

HEALTH DIPLOMACY MONITOR

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The Health Diplomacy Monitor aims to report and inform readers about key international negotiations currently underway which have a significant impact on global health. The objective is to “level the playing field” by increasing transparency and making information about the issues and proposals being discussed more readily available.

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Editor

CHANTAL BLOUIN

chantal_blouin@carleton.ca

1125 Colonel By Drive
Carleton University
Ottawa, Canada K1S 5B6
t: +1-613-520-6696
f: +1-613-520-3981

www.ctpl.ca
www.ghd-net.org

@GHD_net

Global Health Diplomacy Network

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A WORD FROM THE EDITOR

After four year of arduous negotiations, the member states of the WHO have agreed to a new framework for Pandemic Influenza Preparedness, which specifies the rules regarding the transfer of flu virus samples and the benefit sharing system associated with it. At the same time, the World Health Organisation (WHO) is in the midst of rethinking its role within the global health architecture, with discussions of reform triggered by financial difficulties. It is in this context of diplomatic success and transforming governance that the 64th World Health Assembly (WHA) was held in Geneva from May 16th to May 25th.

Several contributors to the Health Diplomacy Monitor were on site to report on the discussions taking place at the Assembly; this special issue provides an account of

the main outcomes of these discussions. The issue begins with an editorial from Ilona Kickbusch on the responsibilities of member states guiding the reform efforts at the WHO; without their leadership and engagement, the concept of member-state driven reforms will remain empty words. Bente Molenaar then reviews the final lap of negotiations for the Pandemic Influenza Preparedness Framework and the key components of the final agreement. The new system for sharing flu viruses and improving access to vaccines, diagnostics and medicines has been hailed by the the WHO Director-General as a “very significant victory for public health.” Miriam Faid and David Gleicher report on the debate during the WHA involving WHO reform, focusing on the main issues on the table: the creation of

a multi-stakeholder forum, financing options for the WHO, the role of regional and country offices, and reforms of management for better transparency and accountability. The proposal of a multistakeholder forum was the most controversial, with several member states and non-governmental organizations expressing concerns that it may compromise the WHO's legitimacy by increasing the influence of private actors.

Another controversial negotiation concerned the destruction of smallpox virus stocks held by the Centre for Disease Control in the United States and the State Centre for Research on Virology and Biotechnology in Russia. In 1996, the Assembly had agreed to the destruction of the stock by 1999, but temporary authorizations for research purpose have been granted since. As Health Diplomacy Monitor contributor Ranga Machedze explains, the United States and Russia, with support from twenty-five other Member States, requested authorization to maintain the stock to allow for further research on the virus. The discussions concluded with a resolution to bring back the issue to the WHA in 2014, but also to re-affirm that the stock will have to be destroyed.

In September 2011 in New York, the United Nations (UN) will hold a High-Level Meeting on Non-Communicable Diseases. In this WHA special issue, we have two articles reporting on the Geneva preparations for the summit. Monique Moreau explains that the debate took place on a general level of specificity, reflecting the content of the Ministerial Declaration that was adopted at the Moscow Meeting on Healthy Lifestyles and NCD in April. Rene Loewenson focuses on the perspectives from Sub-Saharan Africa on the desired outcome from the UN meeting. African member states have stressed that they continue to face challenges with infectious diseases, and urged that the new focus on NCDs should not lead to any reduction in investments addressing communicable diseases. Rene Loewenson also writes about the adoption of the new WHO strategy on HIV/AIDS. The most common concern raised by countries at the WHA was on implementation, particularly how the strategy would be funded.

The issue of resources for implementation was raised for other agenda items as well. The WHA welcomed the report of the independent expert committee, which was mandated to examine how well the new International Health Regulations (IHR) have been functioning, in view of the H1N1 pandemic of 2009. Concluding that the world is ill-prepared to respond to a severe influenza pandemic or to any similarly global public-health emergency, the committee made a number of recommendations to improve pandemic preparedness. During the Assembly, many countries raised concern over a lack of resources for implementation of these recommendations.

Some items on the WHA agenda remain ongoing discussions that did not find resolution during the Assembly. For instance, participants to the WHA were not able to overcome the stalemate of one of its working groups regarding the definition of counterfeit medicines. Ranga Machedze reports that the Assembly decided to extend the period of the working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products and asked the working group to report on its results at the next WHA. The interventions by 47 member states during the WHA on this issue highlighted the very divergent views that will have to be reconciled. Bente Molenaar provides an update on the negotiations on the selection/election of the WHO Director-General, with the unresolved issue of whether geographical rotation should be a central criterion. The working group created to discuss the selection process provided a progress report to the WHA and will provide its final recommendations next year. The final article of this issue, from Priyanka Kanth, highlights the WHA deliberations on the adoption of five resolutions on health system strengthening. As she reports, the resolution on financing and universal coverage drew some debate, as the Thai delegation proposed to shift the issue of universal coverage to the UN General Assembly, with a view to ensuring that it receives more political attention.

- Chantal Blouin

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 1125 Colonel By Drive | Ottawa, Ontario | K1S 5B6 | www.ctpl.ca
 t: 613-520-6696 | f: 613-520-3981
www.ghd-net.org

CONTRIBUTORS

Miriam Faid
 David Gleicher
 Ilona Kickbusch
 Priyanka Kanth
 Rene Loewenson
 Rangarirai Machedze
 Monique Moreau
 Bente Molenaar

EDITOR

Chantal Blouin

MANAGING EDITOR

Monique Moreau

EDITORIAL ASSISTANT

Julian Barbieri

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WHO'S REFORM — A KEY CHALLENGE FOR THE MEMBER STATES

Iлона Kickbusch

In the discussion of the reform proposals presented by the Director General of the World Health Organization (WHO) Dr. Margaret Chan during this year's World Health Assembly (WHA), much of the focus was on the concern that the reform be "member states driven". Suggestions about the inclusion of other actors in global health through a "multistakeholder forum" tentatively called World Health Forum as well as the proposal for a mechanism to pool funds from private entities led a number of countries to come back consistently to the nature of the organisation. To quote the statement of Brazil: "We are convinced that the WHO needs to rediscover and better value its fundamental multilateral identity."

Countries like Thailand did not hold back with the opinion that they considered WHO to be an outdated, lawyer-controlled, overly bureaucratized and donor-driven organization. While they did not analyze how it got there - their conclusion was that is necessary to initiate a "real reform" and create a "new WHO" which would bring other voices into the organization along the model of multistakeholder organizations such as the Global Fund for AIDS tuberculosis's and malaria (GFATM) or the Global Alliance for Vaccines and Immunisation (GAVI). "We need an organisation where partners work together based on trust".

So while one group of countries wanted to ensure that all decision-making power remains with member states, others felt the need to open up the governance structures of the WHO to non-state actors, in particular to civil society, in order to make the organization fit for purpose. All this will now be debated – based on concept papers that will be prepared - not only in the governing bodies of the WHO but among the many other actors who have a stake on global health. They are encouraged, for example through the proposal of the World Health Forum, to come forward with constructive proposals on how inclusiveness could work and on what principles it needs to be built. Already ahead of the WHA a group of civil society organisations had met in New Delhi to discuss their positions. This was summarized in the Delhi Statement, which called on the WHO to "take advantage of its reform process to rethink and reassert itself as the leading actor in a broader governance for health." [1]

The Delhi Statement makes the critical point that all good

global governance begins at home at the national level and that in the final crunch it is governments who need to show the willingness to "tackle the structural downsides associated with the current global health governance - its fragmentation, inadequate global leadership, institutional weakening of mandated bodies, inadequate health financing, erosion of poor countries' ownership of their health and development agenda, etc. - and overcome the poor accountability of the ever-growing number of agencies and initiatives, which has led to unnecessary high transactions costs, wasted resources, and drained absorptive capacity". [1]

While the issues of transparency, inclusiveness and accountability were flagged continuously in the debate at the WHA, the words coherence and responsibility of member states were not heard as frequently. This is the issue that must be faced in the WHO reform debate: to what extent will the success of a reform process depend not only on the Director General and the WHO secretariat but first and foremost on the member states themselves and how they act in the governance bodies and shape their multiple relationships towards the organisation? Very few countries have structures at the national level which ensure coherence in their approach to the WHO. For example, while the representative of the Ministry of Health might vote on certain priorities for the organization and have the responsibility for the assessed contributions to the organisation, the representative of the development agency of the same country might well give the organization significant funds earmarked for a project that is a priority to this agency, not the WHO. The WHO does not yet have a mechanism to stop the counter productive processes under way, including competition between staff and programmes for funds. It is clear – both the WHO and the countries must act differently with urgency.

Decisions are taken at country level to provide significant funds to new organizations like the GFATM or new global health initiatives because this is attractive to the head of state, but the systemic impact of such decisions and their impact on the role of the WHO will not be discussed with colleagues in the Ministries of Health. Very few countries have explicit strategies across government towards global health in general (bringing together for example Ministries of Health, Foreign Affairs and Development or Economic Cooperation), a few now have WHO strategies, linked to their membership in the Executive Board in particular; some have informal and irregular meetings. Very few have mechanisms where they consult with other global health actors in their country or hold web-based consultations on key issues before they come to the World Health Assembly; very few include other actors in their delegations. But if

reforms are to be member states driven they need to be well prepared “back home” in order to carry weight and be sustainable at the global level.

The debate at the WHA and the ensuing discussions at the Executive Board have also highlighted the need to reconsider the governance structures and bodies of the WHO and the role of the member states as they serve on these bodies. This work is now too important to be done in a “fly in – fly out” manner, as might have been sufficient in the past. Many of the issues are highly complex and have impacts far beyond the health sector and the preparation and the conducting of the decision require a high level of commitment, time and expertise. Those member states that have conducted an in depth analysis of a WHO budget will attest to this. Member States will need to consider this as they apply for membership in the governing bodies and it will be critical to think about ways in which countries with fewer resources can be supported to engage fully. Everyone involved, WHO staff and member states representatives must have a better understanding of context and of the negotiation processes involved – not just of the technical issues at stake. The recent negotiations on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits are an excellent example of an interface between health expertise and diplomatic skills. As Dr. Chan stated in her WHA closing speech: PIP is a triumph for health diplomacy.

In order to progress, WHO and member states must look to the structures and processes that have evolved in the United Nations in New York where discussions and negotiations are conducted all year around – mostly by attachés assigned to the issues. More countries should consider dedicated health attachés in Geneva – this will serve both the countries interest and the interests of the global health community, any increase the overall quality and coherence of the negotiations at the WHO and other health agencies. Once the member states have organized their own responsibilities better and once they become a guarantee for quality and coherence of governance then the ownership of the WHO reform process will not be in question. If WHO must earn its leadership, so must the member states – the reform of one is not possible without the other.

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Ilona Kickbusch is the Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva.

THE WORLD HEALTH ASSEMBLY ADOPTS FRAMEWORK TO IMPROVE PANDEMIC PREPAREDNESS



Photo: WHO; P. Viot

Bente Molenaar

bentemolenaar@yahoo.co.uk

Research Associate, Centre for Trade Policy and Law

BACKGROUND

THE ISSUE

The World Health Organization (WHO) Global Influenza Surveillance and Response System (GISRS) has been developed over the past five decades. The system comprises some 100 National Influenza Centres in 90 countries, WHO Collaborating Centres, WHO H5 Reference Laboratories and Essential Regulatory Laboratories. It collects and analyzes influenza virus samples to assess how influenza strains are mutating. This information guides influenza-preparedness efforts and assists in the development of effective influenza vaccines.

At the end of 2006, Indonesia stopped sharing H5N1 virus samples with the GISRS to express its opposition to the system, in which developing countries freely provide samples to the WHO, which are then provided to pharmaceutical companies to develop and patent vaccines that developing countries cannot afford.

GLOBAL HEALTH IMPACT

To date, the virus sample sharing system has fostered the informal sharing of data, which in turn has facilitated the development of vaccines to control seasonal influenza. Many WHO Member States saw the Indonesian decision as undermining pandemic influenza surveillance and pandemic preparedness efforts. Others stressed that this decision led the WHO and developed countries to address global inequities in access to vaccines and other benefits.

THE ROLE OF DIPLOMACY

Resolution WHA 60.28(2007) requested the Director-General (DG) to convene an Intergovernmental Meeting (IGM) to oversee the development of an improved system for virus sample sharing and access to vaccines. At the January 2010 meeting of the Executive Board of the WHO, it was agreed that an open-ended working group be formed with a view to resolving some of the outstanding issues. The Open-Ended Working Group of Member States on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (OEWG) met in May 2010, December 2010 and April 2011.

INTRODUCTION

As delegates at the 64th session of the World Health Assembly (WHA) moved to approve the Pandemic Influenza Preparedness Framework (PIP Framework), a sense of relief in the room could be felt. Negotiations have been ongoing for 4 years, and have often been extremely difficult. The draft Framework and resolution presented to delegates at the WHA had been discussed and in large part agreed to, at the latest meeting of the OEWG which took place in Geneva in April (11-16). Eighty Member States worked into the early morning of Saturday, April 17 to reach agreement. Following the meeting, the WHO issued a press release announcing the milestone agreement. In the words of Dr. Margaret Chan “this has been a long journey [...] but the end result is a very significant victory for public health.” [2]

Between the April meeting and the 64th WHA, Member States worked to resolve a few outstanding issues. In particular, Australia led work to resolve language setting out the relationship between the Nagoya Protocol of the Convention of Biological Diversity and the PIP Framework. The solution, in the end, was to drop reference to the Nagoya Protocol.

THE NEGOTIATIONS TO DATE, AND IMPORTANT COMPONENTS OF THE FRAMEWORK

April Consultations:

Going into the April meeting, there was broad agreement that concluding negotiations and coming up with a PIP Framework to increase predictability and preparedness would represent a significant step forward. After four years of tense negotiations, the mood for compromise prevailed. The ambitious co-chairs, Geneva-based Ambassadors J. Gomez-Camacho of Mexico and B. Angell-Hansen of Norway provided leadership and direction that helped conclude the negotiations. One of the fundamental challenges was to strike a balance between timely and equitable access to vaccines, medicines and other benefits while ensuring incentives for innovation. In the course of negotiations, a series of consultations with stakeholders, including civil society and industry groups were held. The International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) called the consultations ‘constructive and productive’.

The agreed PIP Framework sets out roles and expectations for multiple stakeholders, including industry. The IFPMA notes in an April 18 press release that “the IFPMA submissions to the OEWG/PIP were based on a recognition that the industry had a responsibility to work with the World Health Organization.” [3] Reactions

to the PIP framework from civil society have been cautiously optimistic. The Third World Network and the Berne Declaration, for example, noted that coming to an agreement represented a milestone. They do, however, emphasize that the Framework does not go far enough in securing reasonable levels of benefits for developing countries. [4]

Some key components of the framework:

1. Standard Materials Transfer Agreements (SMTA): the transfer of virus samples and benefits is governed by two separate legally binding SMTAs. SMTA I deals with influenza laboratories designated or recognized by the WHO that work within the Global Influenza Surveillance Network. According to Article 6.1 of SMTA I, “neither the Provider nor the Recipient should seek to obtain any intellectual property rights (IPRs) on the Materials.” For SMTA II, dealing with entities outside the WHO’s Global Influenza Surveillance Network, the focus is on benefit sharing options. This allows for flexibility, recognizing that larger manufacturers might offer a different pool of benefits than smaller producers. Recipients must agree to a selection of benefits. For example, among the options for producers of vaccines and/or antivirals the options include: donation of at least 10% of real time pandemic vaccine production to the WHO; reserve at least 10% of real time vaccine production at affordable prices for the WHO; reserve a specified amount of treatment courses of needed antiviral medicine for the pandemic to WHO; and royalty free licenses for manufacturers in developing countries, or granting WHO royalty-free non-exclusive licenses on IPR.

2. Pandemic Influenza Preparedness Benefit Sharing System: Section 6 of the Framework calls upon all relevant institutions, organizations and entities to contribute to the Benefit Sharing System. The system will seek to provide pandemic surveillance, risk assessment and other benefits including antiviral medicine and vaccines. Article 6.14.3 holds that “influenza vaccine, diagnostic and pharmaceutical manufacturers, using the GISRS will make an annual partnership contribution to the WHO for improving global pandemic preparedness and response.” The partnership contribution will be 50 percent of the running costs of the GISRS. In 2010 this amounted to US\$ 56.5 million.

The Agreement also gives a nod to the importance of capacity building in receiving countries. Article 6.1.2 (iv) states that such capacity should be built “over time for and through technical assistance and transfer of technology, skills and know-how.” Further Articles in

this section support the establishment of antiviral and vaccine stockpiles for use in the containment of influenza outbreaks with pandemic potential. Article 6.13 tackles the question of technology transfer. Critics, including the Third World Network and the Berne Declaration note that there are no mandatory requirements, and Member States are merely asked to “urge influenza vaccine, diagnostic and pharmaceutical manufacturers to make specific efforts to transfer these technologies to other countries, particularly developing countries, as appropriate” [4]

REACTIONS TO THE PIP FRAMEWORK AT THE WORLD HEALTH ASSEMBLY

The 64th WHA was asked to adopt the PIP Framework through the draft resolution presented to them by the OEWG. The OEWG strongly recommended that the WHA consider the outstanding issues around the reference to the Nagoya Protocol, without re-opening the Framework for negotiation. [5]

At the WHA, the Australian delegate spoke first, reporting that it had been impossible to reach agreement on reference to the Nagoya Protocol. Consequently, they proposed deleting the reference as a way forward. As Member States had discussed this issue extensively, there was broad agreement with this approach.

The vast majority of interventions at the WHA expressed support of the PIP Framework and the resolution with the proposed amendment, and re-emphasized the importance of a more equitable and predictable global system. Indonesia, speaking on behalf of the South East Asian region, noted that these negotiations had brought all parties out of their comfort zone, engaging positively with other actors, such as industry. The Indonesian delegate further noted that this global system is more equal and more transparent and that the Framework will contribute to increased preparedness. The Brazilian delegate called the agreement ‘historic,’ and noted that the PIP process could serve as a model for future negotiations as it involved non-state actors from civil society and industry - representing an example of democratisation in process.

As an addition to the resolution, the US asked for the insertion of a reference to Article 23 of the WHO Constitution in operational paragraph 1, which was accepted. Article 23 states that “The Health Assembly shall have authority to make recommendations to members with respect to any matter within the competence of the Organization.” The Hungarian delegate, speaking for the EU, and the delegate from Canada stressed that the Framework will be the Framework to govern the sharing of pandemic influenza materials. The delegate from Jamaica caused a last minute stir as she proposed the insertion of a

new paragraph to the draft resolution; the proposed amendment was later withdrawn. Bolivia provided a statement on its national position. In it, they express their concern with the Standard Materials Transfer Agreement with entities outside the WHO GISRS. Bolivia presented a proposal at the latest open-ended working group meeting to ensure that “the biological materials and parts thereof shared through the Pandemic Influenza Preparedness Framework are not appropriated by entities outside the WHO GISRS through the patent system.” In the spirit of collaboration, Bolivia withdrew its proposal, but continues to strongly state their reservation. [4]

NEXT STEPS

The Swiss delegate reminded the Assembly that the International Health Regulation Review Committee on the H1N1 pandemic found that the world is not yet well enough prepared for future pandemics. He urged the WHO to move swiftly towards implementation, a sentiment echoed by several other delegations including Zimbabwe, which spoke on behalf of the African region.

The DG, along with an Advisory Group will play an important role in the over-sight mechanism of the Framework. The Advisory Group was established in 2007 (Interim Statement of 2007), and is composed of international experts “serving the Organization exclusively.” Its role and obligations are set out in section 7 of the Framework. The DG, with the Advisory Group, is requested to report to the WHA on implementation biannually.

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WORLD HEALTH ASSEMBLY DISCUSSES REFORMS OF THE WHO



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Miriam Faid

miriam.faid@graduateinstitute.ch

Research Assistant, Global Health Programme, The Graduate Institute, Geneva

David Gleicher

davidgleicher@globalhealtheurope.org

Project Officer, Global Health Europe

BACKGROUND

THE ISSUE

The World Health Organization (WHO) is embarking on the most extensive administrative, managerial, and financial reforms in its 63-year history. While reform discussions started in 2010 under the title “Future Financing for the WHO,” they have since expanded to encompass questions around the WHO’s position within today’s fragmented global health governance architecture. Reform discussions have also included deliberations about convening a multi-stakeholder forum for global health with the purpose to increase the engagement of global health-relevant actors. The first such World Health Forum is planned to be held in Geneva in the last quarter of 2012 with participants representing member states, civil society, private sector, academia, and other international organizations.

GLOBAL HEALTH IMPACT

The reform agenda is guided by the ambition to turn the WHO into a more effective, efficient, responsive, objective, transparent and accountable global health agent. Core business areas of a more “fit for purpose” WHO include: the WHO as convenor; as a facilitator to collect, collate, analyze, and disseminate health data worldwide; as a key source of authoritative advice on health through the production of norms, standards, and guidelines; as a coordinator in health security; and as an important co-player in strengthening health systems and institutions. Currently, financial (mostly ear-marked) support for the WHO does not give priority to the WHO’s key strengths, thereby hampering the organization to leverage the biggest possible improvements in health worldwide. Increasing flexible funding therefore remains an essential reform component to enable the WHO to live up to its priorities.

THE ROLE OF DIPLOMACY:

The World Health Assembly (WHA) discussions on agenda item 11, “The future of financing for WHO,” were

based on three documents: (1) the Director-General Report on “The future of financing for WHO” (A 64/4); (2) a report on “Financial and Administrative Implications for the Secretariat of Resolutions Proposed for Adoption by the Executive Board or Health Assembly” (A 764/4 Add.1); and (3) a “Development Plan” with further details on the reform. Following the adoption of the documents by this 64th WHA, detailed plans for each of the specific elements of the WHO reforms will be further presented at the 130th session of the Executive Board in January 2012, and the 65th World Health Assembly in May 2012.

THE WHO AND MEMBERSTATES

The World Health Organization (WHO) was founded to attain higher levels of health for all people, but the world in which the WHO operates today is very different from that of 63 years ago. While this overriding aim is still guiding the WHO’s work, the strategies and the context in which the WHO strives to pursue this goal have certainly changed in today’s highly complex – multi-level, multi-actor, multi-issue– global governance system. Hence, reforming the WHO to make it fit for purpose is essential in order to maintain a critical role as the world’s leading technical authority on health. According to the WHO Director-General Report A 64/4, the reform framework aims to provide: (1) a greater coherence in global health, with the WHO playing a leading role in enabling the many different actors to play an active and effective role in contributing to the health of all peoples; (2) improved health outcomes, with the WHO meeting the expectations of its member states and partners in addressing agreed global health priorities, focused on the actions and areas where the organization has a unique function or comparative advantage, and financed in a way that facilitates this focus; and (3) an organization which pursues excellence.

During the World Health Assembly (WHA), the discussions on reforms of the WHO, summarized below, focused on five issues: the creation of a new multi-stakeholder forum, financing options for the WHO, the role of regional and country offices, and reforms of management for better transparency and accountability.

CREATION OF A MULTI-STAKEHOLDER FORUM FOR GLOBAL HEALTH

The biggest controversy during these WHA discussions emerged around the WHO’s current deliberations to convene a first-ever multi-stakeholder forum for global health. While a number of member states welcomed the idea of the forum, several member states criticized the current lack of details on its establishment, as well as the potential threat to eventually compromise the WHO’s nature and objectives through the increasing influence of

private actors. This view was particularly supported by the four intervening NGOs: Medicus Mundi International, World Vision International, CMC Churches' Action for Health, and Corporate Accountability International. They articulated shared concerns that the Global Health Forum could institutionalize conflict of interest as a norm of the WHO. Despite the call for a more inclusive WHO, Thailand rejected the initiative all together, arguing that it would not present a good starting point for genuinely reforming the WHO. All EU countries, Australia, Canada, Finland (on behalf of the Nordic countries), India, Sri Lanka, Switzerland, and the United States, requested further clarification on the possible parameters and financing structure of the forum. In particular, the WHO would have to ensure that such a forum would be representative, legitimate, cost-effective, and transparent, with clear objectives and clarity on its role vis-à-vis the WHO.

FINANCING

Since many of the WHO's traditional donors face their own budgetary challenges at home, the WHO must attract new donors and explore new funding sources in order to extend the core financial resources. Director-General (DG) Margaret Chan underlined that it will still take time for emerging economies to make financial contributions to the organization. In particular, the WHO seeks to increase the proportion of flexible funding, i.e., non-earmarked funding. According to commonly cited numbers, extra-budgetary funding currently represents almost 80 percent of the organization's total budget and steers WHO action into health policies that do not take into account the disease burden of countries. Thailand called the WHO a donor-driven organization, adding that current reform discussions would not enable a necessary genuine reform movement that could turn the WHO into a publicly steered institution. While most countries commented on the necessity to increase flexible funding, there was disagreement on whether flexible funding should merely come from member states or whether private actors could be considered as alternative sources. The UK announced that it would maintain its voluntary contributions for the next two years, with the option of reviewing WHO performance by then and adjusting its funding according to the results-driven quality of the WHO. Germany took a very different stance in proclaiming that the common assumption that more flexible funding would be needed was simply wrong. Earmarked funding would only need to be better coordinated, also in view of eliminating the ineffective situation of having different WHO clusters fighting for the same funding sources. Brazil cited a WHO-envisioned outcome from the development plan, whereby one of the reform outcomes would be "an expanded

resource base, including a mechanism to pool funds from private entities." Brazil emphasized that it would not approve this stance. "WHO must not be driven by private donors," Brazil underlined.

THE ROLE OF WHO REGIONAL AND COUNTRY OFFICES

DG Chan has proposed reforms that align the work of Geneva's headquarters with activities undertaken in its six regional offices, which are autonomous agencies "to an extent seen in no other UN agency, electing their own heads, controlling large amounts of the WHO's funds and largely fixing their own policies."

While member states agreed to ensure coherence across all WHO governance levels, France underlined that the principle of subsidiarity would be indispensable in attaining coherence, with implementation and independence of action being delegated to the lowest level at which responsibilities can be properly fulfilled. South Africa stressed that "WHO needs to be globally empowered and locally enabled" and that this approach should be considered by WHO when redefining its structural arrangements. Switzerland and China both urged the member states to make complementary efforts in this regard, in that they should all become more coherent at the national level as well. Discussions about improving WHO governance also entailed the future role of WHO country offices. Currently, the WHO's role at country level has "increasingly geared towards helping member states to coordinate other partners, articulate and develop national health priorities and strategies and to manage a growing range of emergencies and disasters." While member states in principle agree with strengthening the role of country offices, Bangladesh said that the specific situation within countries would need to be considered in order to account for the countries' disproportions in disease-burden. Local and regional actors would have to be considered through a needs-based approach. Iran added that country officers, especially in developing countries, are better positioned to determine what needs to be done locally in order to enhance the effectiveness at country level.

STRONGER RESULTS-BASED PLANNING, MANAGEMENT AND ACCOUNTABILITY

The WHO reform package as it is currently outlined in the DG report A 64/4 is also reviewing the relationship between WHO's planning instruments, notably on strategic planning, budgeting, and report preparation. "A key objective is to ensure that the next programme budget, to begin implementation in 2014, is developed in such a way that it can act as a more effective framework for accountability and transparency, as the main instrument

for resource mobilization, and as a programming tool that is actually used by managers.” The 2012-2013 budget is a transitional budget that aims to move the WHO towards more realistic, predictable, and sustainable programme budgets in the future. The importance of this reform element was stressed in the comments made by Finland (on behalf of Nordic countries and aligned with the EU statement), Germany, Switzerland, and the United States.

Member states also commented on the suggestion made in the DG report A 64/4 on the use of independent evaluation, where it is stated that “independent evaluation will play an important role in further shaping and guiding the reform process.” Algeria (on behalf of WHO/AFRO), Australia, Canada, France, Switzerland, and the United States all welcomed the idea of conducting independent evaluations. Algeria stressed that such a process would be seen to be critical for African and other developing countries to meet the Millennium Development Goals. Responding to Member States’ comments, DG Chan emphasized the need for independent evaluations focusing on WHO’s work in strengthening health systems.

CONCLUSIONS

Closing the session on agenda item 11, “Future Financing for WHO,” Director-General Margaret Chan reiterated the WHO’s willingness to continue consultations with member states through an inclusive and transparent process. At the same time, Chan also emphasized that she would need to include other partners in her deliberations as well, such as civil society organizations, global health initiatives, or the private sector. “Let me emphasize that WHO will always be a member states-driven organization. I will therefore consult, consult, and consult to achieve inclusive and transparent results, but you member states also have to play your parts,” Chan concluded. With the member states accepting resolution WHA64.2 on “The future of financing for WHO,” the Director-General is asked to: (1) present a detailed concept paper for the November 2012 World Health Forum, setting out objectives, numbers of participants, format, and costs to the Executive Board at its 130th session in January 2012; and (2) develop an approach to independent evaluation in consultation with member states. An update on the progress will be presented through the Executive Board at the 65th World Health Assembly.

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SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS SPARKS DEBATE



Photo: BBC News Health

rmachemedze@seatini.org

Rangarirai Machemedze

Deputy Director, SEATINI

BACKGROUND

THE ISSUE

The destruction of stocks of variola virus, the agent that causes the disease smallpox, has been discussed at the World Health Assembly (WHA) since 1986, following the declaration of smallpox eradication in 1980.[1] Several WHA committees have held intensive discussions on whether the remaining live variola virus stocks, held in the two official repositories at the US government's Centres for Disease Control (CDC) in Atlanta and at the Russian State Centre for Research on Virology and Biotechnology (VECTOR), should be retained for further public health research.[2] The United States and Russia still retain smallpox virus (*Variola major*), an easily transmitted disease. Now, at the 64th WHA, the World Health Organization (WHO) members are divided over the destruction of the virus stocks.

GLOBAL HEALTH IMPACT

Although smallpox has been completely eradicated, the disease left a scar on the conscience of the world and concerns have been raised that any accidental release of the virus would be catastrophic. According to reports,[3] "the last reported human smallpox cases occurred in 1978 at the University of Birmingham in the United Kingdom. A medical photographer who worked above a laboratory where smallpox virus was being studied contracted the disease from a laboratory leak. Before dying, the photographer infected her mother." Smallpox is thought to have killed around 300 million people in the 20th Century alone. As late as the 1960s, the disease still killed more than two million people every year. The last naturally occurring smallpox outbreak was in Somalia's Kurtunwaarey District in October 1977, a year before the UK tragedy.

THE ROLE OF DIPLOMACY

In 1978, the WHO established a global commission to certify that smallpox was no longer transmitted in nature, and, in Resolution 33.3 of the 1980 WHA, declared the total eradication of the disease.[4] In the preceding year, in December 1979, the WHA adopted the global commission's conclusions in Resolution 33.4, which states: "No more than four WHO collaborating centres should be approved as suitable to hold, and handle, stocks of variola virus" and that "other

laboratories should be asked to destroy any stocks...or transfer them to an approved WHO collaborating centre." In accordance with WHA 33.4, in the late 1970s and early 1980s smallpox samples were eventually transferred to only two laboratories in the United States and Russia. In 1996, at the 49th WHA, Resolution WHA 49.10 recommended the destruction of the remaining stocks of variola virus on 30 June 1999, after a decision by the Health Assembly. Subsequent to this, the 1999 52nd WHA in resolution WHA52.10 authorized temporary retention of the virus stocks, and in WHA 55.15 in 2002 the WHA further authorized the same for research purposes, provided the research was outcome oriented, time limited, and periodically reviewed, and agreed to propose a new date for destruction.

The eradication of smallpox was successful largely because of the WHO-led public health surveillance and targeted vaccination program that began in 1967. The UK case is a reminder to the world that any deliberate or accidental leakage of the viruses that are kept in the laboratories can infect millions of people, especially given the fact that many countries do not have vaccines at hand should that happen. This case highlights the importance for WHO members to respect their resolutions, and build trust and come together to destroy the remaining stockpiles of the deadly virus.

INTRODUCTION

The United States of America, supported by the Russian Federation and 25 other members that include seven Sub-Saharan African countries, co-sponsored a draft resolution for consideration by the 64th World Health Assembly (WHA) to further retain the existing stocks of live variola virus "at the current locations specified in resolution WHA52.10." [5] According to the proposed resolution, the motivation to temporarily retain the virus stocks was to allow for further international research on the viruses. This echoes previous resolutions of the WHA that had authorized the retention of the virus for the purpose of "further international research into antiviral agents and improved vaccines, and to permit high priority investigations of the genetic structure and pathogenesis of smallpox." [6]

One of the delegations that supported the US-sponsored resolution was forthright when they noted that, in the present day when the fight against terrorism is a priority, it is important to always be prepared for any potential threat of "mass destruction like the one posed by smallpox." [7] Smallpox is a potential weapon of bioterrorism and a real security concern for the international community. According to the US National Science Advisory Board for Bio-security, biological select agents, like the variola virus, "are living organisms that can be grown into large quantities from a minimal starting sample, manipulated in non-laboratory settings, and disseminated. These attributes make attempts to maintain

inventories far more challenging.”[8]

The 60th meeting of the WHA adopted resolution WHA60.1 on smallpox eradication, which requested the Director General (DG) of the WHO to undertake a major review by 2010 of the relevant research in order to enable the 64th WHA meeting in May 2011 to reach a global consensus on the timing of the destruction of the existing variola virus stocks.

The review was undertaken and findings of the report indicate that most of the research is complete. However, there are differences in opinion on the need to retain the live virus for the purpose of licensure of at least two vaccines, as well as development of antivirals. This may have prompted the United States to sponsor the above resolution. One of the observations, in the concluding discussion of the report, notes that “it is not currently possible to predict how much longer work with live VARV [variola virus] will be required. However, it would certainly be required until at least two drugs are approved for treatment of clinical smallpox.”[1]

DISAGREEMENTS

The proposed US-sponsored resolution was met with vehement opposition from other members of the WHO, who felt that the continued retention of the stocks was a threat to global health security. Zimbabwe noted that as long as the two repositories in the United States and the Russian Federation exist and maintain stocks of the variola virus, there will always be a potential global threat of the resurgence of the disease:

We are concerned that despite that there was consensus in the WHA in 1986, 1990, 1994 on the destruction of the remaining stocks, the US and the Russian Federation continue to maintain these. If the two countries continue to maintain virus stocks, against the wish of the majority of member states, then they do not have any moral authority to request others to destroy or transfer stocks to their repositories, stated the Zimbabwean statement.[9]

The above was in apparent reference to the draft resolution which further called on “each member state to confirm to the Director General [of WHO] by May 2012 through official written communication that they do not currently possess live variola virus within their borders and, if they previously possessed variola virus stocks, that those stocks and samples have been transferred to the official repositories or destroyed in accordance with resolution WHA33.4.” Other delegates, who preferred anonymity, further questioned the real motive of keeping the variola virus. They argued that what the United States was proposing was taking everyone two decades back, to the Cold War era when there was a lot of mistrust between countries, despite there being no documented evidence of any other stocks besides the ones held by the United States and the Russian Federation.[10]

As views in the meeting became polarized, the issue was referred to an informal group to allow members to narrow their differences. The informal group met in two sessions in which

50 member states participated. The discussions in the informal group were centred mostly on three issues. The major issue was to agree on whether the current WHA should decide on a date for the destruction of the variola virus stocks. Another issue was the concern that there could be some unknown and unauthorised existence of virus stocks held in some countries. The third issue surrounded references to global security, which some member states said was beyond the mandate of the WHO. The call for member states to confirm that they had no stocks was also opposed by other member states. They also opposed the linking of the date of destruction to assurances that no other variola virus stocks existed. The informal working group could not reach a consensus on these issues and agreed to refer the matter back to Committee A for a decision.

In the Committee A meeting on the last day of the WHA, positions were still polarised with some delegations supporting the idea that the issue be dealt with at the 67th WHA in 2014, as proposed by Switzerland. Other members thought that to wait for three years was unacceptable and proposed the 65th WHA meeting to give members more time to consult. A compromise date suggested by Thailand was the 66th WHA, and this further polarised the discussions. The meeting was temporarily suspended to allow the Director General to consult with various members on a possible compromise. After some diplomatic shuttling between the different delegations, the DG, through the chairman of the meeting, announced that the member states had agreed on a compromise text.

NEXT STEPS

The text has three paragraphs which reaffirm the previous decisions of the WHA that the current variola virus stocks held by the United States and the Russian Federation should be destroyed. The decision also agrees to put the issue on the agenda of the 67th World Health Assembly in 2014 through the Executive Board following the 66th WHA.

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SMALL STEPS TAKEN AT THE MOSCOW MINISTERIAL MEETING AND WHA ON PREPARING FOR THE UN HIGH-LEVEL MEETING ON NCDs



Photo: World Lung Foundation

Monique Moreau

monique_moreau@carleton.ca

Centre for Trade Policy and Law

BACKGROUND

THE ISSUE

The UN General Assembly will hold a High-Level meeting on non-communicable diseases (NCDs) in New York from September 19-20, 2011. This is the first time that the world's leaders will convene to discuss concerted actions to address the challenges posed by NCDs, and the second time only that the UN General Assembly focuses on global health, following its Special Session on HIV/AIDS in 2001.

Member states, international organizations, civil society, and the business community are now engaged in discussions as to what commitments should be included in the outcome document that will be agreed upon at the Summit.

Prevention and control of NCDs have risen on the global health agenda not only due to the increasingly heavy global disease burden associated to them, but also because of a greater attention given to the economic impact of NCDs. For instance, in its annual report on global risks, the World Economic Forum highlighted chronic diseases as one of the key risks to the global economy. The economic risks are not only caused by rising healthcare costs, but even more so by the productivity losses associated to death, disability, and work absence caused by NCDs. [1]

GLOBAL HEALTH IMPACT

NCDs, mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are the world's biggest killers, causing an estimated 35 million deaths each year - 60% of all deaths globally - with 80% in low- and middle-income countries. [1] These diseases are preventable. Up to 80% of heart disease, stroke, and type 2 diabetes, and over a third of cancers, could be prevented by eliminating shared risk factors, mainly tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.

THE ROLE OF DIPLOMACY

In the resolution proposed by CARICOM and adopted last September at the UN General Assembly to convene

the Summit, governments expressed their conviction that there is urgent need "to undertake multilateral efforts at the highest political level to address the rising prevalence, morbidity and mortality of non-communicable diseases worldwide and to raise the priority accorded to non-communicable diseases in development cooperation".[5] The outcome document that will be adopted by leaders at the High-level meeting brings this challenge beyond the traditional health forum in order to receive this higher level of attention from political actors.

MOSCOW MINISTERIAL DECLARATION

On April 28 and 29, Health Ministers met in Moscow for the First Global Ministerial Conference on Healthy Lifestyles and noncommunicable disease (NCD) Control. The meeting resulted in a declaration which did not include specific measurable targets; consultations with member states and stakeholders have highlighted that the outcome document adopted in New York should include such targets. [6] Rather, the Declaration reiterates commitments and rationale for action that do not go much further than what we can find in the 2008-2013 Action Plan for the Global Strategy on Prevention and Control of NCDs. The Ministerial meeting was neither the occasion for countries to make financial commitments to devote resources to the global responses to the prevention and treatment of NCDs. The declaration prudently states that member states are committed to "investigating all possible means to identify and mobilize the necessary financial, human and technical resources in ways that do not undermine other health objectives." [6] In terms of the importance of stakeholder engagement, the Declaration is explicit that the role of civil society and the private sector is crucial for success, but does not specify how such engagement should take place. The Ministerial meeting was also an opportunity for member states to share their experiences with NCD prevention and control. Some participants highlighted this as positive component of the meeting. [7]

DISCUSSIONS AT THE WHA

During the World Health Assembly (WHA), Member States adopted the resolution "Preparations for the High-level Meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, following on the Moscow Conference." [9] The brief resolution endorses the Moscow Ministerial Declaration, and urges Member States to ensure the attendance of their Heads of State/Government at the UN High-level Meeting to be held in New York on September 19-20, 2011. This element is particularly important, since, as

mentioned in informal discussions and side events held during the Assembly, some delegates expressed concern that if the messaging surrounding the importance of NCDs was not appropriately managed, their Heads of State/Government may not be convinced to participate to the UN High Level Meeting.

Although originally set for discussion early on in the agenda at the WHA, the negotiations on the resolution were moved to private, delegate-only meetings where negotiations went on for several days. Despite the adoption of the resolution, some delegates and representatives civil society groups expressed concerns with the lack of specific commitment in the resolution, with the exclusion of mental health and with allocation of financial resources for NCDs.

EXCLUSION OF MENTAL HEALTH

In the introductory interventions leading up to the adoption of the resolution, many countries and civil society groups expressed their concern that mental health was not integrated in the preparation to the UN High-level Meeting. Some Members feared that the WHA resolution would separate or fail to include mental health-related issues from the four priority diseases that the WHO had defined as requiring immediate attention. Although the Moscow Declaration, which was endorsed by the WHA resolution, includes mention of the burden mental health diseases place on NCDs, it is not highlighted as a separate issue, but merely included as a disease among the many “other” NCDs. [10]

CONCERNS ABOUT FUNDING NCD PREVENTION AND CONTROL

Despite the general sense of cooperation amongst members on the issue of prevention and control of NCDs, some members, especially from African delegations, were concerned with the question of how to finance the outcomes from the Resolution and any forthcoming commitments made at the UN High-level Meeting to be held in September. There was a general sense of concern that funds could be diverted from achieving the Millennium Development Goals (MDGs) and their focus on addressing communicable diseases. A delegate from Zambia, although supportive of the resolution, expressed concerns about any “shift in resources” which may divert funds from malaria and tuberculosis, diseases that remain problematic in his country. [11]

Similarly, a delegate from Togo noted that although the resolution is not perfect, the members had to “start somewhere” and ultimately it will require a few years to see if any of the suggested actions in the resolutions will have had an impact. [12] As mentioned by his other African

colleagues, he noted that at the Brazzaville meeting of the African region countries held on April 6, 2011, delegates were firm that any funding for NCDs could not come from funding in place for communicable diseases.

On the morning of the release of the resolution, a delegate shared that although the discussions were intense, ultimately they were disappointing, as the Assembly did not appreciate the immediacy of the NCD issue. Some delegates had tried to encourage their counterparts to take action now, and not wait for the UN High-level Meeting in September. However, most Members were not prepared to make commitments at the WHA and were waiting for further discussions to take place regarding the outcome document for September.

CIVIL SOCIETY CONCERNS

A number of civil society groups and other intergovernmental groups (IGOs) are concerned with the prevention and control of NCDs. Sixteen NGOs and IGOs intervened during the Assembly with their concerns. Reflecting the vast number of organizations around the world that deal with NCDs, four international federations representing the four main NCDs have combined forces as the NCD Alliance, and were represented during the Assembly interventions by the Union for International Cancer Control. The NCD Alliance is also comprised of hundreds of organizations that form their Working Group and Common Interest Groups. The NCD Alliance has proposed thirty four outcomes for the UN High-level Meeting, calling on member states to take leadership in their own countries, with suggested commitments ranging from reducing NCD death rates by 2% per year, accelerating the effective implementation of the Framework Convention on Tobacco Control, and the development and implementation of regulatory measures to achieve substantial reductions in levels of saturated fats, trans-fats, salt and refined sugars in processed foods, among others. [13]

Interventions from other IGOs and NGOs reflected some of the same apprehensions of the African delegates and others who had concerns about mental health. Ilker Kayi, who intervened on behalf of the People’s Health Movement (PHM) and Medicus Mundi, noted in his intervention that the current approach was too narrow and should include mental health. He also indicated that any outcome document should include preventative measures for the social and environmental factors that contribute to NCDs. [14] The PHM also called on Member States to reconsider the old “victim blaming” approach they feel the WHO is using instead of core determinants, referring to the Commission on Social Determinants and Health’s report that lists marketing pressure, education, income,

gender and ethnicity. [15] Also, while they recognize the importance of prevention for NCDs, they also urge Member States to consider affordable treatment for these diseases. [15]

NEXT STEPS BEFORE THE UN HIGH-LEVEL MEETING IN SEPTEMBER

On June 16, 2011 in New York, the President of the UN General Assembly is holding an Informal Interactive Hearing on Non-Communicable Diseases (NCDs) with non-governmental organizations, civil society organizations, the private sector and academia. Organisations and individuals can also submit their views to the President electronically by June 10, 2011. [16]

Discussions will be ongoing over the next several weeks and months in anticipation of the UN High-level Meeting. The draft outcome document will be written in the coming weeks and a draft version should be made available online before the September 19-20, 2011 meeting of Heads of States and Governments.

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BRINGING AFRICAN PRIORITIES TO GLOBAL ACTION ON NCDs



Photo: The Common Wealth Secretariat

Rene Loewenson

Training and Research Support Centre

admin@tarsc.org

BACKGROUND

THE ISSUE

African countries and communities seek to ensure that the global response to non-communicable diseases (NCDs) takes into account African contexts and concerns, including the double burden of communicable and non-communicable diseases; priority NCDs such as injury and mental disorders; health system challenges to address chronic care; and the impact of globalization, trade, and urbanization in intensifying risk environments for NCDs in Africa.

GLOBAL HEALTH IMPACT

Nearly two thirds of the 57 million global deaths in 2008 were due to NCDs, principally cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases — the “global four” prioritized by the World Health Organization (WHO).[1] While NCD prevalence will increase globally by 17 percent in the next ten years, in the African region it is projected to increase by 27 percent.[5] Already burdens are high, with surveys showing, for example, a prevalence of hypertension of between 30 and 60 percent in West and South Africa. [5] African countries face this increasing NCD burden in the context of still high levels of communicable disease. Lifestyle factors that lead to NCDs arise within economic and social conditions in African countries that are affected by globalization, trade, and urbanization. The burdens are highest for the lowest income groups, increasing global inequalities in health. African countries face resource, capacity, and technology constraints in improving detection, prevention, and management of NCDs.

THE ROLE OF DIPLOMACY

After the 2011 Brazzaville meeting of African Ministers of Health on NCDs, the 2011 Moscow Ministerial meeting, and the resolution on NCDs at the World Health Assembly (WHA), the United Nations (UN) High-level Meeting on Prevention and Control of NCDs in New York in September 2011 will be a major global forum for consolidating commitments and action on NCDs. African concerns on NCDs will need to be raised at this forum, including for investments additional to current contributions.

RAISING THE PROFILE OF NCDs IN AFRICA

In African countries, mortality from NCDs is projected to exceed communicable, maternal, perinatal, and nutritional diseases as the most common cause of death by 2030 and is already slowing progress in Africa’s achievement of the Millennium Development Goals.[1,2,3] While accepting the priority given by WHO to the “global four” diseases above, in their 2011 Brazzaville Declaration[3] and their contributions to discussions at the recent WHA, African countries urged for attention to other NCDs affecting Africans, including haemoglobinopathies (in particular sickle cell disease), mental disorders, violence and injuries, oral and eye diseases[3,4]. The global response to NCDs is applied within specific country contexts. While 22 African countries have implemented WHO “STEPS” surveys to generate data on their NCD situation, it was also proposed at the WHA that countries implement situation analyses of their health and risk profiles for NCDs and of their capacities to respond.

WITHOUT LOSING FOCUS ON (OR RESOURCES FOR) COMMUNICABLE DISEASES

African countries cautioned at the WHA that communicable diseases remain the major contributor to mortality in Africa, and interact with NCDs. For example, patients with HIV have a higher prevalence of insulin resistance, diabetes, cancer, and cardiovascular diseases.[5] A Commonwealth health ministers meeting on NCDs held immediately prior to the 2011 WHA proposed that next year’s meeting will focus on the links between communicable and non-communicable diseases. In their Brazzaville Declaration and at the WHA, African countries repeatedly urged that the new focus on NCDs should not lead to any reduction in investments in managing communicable diseases.[3] Nigeria proposed at the WHA that a global fund for NCDs be established to assist in financing the health sector response to NCDs.

MEETING TREATMENT NEEDS...

At present, many countries rely on hospital-centred care for NCDs, with patients presenting late with complications. This is an expensive, ineffective approach, denying people the benefits of early intervention.[1] Capacity for early detection and chronic care in African countries is underdeveloped. Health care systems face challenges in ensuring a steady supply of affordable, appropriate, and good quality medicines, vaccines, and diagnostics, supported by generic production, rational use of medicines and diagnostic tools, and incentives for research and innovation.[6,7] At a meeting in Kampala in 2009, the International Alliance of Patients’ Organizations (IAPO) also raised the need for greater involvement of people with NCDs in shaping service practices and improved interaction between health professionals and patients.[8]

BUT GIVING PRIORITY TO PREVENTION, ALTHOUGH WITH DEBATE ON WHAT THIS IMPLIES

African ministers cautioned that “for Africa, the cost of intervention will be cheaper if we focus on prevention strategies,, whilst wishing “that NCDs were like childhood diseases prevented through “vaccines and immunization.”[4] In fact, vaccinations are now available against Hepatitis B, a major cause of liver cancer, and against human papillomavirus (HPV), the main cause of cervical cancer. New opportunities appear to be growing for such prevention technologies, and African countries will need to overcome the same cost, technology, and patenting constraints to access these vaccines as they are facing for vaccinations for communicable diseases.

Speaker after speaker in support of action on NCDs at the WHA focused on the need for “lifestyle changes.” The title of the First Global Ministerial Conference in Moscow in April 2011, “Healthy Lifestyles and NCDs,” profiled lifestyle issues.[9] Yet the sedentary lives, unhealthy diets, consumption of alcohol and tobacco and other lifestyle factors associated with the rise in NCDs in Africa are an outcome of deeper social determinants, referred to by some countries and civil society groups at the WHA (Ecuador, the European Union, Canada, Unión de Naciones Suramericanas (UNASUR), People’s Health Movement (PHM), Medicus Mundi, and the World Medical Association). They called for multi-level, multi-sectoral measures to act on the deeper social determinants that contribute to the increase in the NCD burden.[10] In Africa, these underlying causes are themselves being accelerated by wider social and economic changes, including aggressive trade and marketing of unhealthy products, rapid unplanned urbanization, unhealthy transport systems, insecure jobs, and so on.[2] In the 2011 Brazzaville declaration, African countries noted that while “globalization, trade and urbanization” are important for human development, they are also major external drivers of health problems and widening health inequities.[3] Vertical initiatives within the health sector are insufficient to address these issues and “whole of government” action is needed, such as in transport and urban planning, or industry and trade.[10] Many population-wide interventions already exist, particularly in high income countries, such as banning smoking in public places; restricting access to retailed alcohol; banning advertising for and raising taxes on alcohol and tobacco; reducing salt content of food; replacing trans-fat in food with polyunsaturated fat; and using food taxes, subsidies, and marketing controls to promote healthy diets.[2] Many African governments have, however, had difficulty in keeping up with the pace of economic change through such health promoting

policies, laws, and services. They may also be reluctant to implement these policies if they are seen to impede economic growth. Without the protection of healthy public policies, however, those in lower social and economic positions are more likely to become ill, to spend more on catastrophic illness, and to die sooner as a result of NCDs. [2] With existing high levels of poverty, global support for action on “upstream determinants” has key importance in Africa.

GLOBAL DIPLOMACY ON NCDs: NEXT STEPS

Within Africa, the Brazzaville Declaration on NCDs[3] adds to other African declarations, such as the Libreville Declaration on Health and Environment in Africa (2008), and builds on alliances for action such as the African Tobacco Control Consortium.[5] The effort now is to consolidate these various platforms. The UN High-level Meeting on NCDs in New York in September 2011, with participation by heads of states and global health organizations, will be a major global opportunity for this.

The success of the September UN meeting will lie in the extent to which it is able to bring global commitment and resources to local contexts, such as those in Africa. At the WHA, African countries indicated their desire to see action on specific common determinants like tobacco use, alcohol, diet, and physical activity, but also investments additional to current contributions for health systems to deal better with chronic care. Civil society through PHM also wanted to see change in the practices of companies that generate risks for NCDs. African countries will review what has been done and with what impact at the Africa Regional Committee of Health Ministers in 2014.[3] In the meantime, African countries have called for the UN to include NCD prevention and management in all future global development goals, and to establish a mechanism to monitor delivery on commitments made at the UN high-level meeting. The NCD Alliance called for a high-level Commission on Accountability for Action on NCDs to ensure this monitoring.[7] Representatives of patient organizations at the WHA made clear that they want to see greater inclusion of patients in all processes at all levels: “For us fighting for our lives against cancer, diabetes, serious heart or lung disease... not including patients in the mobilization is wrong.”

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KEEPING THE GLOBAL MOMENTUM ON AIDS: WHA ADOPTS STRATEGY FOR 2011-2015



Photo: Shout-Africa.com

Rene Loewenson

admin@tarsc.org

Training and Research Support Centre

BACKGROUND

THE ISSUE

In May 2011, the World Health Assembly (WHA) adopted a global health sector strategy for HIV/AIDS 2011-2015. The strategy asserts a global leadership and "pathfinding" role for the World Health Organization (WHO) in health governance on AIDS, and provides four strategic directions for the future response. Mobilising adequate resources will be a critical challenge, as will co-ordinating the global actors and supporting countries to implement the strategy.

GLOBAL HEALTH IMPACT

An expansion of funding for AIDS to US\$15.9 billion by 2009 has supported actions from community to global level, with a 19 percent fall in new HIV infection and AIDS mortality, and 35 percent of those in need receiving antiretroviral therapy (ART).[1] However, this progress is "fragile and unevenly distributed,"[1 p9] with increasing HIV incidence in some regions, new infections outpacing the number on treatment, and most people not accessing ART, especially in vulnerable groups and in Sub-Saharan Africa where 68 percent of global infections occur.[1] The global strategy will need to demonstrate its effectiveness in consolidating gains made to date, while addressing the continued shortfall in delivery on global commitments for many countries and communities.

THE ROLE OF DIPLOMACY

AIDS remains firmly on the global agenda. Adoption of the WHO global strategy for HIV/AIDS 2011-2015 is timely. On 8-10 June 2011 the UN General Assembly will hold a high-level meeting on AIDS to review progress and chart the future course of the global AIDS response. Member States are expected to adopt a new Declaration that will reaffirm current commitments and commit to future actions. [3]

FROM THE 2010 TO THE 2011 WORLD HEALTH ASSEMBLY

In 2010, the World Health Assembly (WHA) requested the Director-General of the World Health Organization (WHO) to develop a WHO HIV/AIDS strategy for 2011–2015,

aligned with broader strategic frameworks. During June–September 2010, consultations were held involving 110 countries, the United Nations (UN), and other multilateral and international agencies, civil society, nongovernmental organizations, scientific and technical institutions and networks, and the private sector. The WHO also hosted a public online consultation for seven weeks from July to September 2010.[1] When it was tabled with the January 2011 Executive Board (EB), member states broadly agreed with the strategy, but called for it to better reflect different country contexts; to give more focus to prevention, community systems and vulnerable groups; and to address concerns about how to address the funding gap at global and national levels.[2, 3] The revised strategy tabled at the WHA in May 2011 drew support from countries across all regions, with the countries at the Assembly appreciating the greater recognition of country context, including through involvement of community systems and service providers in adapting service delivery models to suit local contexts.

THE WHO HIV/AIDS STRATEGY, 2011-2015

The strategy adopted at the 2011 WHA is consistent with UNAIDS strategy for the same period, “Getting to Zero,” with international commitments to achieve universal access to HIV prevention, diagnosis, treatment, and care, and with the health-related Millennium Development Goals by 2015. It terms itself a “blueprint” for “co-ordinated action”[1 p6] and sets four strategic directions, to:

1. Optimize HIV prevention, diagnosis, treatment, and care outcomes;
2. Leverage broader health outcomes through HIV responses;
3. Build strong and sustainable systems; and
4. Reduce vulnerability and remove structural barriers to accessing services.

In each of these directions there are core elements, areas for country actions and WHO contributions and proposals for monitoring. The activities seek to improve the efficiency and effectiveness of HIV responses, better integrate HIV programmes within and support health and community systems, improve health access and equity, and ensure that the health sector informs broader multi-sectoral responses.[1] In adopting the strategy, member states noted that they would use it in shaping their national responses, and called for a report on implementation at the 2012, 2014, and 2016 World Health Assemblies.

RAISING THE PROFILE OF PREVENTION, COMMUNITY SYSTEMS, AND VULNERABLE GROUPS

The strategy outlines its aim to “revolutionize HIV prevention,” through combined interventions that tackle behavioural and social drivers of the epidemic.[1] Many

countries at the 2011 WHA raised the need to tackle continuing stigma and discrimination, and the strategy gives a specific focus to vulnerable groups often affected by stigma, such as sex workers, men who have sex with men, transgender people, people who use drugs, rural and displaced people, calling for their involvement in the design, implementation, and evaluation of responses. The regional consultations also pointed to other vulnerable groups, some raising cross-border and multisectoral issues, such as migrant populations and asylum seekers. [4] The strategy recognizes that the WHO needs to facilitate co-ordination and coherence across agencies and sectors to address the many determinants of HIV that lie beyond the health sector.

The global responsibility for treatment access remains a major concern. Only six in every ten people needing treatment are on antiretroviral therapy and Médecins Sans Frontières (MSF) called on the Assembly for an “ambitious” treatment target of 15 million by 2015 to mount a “credible global response” to break the back of the epidemic.[6] At the Assembly, the WHO launched “Treatment 2” at a side event.[5] Dr Gottfried Hirnschall, WHO’s HIV Director, committed the WHO and UNAIDS to this ten-year initiative to radically simplify and expand quality treatment through optimising low cost, accessible regimens. The strategy points to an important synergy between such technical options and the health system implications, with possibilities for expansion of access through more community-based forms of service delivery. [7]

ADDRESSING THE FUNDING GAP

Some countries at the WHA – Thailand, Hungary, Japan – raised the need for effective, but not burdensome, monitoring and reporting of progress. However, the most common concern raised by countries during consultations and at the WHA was on implementation, and particularly how the strategy would be funded.[4; 10] The strategy proposes that financing come from both domestic sources and external funding. Speaking on Malawi’s response, Dr Frank Chimbwandira, Director of HIV and AIDS of the Malawian Ministry of Health, cautioned that medicines are a major cost driver in the response, and 90 percent of HIV medicines in Malawi are purchased with money from external funders, raising concerns about the predictability of these funds.[5] When the October 2010 pledging conference for the Global Fund for AIDS, TB and Malaria (GFATM) set a target of between \$13-\$20 billion and received pledges of only \$11.7 billion, it triggered pessimism about scale up of the response,[8] and was labeled a “failure of charity” by civil society.[3 p4] African Health Ministers called for continuing global

for sustainability of global funding to be addressed through more predictable measures, like a financial transaction tax, while the People's Health Movement (PHM) cautioned at the Assembly that a reliance on external funds should not also reinforce unsustainable vertical approaches.[3] The PHM, as well as the representative of the Democratic Republic of Congo at the WHA both called for greater attention to be given to reducing the cost of inputs as a means to sustainability, particularly through an open, competitive market for medicines and diagnostics, using the flexibilities available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs), patent pooling, and voluntary licence agreements between patent holders and generic manufacturers.

WORLD LEADERSHIP IN THE GLOBAL RESPONSE

Countries and partners have urged the WHO to assert its leadership role to ensure co-ordination on responses related to health.[3,4,7] The HIV response has stimulated change in the UN system in areas such as involvement of affected populations and civil society and accountability across stakeholders. The strategy commits the WHO to sustain this "pathfinding" role.[1 p32] Debates continue on what this means, such as in the nature of the WHO's advocacy role in multilateral and bilateral trade forums, where intellectual property and access to medicines are discussed.[3] Consumer International also raised at the WHA their expectation of the WHO playing a stronger role in ensuring that conflicts of interest are identified and avoided where industry is involved, such as in ensuring that the use of substitute feeding in relation to HIV prevention is not used by the baby food industry as a marketing opportunity.

One sign of leadership was in how inclusive the process for development of the strategy was, a concern raised by African countries, through Uganda, at the January 2011 EB.[2] The consultation process for the strategy involved over 1,500 individuals from different constituencies and countries.[4] Seven weeks of online Internet consultation in the WHO's six official languages brought a further 91 organisational contributions, enhancing inclusiveness and transparency. While it brought in 13 respondents from Africa, such online input still favours higher income (e.g., 47 percent from Europe) and English-speaking (88 percent) respondents.[4, 9]

NEXT STEPS

Analysis of AIDS strategies of global/multilateral agencies suggests a shift from the initial emergency response mode towards sustainable approaches.[8] The WHO HIV/AIDS strategy for 2011–2015 reflects the same shift, with a more

system- based, integrated approach. At the same time, aspirational targets continue to be called for: UN Secretary General Ban Ki-Moon called, for example, for 13 million people in need of HIV treatment to be on antiretroviral therapy by 2015.[11] There is concern that in global diplomacy, the longer-term, systems approaches, such as those in the strategy, do not reduce the demand for political commitment to resourcing and reaching agreed goals.[11] The 8-10 June 2011 UN General Assembly High-Level Meeting on AIDS charting the future course of the global AIDS response will be the first global forum after the WHA that will test this political commitment.

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GENERAL SUPPORT FOR THE IHR REVIEW COMMITTEE REPORT



Photo: Forbes.com

Bente Molenaar

Bente.molenaar@yahoo.co.uk

Research Associate, Centre for Trade Policy and Law

BACKGROUND

THE ISSUE

In January 2010, the Executive Board of the WHO accepted the request of the 61st World Health Assembly (WHA) to formally review the International Health Regulations (2005) (IHR) and the Director General's (DG) proposal to use the recent H1N1 pandemic as a test case for that review. The mandate of the committee is to consider both the functioning of the IHR more broadly, and to consider the WHO Secretariat's response to the H1N1 pandemic more specifically. The IHR review committee has released their preliminary report. It contains a range of recommendations, identifying how the WHA needs to change in order to better respond to future public health emergencies. The report also contains a review of how the WHO dealt with the H1N1 pandemic.

The IHR is an international legal instrument that is binding on all the Member States of the World Health Organization (WHO).[1] The revised IHR entered into force on June 15, 2007, following an extensive revision process. Member States have until mid-June 2012 to ensure they have built and/or maintained, "core capacities" to conduct disease surveillance and are able to respond to a Public Health Emergency of International Concern (PHEIC).

GLOBAL HEALTH IMPACT

The IHR exists as the primary legislative instrument to prevent the spread of infectious diseases, and minimize disruptions to international traffic and trade. Without robust disease surveillance systems, new and resurgent diseases have the potential to spread unchecked, causing human suffering and death, as well as economic damage. It is therefore critical that every member state fully implement the revised IHR.

THE ROLE OF DIPLOMACY

International efforts will be necessary to ensure that low- and middle-income countries become compliant with the revised IHR. Many low-income countries will require significant resources and technical support to implement compliance measures. Member States have until 2012 to comply with requirements under the IHR.

INTRODUCTION

The International Health Regulation Review Committee presented its final report to the 64th session of the WHA. The mandate of the Review Committee was two-fold: to evaluate the Secretariat's responses to the H1N1 pandemic, and to assess how the IHR facilitated the response. Based on these assessments, the Review Committee was asked to identify lessons learnt and to make recommendations to improve preparedness for public health emergencies.

THE KEY ELEMENTS OF THE IHR REVIEW COMMITTEE REPORT [3]

Dr. Harvey Fineberg, the chair of the Review Committee introduced the report to the Assembly, reminding Member States that evidence was taken from a wide range of sources, including internal and confidential WHO documents. He further noted that in considering the WHO's response to the H1N1 pandemic it is necessary to recognize, among other factors, the unpredictable nature of influenza and "the limitations of systems that were designed to respond to a geographically focal, short-term emergency, rather than a global, sustained, long-term event."

The report presents 3 over-arching conclusions, supported by explanations and recommendations for each. The summary conclusions are:

- The IHR helped make the world better prepared to cope with public-health emergencies. The core national and local capacities called for in the IHR are not yet fully operational and are not now on the path to timely implementation worldwide.
- WHO performed well in many ways during the pandemic, confronted systemic difficulties and demonstrated some shortcomings. The Committee found no evidence of malfeasance.
- The world is ill prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public-health emergency.

Many State Parties are not on track to have the core capacities required to detect, assess and report potential health threats as required by the IHR. The Review Committee notes, with some concern, that of the 194 Parties to the IHR, only 66 percent completed a recent WHO questionnaire on their progress, "and as few as 10% of reporting countries indicated that they had fully established the capacities envisaged by the IHR." (para 23) Recommendations to rectify this include:

- The WHO could work with agencies and organizations that would be willing to provide technical assistance to help interested countries both to assess their needs and to make the business case for investment.
- Improve the WHO Event Information Site. Countries should be able to rely on the site for up to date information.

The source of much criticism both during and after the H1N1 pandemic was related to the WHO's ability to effectively communicate risk. The Review Committee found that the lack of a clear and consistent understanding of severity of the pandemic, as well as a definition of 'pandemic' that involved several phases, was not helpful. (paragraph 33) Recommendation 7 and 8 call for a consideration and revision of severity and the phased definition of pandemic, while recommendation 10 calls for the development of a strategic, organization-wide communication strategy.

The lack of funding to cope with public health emergencies is a concern frequently voiced, especially by less-well resourced Member States. To this end, the Review Committee recommends the creation of a contingency fund of at least US\$ 100 million that would be readily accessible to the WHO when the need arises. The recommendation lacks specifics, and some countries - including Mexico and Australia - pointed out in their interventions that further details would be required.

The report contains a wealth of recommendations, both for Member States and for the WHO. They come at a time when the WHO is under-going reformss and a process of streamlining. The budget is down from the last period, and some 300 staff will be made redundant. Implementation of these recommendations takes political will, as well as funding. Dr. Fukuda, speaking on behalf of the WHO Secretariat at the WHA, noted in response to the interventions that "it is clear [...] that there is a strong wish among the Member States to go ahead and implement the recommendations."

REACTION TO THE REPORT AT THE WHA

Interventions by Member States at the WHA were overwhelmingly in support of the Review Committee's report and the draft resolution urging implementation (Resolution 64.1). The Mexican delegate urged all Member States to meet the core capacity requirements under the IHR, suggesting that the deadline for implementation be shortened. Argentina expressed concern that few State Parties had engaged in the self-assessment and questionnaire. Turkey concurred, noting that all countries must implement the IHR in order to maximize global health security.

Countries including the Bahamas, Algeria, Brazil and Thailand spoke in support of the establishment of a contingency fund that would facilitate a rapid response to future international health emergencies. Many countries raised concern over a lack of resources for implementation of even core capacities. Kenya called for increased financial support, while the delegate from the Democratic

Republic of Congo noted the acute need for support from the WHO for staff training.

Canada noted that implementation of the recommendations would put additional resource pressure on the WHO. The Canadian delegate asked for some clarification of which recommendations could be achieved within the current budget, and which would require new money.

NEXT STEPS

While Member States overwhelmingly supported the findings of the Review Committee, it remains to be seen if they will implement the recommendations.

The resolution WHA 64.1 called upon the DG to present and update Member States on the progress made in taking forward the recommendations of the Review Committee's report.⁴ The update will be made through the WHO Executive Board, in 2013, at the 66th session of the WHA. The Executive Board meeting in January 2013 and the following WHA in May will provide a much clearer picture of the extent to which the recommendations have been taken to heart by State Parties and the WHO.

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COUNTRIES AGREE TO EXTEND THE PERIOD OF THE WHO WORKING GROUP ON SUBSTANDARD/SPURIOUS/FALSELY-LABELLED/FALSIFIED/COUNTERFEIT MEDICAL PRODUCTS: FOCUS ON AFRICAN POSITIONS



Photo: European Association of Hospitals

Rangariri Machedze
Deputy Director, SEATINI

rmachedze@seatini.org

BACKGROUND

THE ISSUE

At the last meeting of the Working Group on substandard/spurious / falsely-labelled / falsified / counterfeit medical products at the end of February and beginning of March 2011, the member states of the World Health Organization (WHO) had reached a stalemate regarding the definition of counterfeit medicines. The meeting could not resolve the differences amongst the member states and ended up focusing their discussions on identifying and setting up principles. Because of the divergent views of the member states on this issue, the Working Group requested the 64th meeting of the World Health Assembly (WHA) in May 2011 to consider extending the period set out in WHA63(10) “in order to allow the Working Group to complete its work” after engaging in further deliberations. [1] Although the 193 member states of the WHO, including African countries, agreed to extend the period of the Working Group at the just concluded WHA, positions are still polarized especially with regards to the linking of intellectual property to the issue of quality, safety, and efficacy of medicines, and the role of the International Medical Products Anti-counterfeiting Taskforce (IMPACT).

GLOBAL HEALTH IMPACT

The decision by the WHA to consider the request by the Working Group to extend its period is a positive step to allow member states to further deliberate on the issue. The African WHO member states are all in agreement with the rest of the membership that the “scourge, menace and threat” of substandard drugs must be dealt with in a comprehensive manner as it is a danger to global public health. Although the number of reported cases of substandard/spurious/falsely-labelled/falsified/counterfeit medical products continues to rise, the exact magnitude of the problem is unknown. The WHO notes that “many Member States are showing more interest in quantifying the problem, and are conducting analyses of the trend in the form of market studies.”[2] Nevertheless, it is estimated that counterfeit medicines, with a global market value ranging from between \$75 billion to \$200 billion per year kill a staggering 100,000 people annually, especially in poor developing countries.[3] The interventions made by the African member states of WHO at the WHA all point to the need to expedite the work of the Working Group especially by ensuring that the first meeting is held by the end of June 2011.

THE ROLE OF DIPLOMACY

The WHA considered the report of the Working Group contained in document A64/16 and decided to accept the next steps contained in the report. They also further decided that the Working Group should resume its work “as soon as possible following the 64th World Health Assembly and report on its work to the 65th World Health Assembly through the 130th session of the Executive Board.”[4] This commitment should give African countries more time to consult amongst themselves and engage other members to come up with workable recommendations in the spirit of protecting human health security.

INTRODUCTION

Ambassador Darlington Mwape of Zambia, who chaired the Working Group during its February 28–March 2, 2011, meeting, introduced the report and informed the Assembly that the group focused on four issues, namely:

- a) the WHO's role in measures to ensure the availability of quality, safe, efficacious, and affordable medical products;
- b) the WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations;
- c) the WHO's relationship with the International Medical Products Anti-Counterfeiting Taskforce;
- d) any issue or issues raised in the proposals contained in documents A63/A/Conf.Paper No.4 Rev.1, A63/A/Conf.Paper No.5 and A63/A/Conf.Paper No.7 starting with those issues referred to in subparagraphs (a)–(c) above.[1]

In their deliberations, the member countries could not come to an agreement on any of the issues as there are still major differences and perspectives. They therefore requested the WHA to give them more time to narrow their differences and come to some workable recommendations.

DISCUSSIONS AT THE WHA

The decision to extend the period of the working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products was reached without any controversy. However, the interventions by 47 member states during the WHA on this issue, as they all supported the need to have further discussions, has brought out the divergences that still exist amongst the members. Almost all the member states that intervened made specific reference to intellectual property (IP) issues and the role of IMPACT on issues related to the safety and quality of drugs. On IP, developing country members, including those from Africa, reiterated their positions that the deliberate linking of intellectual property and issues of quality and safety of drugs was unfortunate. Kenya expressed its delegation's

dissatisfaction with the inclusion of the word counterfeit, which they said implied the infringement of intellectual property. “Once we start to introduce trade issues in our discussions, we may lose focus,” they said. Kenya also pointed out that the focus on intellectual property will divert attention from the real issues at stake, since even generic drugs, for example, could be counterfeited. It is imperative therefore to focus on the issue of safety and quality of drugs in order for the WHO and all the member states to achieve their ultimate objective of ensuring safe drugs for all.

Other African countries, through their statement read by the delegation of Tanzania, noted that they were prepared to build on the progress made thus far in the Working Group but emphasized that because they had poor legislation, absence of regulatory authorities, and that counterfeiters were largely driven by profit motives, they (African countries) were at the receiving end of counterfeit medicines. The observations by the African group – also generally confirmed by many observers – are that trade in counterfeit medicines is more prevalent in countries facing a variety of problems including:

- weak drug regulatory control and enforcement;
- scarcity and/or erratic supply of basic medicines;
- unregulated markets and distribution chains;
- high drug prices, and/or
- significant price differentials.[6]

MEMBER STATES DRIVEN PROCESS

One important issue that came out of the WHA discussions was the need to ensure that the process of dealing with drugs of compromised quality, as others preferred to call them, was supposed to be a member-states driven mechanism. In this regard, some delegations were concerned with the role of IMPACT, a controversial issue that also contributed to the stalemate in the work of the Working Group.

Whilst other member countries, particularly the industrial countries, were satisfied with the work of IMPACT, the majority of the developing countries were worried about the activities of the Task Force and its relationship with the WHO. One African country delegate applauded the fact that “IMPACT had moved out of WHO to Italy and this is a positive step that there is no more co-habitation,” he said. Despite the usual unanimity of African countries on such issues, Nigeria in its interventions contradicted the position that others had taken on IMPACT. In its delegation intervention in the discussions, the country reported that it “supported IMPACT in WHO.” This public confirmation, differing from other African countries who had made interventions, further reinforced the fact that perspectives and views on the matter were still polarized.

NEXT STEPS

Despite the failure of the Working Group to come to a conclusion on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, they have an opportunity to reconvene and start work. The delegation of Kenya, supported by other member states, noted that it is best to have a clear schedule of the meetings of the working group rather than to work on an ad hoc basis. The fact that the decision notes the need to begin work “as soon as possible” emphasizes the importance and urgency of the matter.

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UPDATE ON THE DIRECTOR-GENERAL ELECTION DEBATE



Photo: WNI.com

Bente Molenaar

Bente.molenaar@yahoo.co.uk

Research Associate, Centre for Trade Policy and Law

BACKGROUND

THE ISSUE

With the term of the current Director-General (DG) coming to an end in 2012, the issue of criteria for election of the DG has been brought back onto the agenda. Some Member States, primarily those who have not had a DG elected from their region, argue for mandatory geographic rotation. Other Member States argue that putting geographic rotation ahead of other criteria could risk finding the best person for the job.

GLOBAL HEALTH IMPACT

The World Health Organization (WHO) has a central role in global health governance and needs strong and effective leadership. As the WHO is embarking on a debate about future financing and core functions of the organization, effective leadership is perhaps more important than ever before.

THE ROLE OF DIPLOMACY

The question of geographic rotation of the DG's position is not a new issue and has been debated before. The current criteria are set out in Resolution EB97.R10 (1996).

INTRODUCTION

At the last Executive Board meeting, Member States agreed that a working group be established in order to continue negotiations to reach agreement on the process and methods for the election of a future Director-General. Resolution EB 128. R14 sets out that:

- a "time-bound and results-oriented working group" be established
- the working group will be open to all Member States;
- the working group will examine the matter with a view to enhance fairness, transparency and equity among the Member States of all regions of the WHO;
- the working group will provide the 64th WHA with an interim progress report, and a final report to the 130th EB for final recommendation to the 65th WHA (2012). [1]

The DG transmitted the interim progress report of the working group to the 64th session of the WHA.

REACTIONS TO THE INTERIM PROGRESS REPORT [2]

The working group met in Geneva from April 27-29. 98 Member States attended the session, and discussions covered a range of issues related to both technical and political aspects of the DG election process. The issue of introducing geographical rotation among the six regions of the WHO remains the most difficult to resolve. The African region is in favour of the principle of mandatory rotationality, while others, including Canada, Brazil, the United States and Norway do not support this.

At the WHA, Côte d'Ivoire took the floor, speaking for the Africa region. They re-emphasized their position that while merit and competency are crucial, it is equally important to ensure that all regions have the chance to put forth their qualified candidates for the position of DG. The delegate speaking for the Africa region further noted that in a time when Member States are pushing reform, the issue of having a fair, geographical nomination process should be given priority. The delegate of the United States thanked Member States for the constructive approach taken by the working group and urged both sides to be flexible and open.

NEXT STEPS

The working group will meet again in November of 2011. Between the conclusion of the WHA and November, the Director-General will support the work by providing technical clarifications, and collating recommendations from Member States on subparagraphs 3(1) and 3(2) of resolution EB128.R14. There is little doubt that Member States have a lot of work to do before they can reach agreement on this important issue.

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WHA's RESOLUTIONS ON HEALTH SYSTEMS STRENGTHENING



Photo: WHO.int

Priyanka Kanth

priyanka.kanth@graduateinstitute.ch

Global Health Program, Graduate Institute of International and Development Studies

BACKGROUND

THE ISSUE

At the 128th Executive Board meeting of the World Health Organization (WHO) in January 2011, member states put forward five resolutions under the umbrella of health systems strengthening [1]. The resolutions covered five broad themes: Strengthening national policy dialogue to build more robust health policies, strategies, and plans [2]; strengthening nursing and midwifery [3]; health workforce strengthening [4]; strengthening national health emergencies and disaster management capacities, and the resilience of health systems [5]; and sustainable health financing structures and universal coverage [6]. The resolutions put forward priorities of different countries and the process reflected a proactive and participatory approach from all member states. The resolutions also reflected a broader, global trend of moving from vertical programs to horizontal and systemic approaches in addressing health issues. These five resolutions were considered, much debated, redrafted and modified and adopted at the 64th World Health Assembly (WHA) in May 2011.

GLOBAL HEALTH IMPACT

As highlighted in the Report prepared by the WHO for the 128th Executive Board meetings, “a large proportion of the population worldwide remains deprived of access to care, while 150 million people face catastrophic expenditure and 100 million are thrust into poverty because of direct out-of-pocket payments for services and medicines”[7]. “At its broadest, health system strengthening (HSS) can be defined as any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency” [8]. More specifically, health system strengthening incorporates all the essential building blocks that ensure provision of care to a nation’s population, such as existence of adequate health personnel, medical education, infrastructures, access to health commodities (drugs, vaccines and other equipment); service delivery components; sustained financing for health; health information and monitoring systems including production, analysis, dissemination

of timely information; and finally and most importantly, leadership, governance and ownership, which related to “strategic policy frameworks (...) combined with effective oversight, coalition-building, regulation, attention to system-design and accountability” [9].

THE ROLE OF DIPLOMACY

Health-system strengthening has been a key area of focus for member states of the WHO and work in the previous years has concentrated on various aspects of this, such as the World Health Report on Primary Health Care in 2008 [10], the World Health Report on Health System Financing in 2010 [11], and the Report of the Committee on Social Determinants of Health, 2008 [12]. The topic of health system strengthening was on the Agenda of the 128th Executive Board meeting of the WHO in January 2011.

These discussions also occurred at the regional level, and the “WHO regional committees at their sessions in 2010 called on countries to strengthen health systems on the basis of the values of primary health-care, and identified the need to tackle the determinants of health through a multi-sectoral approach, making services more responsive, addressing universal coverage and strengthening health-service delivery at the district level. Resolutions requested the Regional Directors to work more proactively than before with Member States in the development or renewal of comprehensive policies, strategies and plans to improve health outcomes” [13].

INTRODUCTION

At the sixty-fourth World Health Assembly (WHA) in May 2011, the member-states of the WHO adopted five separate resolutions under agenda item 13.4 on Health Systems Strengthening. The article below reports on the WHA discussions about two of these resolutions. The phenomena of forum shifting was also observed when the topic of health systems financing was agreed to be conveyed to the United Nations Secretary General Ban Ki Moon for potential further discussion at the UN General Assembly later this year.

In her introductory remarks, Dr Carissa Etienne, head of the WHO cluster overseeing work on health systems, pointed to the unanimous emphasis that is being placed to building strong and robust health systems as a very positive development. She also highlighted the importance of “integrated, comprehensive, well-functioning health systems” and the need to be inclusive to all stakeholders. Furthermore, she called for donor alignment, based on the principles of Paris Declaration of Aid Effectiveness. Finally, she reassured member states that, despite the financial crisis, the WHO secretariat is finding ways to ensure the “momentum on health systems is maintained.”

MOVING DISCUSSION ON “SUSTAINABLE HEALTH FINANCING STRUCTURES AND UNIVERSAL COVERAGE” TO THE UN GENERAL ASSEMBLY

The resolution on “Sustainable health financing structures and universal coverage” was first tabled by Germany, the European Union (EU) and Switzerland at the WHO’s 128th Executive Board meeting in January 2011. When the item was introduced at the WHA for adoption, Thailand asked for this issue to also be considered and further discussed at the United Nations’ General Assembly (UNGA) later this year. This raised a number of objections and concerns from other countries, notably the USA, Hungary –on behalf of the EU, and Canada. The American delegate was of the opinion that health matters should not be addressed at the UNGA. Thailand disagreed and pointed out the growing number of issues that have been on the UNGA agenda in the recent past—health-related MDGs, resolutions on global health and foreign policy, non-communicable diseases, and HIV/AIDS. Thailand also highlighted that the issue of health systems financing is much broader and more global than some of the other health-related issues addressed at the UNGA, and addresses systemic challenges faced by countries in providing for their populations. The main concern for the EU was the legal and procedural feasibility of doing this and the cost implications it would entail for the WHO and for member-states. The Canadians highlighted that agenda items for the UNGA should be proposed by member-states and not by the WHO secretariat or Director-General. Following a suspension of a few days, the resolution was adopted with a request to the Director-General to “convey to the United Nations Secretary-General the importance of universal health coverage for discussion by a forthcoming session of the UNGA” [14].

Thailand is signatory to the Oslo Ministerial Declaration on global health and foreign policy, a group of countries that were instrumental in bridging the gap between global health and foreign policy and spearheading the attempts to put global health more visibly on the agenda of the UNGA [15] [16]. In that context, a shift from the WHO to the UNGA would provide added political impetus for countries to ensure adequate financing to the healthcare sector and should work to increase countries’ accountability and ownership of the process. The resolution also calls on the Director-General to “work closely with other UN organizations, international development partners, foundations, academia and civil society organizations, in fostering efforts towards achieving universal coverage; to prepare a plan of action for WHO to support member states in realizing universal coverage [...]; to prepare an estimate of the number of people covered by basic health

insurance that provides access to basic health care and services, that estimate being broken down by country and region; [and] to provide [...] technical support for strengthening capacities” [14].

STRENGTHENING NATIONAL HEALTH EMERGENCY AND DISASTER MANAGEMENT CAPACITIES

Members states adopted a resolution which calls on countries to strengthen their response mechanisms to all-hazards health emergencies and to implement disaster risk-management programmes as “part of national and subnational health systems” [17]. Thailand made a statement on the need to add “to facilitate access by concerned governments and other related agencies on types and quantities of hazardous material stored, used or transported, in order to support effective health emergency and disaster risk-management.” While this paragraph was initially rejected by countries such as Hungary—on behalf of the EU and the USA, in fear that it suggests tying in the issue with the International Health Regulations (IHR), the addition does appear in the final adopted resolution [17]. The link with the IHR is made in paragraph 3.2 where the Director-General is requested to “strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private and nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk-management, which includes disaster risk-education, as well as ongoing efforts by member states to implement the International Health Regulations (2005)” [17].

NEXT STEPS

It remains to be seen whether health system financing and universal coverage will be adopted as an agenda item for further discussion at the UNGA later this year. The secretariat will prepare reports and provide the evidence and policy options requested in the various resolutions for further discussion at the 130th Executive Board meeting of the WHO in January 2012.

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