security.

We recognise WHO's achievements in integrating gender analysis and actions into the work of WHO but there is still much to be done. There has been a decrease in the number of women employed in the National professional officer category and there is a continued under representation of women at higher professional grade levels.

We therefore urge the WHO to provide a more gender friendly environment, to keep in view the issue of sexual harassment at the work place in addition to the implementation of the strategic directions already adopted. We also recommend the UN Women continues to promote gender budgeting.

Item 13.17I. Progress in the rational use of medicines (resolution WHA60.16)

This progress report describes a number of conferences and workshops and some progress on the implementation of essential drug lists. However, it reports sadly in Clause 84 that, "the majority of countries have yet to tackle rational use of medicines in their national plans and commit resources as recommended in the resolution."

It would be a mistake to 'blame' member states for this very serious failure. In significant degree it reflects the financial strangulation of WHO's capacity to objectively fulfil its constitutional mandate and its growing dependence on donors with an interest in the profits of big pharma.

The large transnational pharmaceutical corporations have no interest in WHO promoting the rational use of medicines. In fact they spend vast amounts trying to promote the irrational use of medicines. WHO has been forced to depend on big pharma charity in the context of the access crisis and member states refusal to adequately fund WHO. Areas where WHO has allowed its priorities to be 'shaped' by the interests of big pharma include its participation in IMPACT (see WHA Watch comment on <u>Agenda Item 13.07 on Spurious etc Medicines</u>) and its shift in focus from the rational use of medicines and national drug policies to the focus on corruption in medicines procurement.