

HEALTH DIPLOMACY MONITOR

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Health Diplomacy Monitor

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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A WORD FROM THE EDITORS

The World Health Assembly (WHA), which took place this year in Geneva from May 17-21, is an intense moment of health diplomacy where Health Ministers from the 193 WHO Member States meet. At this annual event, Ministers and their delegations adopt policies which guide the work of the WHO; many decisions agreed upon in this forum thus have a significant impact on global health. As such, the Health Diplomacy Monitor sent a team of contributors to Geneva, to report on the negotiations for this Special

WHA issue of the Monitor.

The WHA had a busy agenda this year, given that last year's meeting was cut short so that Member States could focus on the emerging H1N1 pandemic. The nine articles in this special issue thus cover a wide range of topics. During the week, the Members of the WHA created a new Intergovernmental Working Group on Counterfeit Drugs, and a new Consultative Working Group which will examine options for financing for health research and development. Delegates

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also adopted a code on international recruitment of health personnel; global guidelines about marketing of food to children; and agreed upon reducing the negative health impacts of alcohol. This special issue of the Monitor describes and analyses the context, content, and process through which these decisions were agreed upon.

We ask our contributors to provide readers with factual knowledge about the issues, the proposals put forward, and the views expressed by the parties at the table and by stakeholders. Moreover, in the background section preceding each article, we ask them to take a step back and present a broader perspective on what is at stake in terms of improving population health at the global scale.

The Health Diplomacy Monitor is a new publication and we sincerely welcome suggestions and comments from readers. Our goal is to facilitate, through greater transparency, the active engagement of a large community of governmental and non-governmental actors into the negotiations and discussions which will affect global health. You will find in this issue an editorial article from Val Percival about the steps the WHA itself could take to increase access and transparency.

The WHA may be the most obvious fora for a publication aiming to cover negotiations which affect global health. Nevertheless, in the coming issues, we

wish to expand our coverage beyond this arena to a broad range of global and regional forum, in order to represent well the complex and diverse reality of health diplomacy.

Editorial

THE WORLD HEALTH ASSEMBLY: ENGAGE CIVIL SOCIETY

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This issue of The Health Diplomacy Monitor reviews the negotiations and outcomes of an important event for global health governance, the World Health Assembly (WHA). Member States debated strategies to accelerate progress towards the Millennium Development Goals, examined the harmful effects of alcohol, discussed food safety, considered strategies to address non-communicable diseases, assessed the implementation of the international health regulations, and debated the issue of counterfeit medical products [1].

During the WHA, officials repeatedly stressed that civil society engagement is critical to address global health challenges. In her opening remarks to the Assembly, Margaret Chan, the Director General of WHO, stated: “As we enter the second decade

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of the 21st century, and the homestretch for reaching the Millennium Development Goals, we need to draw on every lesson, every approach, instrument, and innovative way of raising funds or collaborating together, from heads of state to civil society” [2]. Closer engagement with civil society was also a theme that the Director-General stressed as important in combating the spread of tuberculosis (TB) on the launch of the Lancet TB Observatory.

Dr. Chan’s statements reflect the accepted principle that active involvement from civil society improves global health outcomes. Civil society’s participation facilitates transparency and accountability. Individuals and groups advocate for policy action, scrutinize the activities of states and multilateral organizations, and mobilize public support for global health initiatives. Civil society events organized on the margins of multilateral meetings provide opportunities for researchers to share their findings, organizations to discuss their experiences in implementing health initiatives, and for advocates to generate support for policy proposals. Given the important role they play, many global health institutions, such as the Global Fund, UNAIDS, and GAVI, include civil society representatives on their decision making boards [3, 4, 5].

Officially, WHO respects civil society engagement. The WHO Constitution facilitates restricted access for civil society to the Executive Board and the WHA. And the latest Medium Term Strategic Plan states “WHO will need to be more systematic in its contacts with civil society and industry, including the international health-care and pharmaceutical industries” [6].

Yet during the WHA, rhetoric was not matched by reality. Several factors constrained civil society engagement. First, while Dr. Chan’s speeches were posted on the WHO website, no webcast was available of plenary sessions, committee meetings or drafting groups. Civil society groups not present in Geneva were left to monitor progress by follow-

ing reports penned by WHO officials or blogs from the few organizations present at the WHA. Groups physically present at the WHA also faced constraints. Public observation of Committee A, where many resolutions were debated, was limited to the 48 seats and ear-sets available in the public gallery. Working and drafting groups were closed to the public as were the meetings of the various regional offices. Such limited access undermines the transparency of the proceedings and the ability of organizations to hold WHO and member states accountable for their actions. Moreover, the number of side events was limited this year, sparking protest [7].

This limited access at the WHA is unique among multilateral forums. Webcams provide global dissemination of discussion and debate at the World Trade Organization, the Human Rights Commission, the United Nations General Assembly, and the Security Council [8]. Side events by civil society organizations are encouraged at most multilateral meetings. Indeed, the UN has announced that from 17-19 September, “broad civil society mobilization” will take prior to the September High-Level Meeting on the Millennium Development Goals [9].

To succeed in achieving its ambitious global health objectives, WHO must promote and facilitate the active engagement of civil society. While some reforms – such as representation of civil society on WHO governance structures – would require extensive negotiations and constitutional changes, others are relatively easy. For example, WHO should provide webcasts of the Executive Board, WHA Plenary and Committee Meetings. Although internet access remains problematic in some parts of the world, webcasts would help ensure that civil society groups unable to travel to Geneva can follow the debates. Those groups most affected by the WHA’s resolutions could see how the debates unfold. We also urge the WHO to provide webcasts of working and drafting groups: in camera sessions could be allowed after a majority, recorded vote of member states

WHA CREATES NEW INTER-GOVERNMENTAL WORKING GROUP ON COUNTERFEIT MEDICINES

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request that cameras be turned off. WHO must also revisit its policy regarding side events, and allow for as many as space allows.

WHO strives to be a flexible, learning organization [6]. We hope that it takes this opportunity to demonstrate this flexibility, and adopts measures that promote the full engagement of civil society. Global health will be better for it.

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BACKGROUND

The Issue

In 2006 the World Health Organization (WHO) established the International Medical Products Anti-Counterfeiting Task force (IMPACT). IMPACT “aims to build coordinated networks across and between countries in order to halt the production, trading and selling of fake medicines around the globe” [1]. The task force also provides technical guidance to countries drafting national legislation intended to curb the proliferation of counterfeit medicines.

Since its inception, the work of IMPACT has been highly controversial because of its definition of the term “counterfeit.” Developing countries like India and Brazil have argued that IMPACT’s definition confuses generic medicines (low-cost, TRIPS-compliant medications), with substandard drugs [2]. This risks impeding progress toward universal access of essential medicines, especially for low-income countries.

Global Health Impact:

Counterfeit drugs pose major public health risks. Because they can be composed of dangerous substances that can cause ill health and/or death, counterfeit medicines undermine patient safety. Moreover, counterfeit medicines with insufficient active ingredients can heighten resistance to antimalarial drugs [3-4].

Statistics on the manufacture and production of counterfeits are scarce, but counterfeiting is believed to be most common in regions that suffer from weak

regulatory and market control systems. According to IMPACT, approximately 30% of medicines for sale in many African countries and parts of Asia and Latin America are counterfeit; in industrial countries, the amount is estimated to be less than 1% [5].

Role of Diplomacy

There is a growing consensus that action on counterfeit medicines is needed to mitigate their negative health impacts; however, developed and developing countries are divided on the appropriate use of the term counterfeit, and the institutional venue best suited to address these products. Divisions are especially acute between EU countries where many brand-name pharmaceutical companies are based, and generic drug suppliers from India and Brazil.

INTRODUCTION

The 63rd World Health Assembly saw little progress on the issue of counterfeit medical products. The definition of “counterfeit medical products” used by the International Medical Product Anti-Counterfeiting Taskforce (IMPACT) emerged as the key obstacle. Developing country delegates, led by India and Brazil, argued that the term “counterfeit” used by IMPACT is too broad and could be interpreted to include generic drugs. The delegation from Brazil asserted that IMPACT is reorienting the WHO away from a focus on public health, toward patent protection and regulatory enforcement.

The WHA Negotiations

The WHA addressed the issue of counterfeit drugs under agenda item 11.20 of Committee A (Technical and Health Matters). The debate took place in a particularly charged environment. Earlier in the month, Brazil and India launched a complaint at the World Trade Organization (WTO), accusing the European Union (EU) of an illegitimate seizure of generic drugs [6]. The delegates from India and Brazil at the Assembly argued that the WTO provides

a better forum to address counterfeit issues due to their clear definition of “counterfeits” under Article 51 of TRIPs.

Delegations were asked to consider three resolutions. The first, proposed by Ecuador on behalf of the Union of South American Nations (UNASUR), urged member states to establish an inter-governmental working group to facilitate cooperation between countries on the public health impacts of falsified medical products (A63/A/Conf.Paper No.4). The second, proposed by the delegations of India and Thailand, asked the WHO to replace IMPACT with a WHO member-based program to address quality, safety and efficacy issues with medical products (A63/A/Conf.Paper No.7). The third, proposed by an alliance of 40 African countries, requested that the WHO continue to provide technical assistance to countries implementing national strategies against counterfeit medical products (A63/A/Conf. Paper No.5). No consensus was reached, however, and the Assembly failed to pass any of these resolutions.

During the debate the Brazilian and Indian delegations acknowledged that falsified medical products pose a global public health threat; a position which was agreed upon by all the delegations. Member states agreed that counterfeit medical products undermine the health of patients, the credibility of health systems, and global pharmaceutical supply chains. Nevertheless, some delegates argued that the counterfeit label is used to justify actions that undermine developing country access to quality medical products, as evidenced by seizures of generic drugs. India highlighted that both generic and brand-name pharmaceuticals are liable to being counterfeited, and action by the WHO must be directed by a clearly articulated and unambiguous definition of “counterfeit medical products” [7].

Members did not reach a consensus on the appropriate institution to deal with counterfeit medical products either. Developed countries like

the United States, Canada, and those from the EU expressed their support for the work of IMPACT and the WHO. Yet members from UNASUR, SEARO, and some African delegations raised serious accountability issues with IMPACT, as it includes representatives from organizations that have vested interests in intellectual property protection; namely, developed countries and members of the pharmaceutical industry. According to the Brazilian delegation, which proposed an intergovernmental working group to take up the issue of counterfeits, some countries are, “trying to disguise trade and commercial interests under public health” [2].

Reaction from Civil Society

Prior to the Assembly, the Third World Network submitted an open letter on behalf of nearly fifty non-governmental organizations, addressed to Dr. Margaret Chan, Director General of the WHO. The letter raised the group’s concern that the WHO’s ambiguous use of the term “counterfeit” “provides an avenue for, “proponents of an extended IP agenda to press for inappropriate IP enforcement standards in developing countries,” [8]; especially in many East African countries which have recently adopted anti-counterfeiting laws. “Most of these legislations define “counterfeit” products as being substantially similar or identical to IP-protected products, which effectively makes every generic pharmaceutical a counterfeit,” [8]. The NGOs urged the WHO to find more appropriate terminologies to address the growing threat posed by falsified and sub-standard drugs.

NEXT STEPS

Although the Assembly was unable to reach agreement on the original three proposals, delegations agreed to form an Inter-Governmental Working Group, open to all member states, to thoroughly examine the issue of counterfeit medicines. The proposal is a compromise between the EU and Indian proposals on next steps to address counterfeit

drugs. The Group will examine the WHO’s: “role in ensuring availability of good-quality, safe, and efficacious and affordable medicine; relationship with the International Medical Products Anti-Counterfeiting Taskforce (IMPACT); and role in prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products,” [9]. Recommendations by the group will be made available to 64th WHA in 2011 [9].

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WHA ADOPTS A CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL

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BACKGROUND

The Issue

In 2004, with the strong backing of African countries, the World Health Assembly adopted resolution WHA57.19, which requested the Director-General to develop a code of practice on the international recruitment of health personnel, and to consider the establishment of mechanisms to mitigate the adverse impact of health personnel migration on developing countries. This issue received sustained attention as resolutions of the East, Central and Southern African Health Community's 42nd Regional Health Minister's Conference in 2006; and the G8 summits in Toyako (Japan, 2008), and L'Aquila (Italy, 2009), also referenced the issue of international recruitment and the WHO Code. The December 2009 United Nations General Assembly Resolution 64/108, on Global Health and Foreign Policy, requested member states to report on efforts to finalize the WHO code, and other initiatives to address the shortage of health workers in developing countries.

The Global Health Impact

In 2006, the World Health Organization (WHO) estimated the global shortage of health personnel at more than 4.3 million workers, with the largest shortfalls primarily concentrated in low-income countries. Africa is particularly hard-hit by this problem. Shortages of health workers undermine local health systems and the implementation of global health initiatives. While migration is not the sole driver of health worker shortages, it impacts

on equity as health workers move from low to high income countries, and from areas of higher to lower health needs. Most skilled international health personnel are recruited by the United States and the United Kingdom [1,2,3].

Diplomacy prior to the WHO Code

Prior voluntary codes of practice on the international recruitment of health workers have been limited in geographical scope (such as the 2003 Commonwealth Code of Practice [4], the 2007 Pacific Code of Practice, and the 2001/4 UK Code of Practice [5]); or focused on specific health services (such as the EPSU/ HOSPEEM Code of Conduct for health personnel working in hospitals within the EU). The South African policy on recruitment and employment of foreign health professionals (April 2006), exemplifies a binding policy, applied by the Department of Health [6]. In Article 4.7, it explicitly forbids, "recruitment of individual applicants from identified developing countries, in particular from another Southern African Development Community (SADC) country" [6].

Introduction

The WHO Code of Practice is the first effort to develop a global code. The WHO initiated a multi-stakeholder process in 2008, with drafts developed and reviewed through national and regional consultation in all six WHO regions. All expressed support for such a code, noting the need for one strategy within a spectrum of interventions to deal with health workforce issues (Region of the Americas), in line with the "values of solidarity, equity and participation," (European Region) [7].

Negotiations on the Code at the WHA

Following a review by the January 2010 WHO Executive, the draft WHO Code of Practice was submitted with comments and proposed amendments to the 63rd World Health Assembly

[7]. The WHA Committee A, established a closed drafting group chaired by Thailand's Dr. Viroj Tangcharoensathien to finalize, the Code. The revised version was approved by consensus.

Provisions of the Code

The Code of Practice is a voluntary set of guidelines that advises both source and destination countries on how to regulate the recruitment of health personnel.

The Code is notable for several reasons, as it:

- Establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel.
- Acts as a reference for Member States to develop or improve the legal and institutional framework required for the international recruitment of health personnel.
- Provides guidance for the formulation and implementation of bilateral agreements and other international legal instruments.
- Facilitates and promotes international discussion and cooperation on the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on developing countries.

The Code's guiding principles urge states to undertake "properly managed" health personnel recruitment to mitigate the negative impacts migration has on the health systems of developing countries; to facilitate health systems strengthening; and to respect the rights of health personnel, including their freedom to migrate, in accordance with applicable laws. The Code advocates that developed countries provide technical and financial assistance to strengthen the health systems of developing countries, and countries with economies in transition. It also appeals to all countries to mitigate the negative effects and maximize the positive benefits of migration on the health

systems of source countries. The Code provides for fair labour practices; equality of treatment for migrant health workers; workforce planning to reduce dependence on migrants; facilitation of circular migration; and the sharing of relevant data and information.

Member states will report to the WHO Secretariat on the code every three years, beginning in 2012. Its contents are considered to be dynamic, subject to review.

Issues and debates

The Voluntary Nature of the Code

A code is always voluntary and only becomes binding if included in law or agreements. However, in submissions to the WHA, Mauritania on behalf of the Africa Group expressed concern with the non-binding nature of the Code [7], particularly given the limited evidence to demonstrate that other voluntary codes have been effective in reducing health worker recruitment [8]. Despite the concerns from the Africa group, the final draft incorporated the submissions by the US, Canada, Japan and Mexico, amongst others, to make the voluntary nature of the Code very clear.

Inequity and Redress

Disputes over compensation reportedly led some high income countries to reject the 2003 Commonwealth Code of Practice for the International Recruitment of Health Workers [9, 10]. Some reference to redress for losses was initially included in the draft for the 2010 Code, with reference to "mutuality of benefits," but this was subsequently removed. The final Code excludes reference to such terms, or to the idea of balancing gains and losses. The Code recognizes the, "negative effects of health personnel migration on the health systems of developing countries," (Article 3.2); and it states that both source and destination countries should derive benefits from international migration. The Code references the role of technical assistance, training, and other support mechanisms, as the means to "promote international co-operation on international recruitment of

nation and cooperation on international recruitment of personnel,” (Article 5.2), rather than including measures to compensate for the negative effects of health personnel migration. The US rejected the use of the term “ethical” in relation to recruitment as “unnecessarily stigmatizing.” Medicus Mundi, a member of the Health Workforce Advocacy Initiative (HWAI), emphasized that, “equity is to be one of the guiding principles for the Code,” [11]. The perceived fairness of the measures once they are applied in practice will test the Code’s impact on equity.

A new concept of “circular migration” emerged in the 2010 Code, which was proposed by the European Union [7]. The 2010 Code calls for member states to, “facilitate circular migration,” while also assessing the scope and impact of migration of health workers. This measure will have implications for immigration, citizenship and labour market laws, including existing barriers to the temporary return of skilled migrants.

Next steps

The chairperson of the session to adopt the Code, acknowledged the role of the US and African delegations in coming to an agreement and thus enabling a consensus adoption. The challenge will now be implementing the Code.

In Article 6 the Code calls for, “comparable and reliable” data collection for ongoing monitoring of health worker recruitment and migration; and reporting to the WHO secretariat every three years. These measures are important means to promote implementation and accountability. Early government and stakeholder engagement is expected to ensure that monitoring is both feasible and effective. The first global review is scheduled for the 2012 WHA meeting.

The International Code of Marketing Breast-Milk Substitutes, also a voluntary code, is perhaps instructive. It was adopted nearly thirty years ago in 1981. Annelies Allain, from the UK’s International Baby Food Action group, argues that it was the raising of regular resolutions on the code at World Health

Assemblies, and the training of officials to integrate the code into their national laws that were key to its broad implementation. Despite this, during the discussions on the agenda item on infant and young child nutrition at the 2010 WHA, the delegate from Swaziland noted that despite the thirty year history of awareness and action on the Code of Marketing Breast-Milk Substitutes, violations of the Code continue.

Realising Rights, a lead organization in the HWAI, noted that bilateral negotiations and agreements will be the next front of action for the Code. Such negotiations will need to reinforce and not disrupt regional agreements on health worker recruitment, training and retention, such as the existing protocols and agreements in the South African Development Community (SADC) [12]. Countries will thus need to prepare for a new phase of diplomacy on both the procedures for, and content of, such agreements.

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IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

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BACKGROUND

The Issue

The International Health Regulations (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 respond to a Public Health Emergency of International Concern (PHEIC).

In April 2009, the emergence and worldwide

spread of the H1N1 influenza virus presented the first real test of the revised IHR framework. Several criticisms of the WHO Secretariat's response to H1N1 have since emerged, including the Secretariat's links with pharmaceutical manufacturers; the decision to declare a Phase 6 (Pandemic); and the WHO's definition of a "pandemic." At the same time, a number of low-income countries struggle to obtain the necessary financial and technical means to implement national action plans to ensure compliance with the Regulations before 2012.

Global Health Impact

The IHR exist 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

Robust international efforts will be necessary to ensure that low- and middle-income countries become compliant with the revised IHRs. Some of these countries may still need to be convinced of the importance of the IHRs, and most will require significant resources and technical support to implement compliance measures.

Introduction

At the 63rd WHA, discussion on the IHRs focused on the performance of the revised regulations within the context of the 2009 H1N1 influenza pandemic. Member States also discussed the establishment of a review committee to evaluate the IHRs effectiveness during the H1N1 outbreak. Delegates expressed their general view that the IHRs served as a useful mechanism to respond to the H1N1 influenza pandemic, given the uncertainty surrounding the virus' emergence and spread; and they also noted their appreciation for the Secretariat's efforts at coordinating the international response.

Negotiations to Date

In light of the earlier request in 2008 by the 61st WHA for a formal review of the IHR (see resolution WHA61.2), the Director-General secured the endorsement of the 126th Executive Board to establish an independent IHR Review Committee comprising 29 experts drawn from the IHR Roster of Experts. The objectives of the Committee, which is headed by Dr Harvey Fineberg, President of the U.S. Institute of Medicine, are to:

- Assess the functioning of the IHR in relation to the 2009 H1N1 pandemic, and other public health events;
- Review the scope, appropriateness, effectiveness and responsiveness of global actions, and the WHO Secretariat's role in supporting pandemic preparedness, alert and response in relation to the H1N1 pandemic; and
- In light of the above, identify and review the major lessons learned to strengthen preparedness and response to future public health emergencies [1].

The WHA Negotiations

The IHR Review Committee's first meeting was held in mid-April 2010 [2], and a provisional report (document A63/5_Add.1) was submitted to the 63rd WHA for consideration. Member States noted the Director-General's report on the progress to date on the implementation of the IHR (document A63/5), and delegates subsequently endorsed the plan for the IHR Review Committee to deliver its final report to the 64th WHA in May 2011.

Following the Assembly's endorsement, Dr Fineberg stated at a press conference, that he will direct the IHR Review Committee to examine some of the more contentious issues surrounding the Secretariat's handling of the H1N1 pandemic. One issue is the WHO's relationship with the pharmaceutical manufacturers of influenza vaccines, and Dr. Fineberg noted: "We will want to have access to certain confidential documents that may be in place here at WHO, or elsewhere," [3]. Dr Fineberg also said that the committee will, "consider carefully the question of pandemic definition, including the aspect of severity as well as spread," [4].

Commenting on the Director-General's report on the progress made to date on the IHRs (document A63/5), a number of delegations from low-income countries spoke of their ongoing concerns regarding capacity-building. Some delegations noted, for example, that they were not entirely satisfied with the level and extent of technical support provided by WHO; and they expressed concern that they currently lack the requisite financial and technical means to build core capacities needed for the IHRs. Further concerns were also raised about the IHR Monitoring Tool, distributed by the Secretariat to Member States to evaluate compliance. The tool was 48 pages long - an impractical length. As a result, several South American countries have developed their own IHR evaluation tool, but this in turn had created some confusion amongst countries.

While noting the concerns, the Secretariat emphasised that it supported countries through training programs, guidelines and technical expertise, as well as through country offices. Little detail was provided on the extent to which countries have sought such assistance; how the Secretariat supports countries to obtain financial assistance; and whether new challenges have emerged as a result of these activities.

Next Steps

The next meeting of the IHR Review Committee is due to take place in Geneva from June 30 - July 2, 2010, with a further meeting provisionally scheduled for November 2010. Following on this, the Director-General is then due to submit the IHR Review Committee's final report to the 64th WHA in May 2011. In the interim, countries are encouraged to nominate representatives to attend the second IHR Implementation Course (IHR i-course), a training program that will take place from September 27, 2010, to February 18, 2011 [5].

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WHA CREATES NEW CONSULTATIVE WORKING GROUP ON FINANCING FOR HEALTH INNOVATION

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BACKGROUND

The Issue

Despite remarkable progress in the areas of prevention, diagnosis and treatment of disease, poor populations are not seeing the benefits of these advances. Diseases disproportionately affecting poor populations receive less funding for research and development.

Global Health Impact

Poor populations in developing countries lack adequate access to medicine, as well as to preventative and diagnostic tools. "Caught in a cycle of poverty and disease, people in the hardest-hit countries are facing shorter life expectancies and economic decline," [1].

Role of Diplomacy

In 2008, the World Health Assembly adopted resolution WHA 61.21 on a Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA). The global strategy is designed to build capacity, improve access and mobilize

resources to promote innovation. Implementation of the strategy is taking place, led by the WHO, governments, nongovernmental organizations and other stakeholders [2].

Introduction

Following a one-day informal consultation on May 13, 2010, and difficult negotiations during the World Health Assembly (WHA), Member States agreed on a resolution on public health, innovation and intellectual property rights. The main outcome of the resolution is the establishment of a consultative working group to take this issue forward.

Negotiations to date

In 2008, in accordance with resolution WHA 61.21, the Director-General of the WHO established an expert working group (EWG), to consider current financing and coordination of research and development for innovation in health, including proposals for new and innovative sources of funding. The DG asked the EWG to complete its work within a year, and to submit their report for consideration by the WHA in May 2010, through the Executive Board (EB). The Chair of the EWG, Sir George Alleyne, presented the executive summary to the January session of the EB, where it created significant controversy. Members shared the following concerns at the EB, which were reiterated at the WHA in May 2010:

- A number of Member States felt that the EWG failed to meet its mandate. Brazil, the leading voice among those critical of the EWG report, expressed its disappointment that there was not a greater focus on intellectual property rights and access to medicines and health products in the report;
- Kenya, Bangladesh and other Member States proposed de-linking the cost of research and development, from the price of medicines and other health products;
- Kenya, speaking on behalf of the African Group, raised questions regarding the transparency of the evaluation of proposals for innovative financing submitted for consideration, and the criteria for inclusion in the final

report;

- Many delegates expressed dissatisfaction that the full report had been released only two days before the EB meeting, and only in English. India, Brazil and the African group pushed for more time to consider the report in full;
- At the Executive Board Meeting in January 2010, Members of the Board also expressed concern over allegations that an early version of the report had been leaked and that the pharmaceutical industry had undue influence on the work of the EWG. An investigation by the DG established that WHO staff did not cause the leak.

The WHA Negotiations

The delegate from Spain, speaking on behalf of the EU, noted that the EWG report was an important first step to consider current financing and coordination of research and development, including proposals for new and innovative sources of funding. The US delegate noted that the mandate of the EWG was broad: “I have no difficulty with the way the EWG looked at [the issue].” Brazil reiterated its disappointment with the report, and was supported by a number of other Member States, including Thailand, Peru and Cuba. A number of proposals came out of the heated debate at the WHA, but no agreement was reached. To break the deadlock, the Swiss delegate suggested informal consultations for those Member States interested to discuss the way forward. Following lengthy informal consultations, the group came up with a draft resolution for consideration by Member States.

The 2010 Resolution

The Resolution adopted at the WHA calls for the establishment of a consultative expert working group to take forward the work of the EWG. Member States are requested to nominate experts for a roster, which following consultations with regional committees to achieve gender and regional balance as well as a diversity of expertise, will be submitted to the DG. The DG will propose the composition of the group to the Executive Board, at its 128th

session in January 2011.

The consultative working group will examine the details of the four proposals for innovative sources of financing proposed by the EWG report [3]. The four proposals examined were:

- An indirect, consumer tax. A tax could be imposed on specific products or transactions, with the aim of raising significant amounts of revenue. Examples given by the EWG report included: A 10% tax on the arms trade market, or a digital tax on internet traffic.
- Voluntary business and consumer contributions.
- Taxation of repatriated pharmaceutical industry profits. Funds would be raised by direct taxation of pharmaceutical company profits gained from operations in non-domestic locations.
- New donor funds for health research and development. The EWG report proposes that there are three main sources of funding: additional funding from non-traditional donors, such as China, India and Venezuela; additional funding from existing donors; or additional funding from philanthropic organizations

Additionally, the consultative working group will review the five proposals identified by the report. These were:

- Open-Source technology; interested parties could contribute knowledge or solutions.
- Patent Pools (based on the UNITAID model).
- Priority review vouchers; producers would be offered “priority regulatory review,” of a commercial product, in return for registration of a drug for a neglected disease.
- Health impact fund; a voluntary system to finance developers of new drugs, where instead of being patented, the fund would offer payment based on the drugs therapeutic value or impact.
- Orphan drug legislation; such legislation encourages developers to make products for low-profit markets by offering both “push” incentives (tax credits, regulatory fee waivers and priority review), and “pull” incentives.

The resolution passed at the recent World Health Assembly also requests that the consultative working group further explore those proposals that did not meet the criteria used by the EWG, and consider additional proposals.

Reaction from Civil Society

This issue has galvanized civil society, and groups including Health Action International Europe, Oxfam International and Médecins Sans Frontières (MSF), have been vocal critics of the EWG's report. At a side-event organized by Knowledge Ecology International, Rohit Malpani of Oxfam International expressed his disappointment with the process, noting: "WHO is meant to go beyond the status quo." Sophie Bloemen of Health Action International Europe, called on the WHA to have a more open and transparent process, ensuring that all stakeholders can be involved. Tido von Schoen-Angerer, director of the MSF Campaign for Access to Essential Medicines, advocated the need for a treaty on research and development, and suggested that the principle of de-linking the cost of research and development from the price of medicine and diagnostics should be a guiding principle for such a treaty.

Civil society welcomed the adoption of the resolution at the WHA. In a statement, Knowledge Ecology International noted: "The resolution was a major victory for developing countries and those promoting transformative reforms in the way that research and development and access to medicine is (sic) managed [4]."

Next Steps

Materials used by the EWG, including all proposals and their sources; criteria used for assessment of proposals; and lists of stakeholders interviewed, will be made available electronically by the end of June 2010. The consultative working group will submit a work plan and inception report to the 129th session of the Executive Board in May 2011; and a final report will be submitted to the 65th session of the World Health Assembly in May 2012, through the 130th session of the EB.

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CONTINUED NEGOTIATIONS TO FINALIZE THE PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK

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BACKGROUND

The Issue

Over the past five decades, the World Health Organization (WHO) Global Influenza Surveillance Network has grown into a system of over 100 National Influenza Centres in 90 countries. The Network 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. This system has functioned reasonably well for seasonal influenza control.

Efforts to prepare for a pandemic influenza have put a tremendous strain on the system. At the end of 2006, Indonesia stopped sharing H5N1 virus samples with the Network, to express its opposition to the system in which developing countries freely provide samples to the WHO, and then pharmaceutical companies use the samples to develop and patent vaccines which developing countries cannot afford. (Indonesia cited an Australian company's application for a vaccine patent derived

from an Indonesian H5N1 strain to make this point).

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, given that it impedes the WHO Network's ability to monitor mutations in the H5N1 virus in Indonesia. Others stressed that this decision led the WHO and developed countries to address global inequities in access to vaccines.

The Role of Diplomacy

Resolution WHA 60.28(2007) required the Director-General to convene an Intergovernmental Meeting (IGM), to oversee the development of an improved system for virus sample sharing and access to vaccines. While several meetings have been held, negotiations have not yet produced an agreement on a new Pandemic Influenza Preparedness Framework[1].

Introduction

In January 2010, the Executive Board (EB) established an Open-Ended Working Group with the aim of finding a way to finalize the Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (the Framework) (see Health Diplomacy Monitor Volume 1, number 1). The Open-Ended Working Group met in Geneva May 10-12 and was attended by 79 Member States [2]. Ambassadors Gomez Camacho from Mexico and Angell-Hansen from Norway were elected co-chairs. Some progress was made by Member States, and a draft proposal was put forward for adoption at the World Health Assembly (May 17-21). The resolution was adopted by the Assembly as proposed, signaling Member States' agreement to continue to work for another year to finalize the Framework [3].

Negotiations to date

Intergovernmental efforts have been on-going, but progress has been slow. The outstanding issues remain drafting and agreeing to a Standard Material Transfer Agreement (SMTA), intellectual property rights and benefit sharing. The co-chairs of the open-ended working group made the following observation about the 2009 H1N1 pandemic: "While viruses were shared in a rapid, systematic and timely manner by all States, benefits such as vaccines were not available in the same manner [4]." Developing countries have argued that benefit sharing must be mandatory, while developed countries do not see a mandatory link as the way forward. Issues related to intellectual property rights remain equally difficult to resolve. Speaking at the World Health Assembly, the delegate from Senegal said that it was simply unacceptable that states can be forced to share virus stock, but not receive timely access to benefits. The difficulty remains finding a balance between IP as an incentive for innovation and ensuring timely and affordable access to vaccines and other benefits.

At the Open-Ended Working Group held prior to the WHA, Member States made some progress. In addition to the commitment to finalize the Framework, text-based negotiations to create a SMTA also began for those entities inside the existing WHO network. Four proposals were submitted and discussed over the course of the meeting: an SMTA proposal from the co-chairs; SMTA I and SMTA II proposed by Brazil, India and Indonesia; and a proposal from the European region. The scope of the SMTA negotiations is limited to influenza laboratories designated or recognized by the WHO, which are bound to work under agreed WHO terms of reference. Brazil, India and Indonesia put forward a proposal for SMTA II, a more inclusive SMTA, applying to WHO network laboratories as well as entities outside the network. Although no agreement was reached at the working group, it was agreed that the four proposals would form the base for future negotiations.

The WHA Negotiations

Since most Member States at the WHA meeting had already agreed to the resolution text at the open-ended working group, many interventions simply supported the resolution and re-emphasised key challenges. A number of Member States reiterated the importance of addressing the imbalance that exists in terms of timely access to vaccines and other benefits. The delegate of Congo Brazzaville emphasized the potential vulnerability of poor countries in a pandemic situation, noting that while they had received access to vaccine during the H1N1 pandemic, it arrived too late. The delegates of Brazil and Indonesia stressed the importance of the transfer of technology, so that countries can build their own vaccine production capacity. The Indonesian delegate thanked the co-chairs for their efforts at the open-ended working group, noting that having all the sensitive issues on the negotiating table represented a step forward. The delegate from Thailand expressed disappointment that there was still no consensus on the SMTA, and urged Member States to find an agreement soon. The Kenyan delegate pointedly summed up the state of the negotiations: "Let's hope that this open-ended working group will not be open forever."

Next Steps

The next meeting of the open-ended working group will likely take place shortly before the next session of the EB. The resolution passed at the WHA calls on the open-ended working group to report through the Executive Board to the 64th session of the WHA (2011).

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ACHIEVING THE HEALTH-RELATED MDGs: WHO FOCUSES ON HEALTH SYSTEM STRENGTHENING

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BACKGROUND

The Issue

With just five years remaining, many low-income countries are far from meeting the targets set for the health-related Millennium Development Goals (MDGs). These goals include MDG 4 (reduce child mortality); MDG 5 (improve maternal health); and MDG 6 (combat HIV/AIDS, malaria and other diseases). Long an issue neglected by donors, weak health systems have undermined progress. MDG 4 and MDG 5, which rely on the availability and accessibility of quality health care services, are particularly difficult to fulfill where health systems are not strong. Without major new investments, and coordinated and coherent action across the health-related MDG's, these MDG targets will not be met.

Global Health Impact

Prior to the Assembly, the World Health Organization released document A63/7, "Monitoring of the Achievement of the Health-Related Millennium Development Goals: A Report by the Secretariat." The report finds that progress on MDG 5 is lagging far off course. "According to estimates made for the year 2005, half a million women – most of them in developing countries – die each year of compli-

cations during pregnancy or childbirth,” [1]. In fact, no WHO region achieved the target set by MDG 5 to reach a 5.5% annual rate of decline in maternal mortality [1].

On MDG 4, the report indicates that between 1990 and 2008, child mortality decreased 30%; falling from 12.4 million total annual deaths in children under five, to 8.8 million [1]; however, “the greatest reductions in child mortality have been recorded among the wealthiest households and in urban areas,” [1]. Concerted international efforts are needed to resolve this inequity to reduce child mortality by two thirds (over 1990 levels).

Despite these conclusions, the report, does note significant progress on HIV/AIDS, tuberculosis, and malaria. New HIV infections declined 16% worldwide between 2000 and 2008, more people are being successfully treated for tuberculosis, and 38 countries are on pace to meet the MDG targets for malaria [1]. Nevertheless, challenges remain. Statistics show that 2.7 million people contracted HIV in 2008, multi-drug resistant tuberculosis is becoming more difficult to diagnose and cure; and the need for insecticide-treated bed nets exceeds supply in most countries [1].

Role of Diplomacy

Diplomacy played an important role in the development of the MDGs, and the MDGs continue to be discussed at high-level forums, from the United Nations, to the G8. The Norwegian government has been particularly active in mobilizing international support for the Joint Action Plan and Accountability Framework towards the achievement of the health-related MDGs. From September 20-22, 2010, the United Nations will convene a high-level plenary session on achievement of the MDGs. This session will be critical in defining the agenda for reaching the MDGs by the 2015 deadline.

Introduction

The 63rd World Health Assembly (WHA) charted a new course towards the achievement of the health-related Millennium Development Goals (MDGs). In her opening address, Dr. Margaret Chan, Director General of the WHO, expressed the WHO’s desire to lead this international

action, and underscored the need to accelerate progress on the MDGs: “Weak health systems blunt the power of global health initiatives to reach their goal. Weak health systems are wasteful [...] Above all, weak health systems waste lives,” [2]. Comments by Dr. Chan were echoed by the Assembly, which made health system scale-up, and MDG4 and MDG5, the focus of new efforts to reach the MDGs by 2015.

The WHA Negotiations

The 63rd WHA adopted the resolution “Monitoring of the Achievement of the Health-Related Millennium Development Goals.” Recognizing the limited capacity of health systems in developing countries to provide sufficient health information, the resolution urges member states to strengthen their health systems in an effort to accelerate progress towards the health-related MDGs; especially MDG 4 and MDG 5.

Debate on the resolution concluded in three points of agreement. First, achievement of the health-related MDGs requires a gender-sensitive approach that emphasizes the health of women and children. Second, investments must prioritize sustainable, well-functioning health systems. Third, these systems must be built upon the principles of public health care, emphasizing health equity and preventative health strategies (ex. immunization campaigns).

Despite consensus on the resolution, delegates raised concerns about current levels of health financing. Ghana urged developed countries to fulfill their pledge of committing 0.7% of gross national product to official development assistance (ODA) by 2015 – as urged by the Monterrey Consensus. Funding for the health-related MDGs also requires more equitable distribution across the MDGs. According to the Secretariat’s Report (A63/7), donor funding for MDG4 and MDG5 remains low, despite significant increases for MDG6. Yet, without defining specific mechanisms to hold donor countries accountable to their commitments, the resolution does not fully address developing country concerns.

Reaction from Experts

In a series of technical briefings at the WHA, inter-

national experts echoed concerns about a lack of donor funds. According to Jeffrey Sachs, the international community faces an annual US\$ 35 billion shortfall in funding for global health by 2015 if efforts to scale-up donor funding are not introduced; Sachs also suggested that funds should be allocated to health systems strengthening, which have been under-financed since the MDGs were launched in 2000 [3].

On a related issue, Michel Kazatchkine, CEO of the Global Fund, indicated that major shortfalls in donor commitments may post-poner the Global Fund's next replenishment round. In addition to the negative impact this would have on the financing of HIV/AIDS, tuberculosis, and malaria services in low-income countries, the postponement could undermine the development of stronger health systems worldwide [4].

Next Steps

The Norwegian Government has announced that it will actively support the United Nations Secretary General to develop 'A Joint Action Plan to Improve the Health of Women and Children' [5, 6]. A draft version of the document was made available at the Assembly during a technical briefing on the health-related MDGs. It calls on governments to substantially increase their financial commitments to women's and children's health. The action plan also seeks to establish an accountability framework to ensure sustained donor funding for health systems, a measure aimed at accelerating progress on MDG 4 and MDG 5. The United Nations hopes to launch the Joint Action Plan and Accountability Framework at the upcoming United Nations High-Level Meeting on the MDGs, September 20-22, 2010.

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INTERNATIONAL TUBERCULOSIS CONTROL AND PREVENTION EFFORTS

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BACKGROUND

The Issue

Tuberculosis (TB) continues to be a neglected disease, despite its inclusion in the Millennium Development Goals and the Global Fund for HIV/AIDS, TB and Malaria (The Global Fund). While incidence rates of TB are falling, which suggests that the Stop TB Strategy is proving effective, this decline is too slow to meet the MDG objectives for 2015. Further, the lack of new diagnostic and treatment procedures, combined with insufficient laboratory capacity and poor access to quality-assured anti-TB drugs, means that in

the absence of substantial investment and support, many of the developing countries most severely affected by TB, will be unlikely to make significant progress in the near future.

Global Health Impact

The WHO reported that TB is estimated to have infected 9.4 million new people and caused 1.8 million deaths in 2008. Currently, more than 2 billion people carry the TB bacilli. Co-infection with HIV has made TB an even more deadly disease. In addition, the emergence of both multi-drug resistant TB (MDR-TB), and extensively drug-resistant TB (XDR-TB), threatens to reverse the gains made in international efforts to control TB.

The Role of Diplomacy

There is an urgent need for a greater focus on TB at the upcoming UN Summit on the Millennium Development Goals in September 2010. In particular, MDR-TB and XDR-TB, pose a grave global health threat, with an estimated 7% or less of cases being detected [2], and a severe lack of funding for new diagnostic procedures and treatment. Unless significant political attention and the requisite financial resources are forthcoming, it is considered likely that MDR and XDR-TB will reverse the previous gains made in the global fight against TB.

Introduction

Pursuant to the 2009 resolution WHA62.15, on the prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis, the Director-General was requested to report to the 63rd World Health Assembly via the Executive Board, on the implementation of the Stop TB Partnership's Global Plan to Stop TB (2006-2015) [1]. In the report submitted to the Assembly, the Secretariat noted that while much progress has been made, it is estimated that some 9.4 million new cases of TB occurred in 2008 and of these, 15% (1.4 million) were also HIV-infected. The majority of new TB cases were in the Asia-Pacific region (55%) and Africa (30%). The Secretariat also noted that although global financing of TB-related work has increased, MDR and XDR-TB remain a challenge.

The WHA Negotiations

Upon commencement of formal Committee A discussions at the 63rd World Health Assembly, delegates expressed their appreciation to the WHO Secretariat for providing a comprehensive summary document on the state of international TB prevention and control efforts (see WHA document A63/14) [2]. Several delegations observed that considerable progress had been made, but that overall efforts continue to lag behind the targets for 2015 as outlined in the MDGs. Delegates noted with appreciation the advances made under the Stop TB Strategy, but also highlighted the lack of progress in developing new diagnostic and treatment procedures and in making them widely available.

Delegates also flagged the rise of MDR and XDR-TB as a key concern, with countries such as Kazakhstan and Botswana stating that MDR-TB currently accounts for 15-40% of new TB cases in their respective countries. Two countries— Papua New Guinea and Namibia – expressed concern over the fact that they are not identified as high-burden TB countries, despite high prevalence of the disease among their populations. Other delegations, including Russia, Brunei, China, and India, called on the WHO Secretariat to further support Member States in combating the spread of MDR-TB. Moreover, while it was generally acknowledged that there has been a notable increase in TB-related funding, delegates expressed concern that previously stated funding targets were not being met, and called for more financial resources to be urgently allocated.

Laboratory capacity amongst low and middle-income countries was identified as a specific area in need of significant investments; with countries such as South Africa (on behalf of the African region), Brazil, and Thailand requesting technical and financial assistance to address their laboratory capacity-building needs. In addition, while a number of delegations expressed their appreciation for the work of the Green Light Committee in facilitating access to anti-TB drugs, countries such as Kazakhstan, South Africa (on behalf of the African region), Botswana, India, and Iran, noted that access to quality-assured anti-

TB drugs remains an ongoing challenge. Following a formal discussion, however, given that no action item was proposed, the Committee simply noted the report and concluded the meeting.

The Lancet TB Observatory

Prior to any formal discussion or debate on Tuberculosis Control (agenda item 11.11), at the 63rd World Health Assembly, delegates were invited to attend a side-event hosted by The Lancet, The Global Fund, and the WHO, to note the launch of The Lancet TB Series and The Lancet TB Observatory. The event was well-attended, and participants were given the opportunity to hear summary presentations from several of the authors who contributed to the May 2010 issue [3]. Richard Horton, editor of The Lancet and the moderator for the event, noted that efforts to control TB needed to, “include more than just ministries of health,” and he stressed the need, “to assess interventions for social and economic determinants, such as malnutrition, alcohol use, poor housing, indoor air pollution, and poverty,” [4].

The TB Observatory is a new initiative based at The Lancet and supported by the WHO, The Global Fund, and the Stop TB Partnership, which aims to:

- Assemble the world’s leading experts to monitor and assess international progress in TB prevention and control;
- Maintain a website and publish quarterly updates on the objectives of the Observatory;
- Provide a forum for open discussion;
- Host meetings every 1-2 years to discuss progress and encourage innovation;
- Publish progress reports in the form of The Lancet mini-series every three years; and,
- Publish an editorial for the UN Millennium Development Goals (MDG) Summit in September 2010, summarizing the situation and issuing a call to action [5].

The Director-General, along with a number of participants at the event, emphasized the need for closer engagement with civil society, and expressed the hope that the TB Observatory will facilitate this kind of participation.

Next Steps

The next high-level meeting to monitor the international progress in controlling TB is due to take place in New York on September 20-22, 2010, as part of the UN Summit on the MDGs [6]. One of the proposals to increase political attention to TB advanced in The Lancet is to adjust the title of MDG 6 to that of: “Combat HIV/AIDS, Malaria and Tuberculosis and other Diseases,” [5]. Dr Mario Raviglione, Director of the WHO Stop TB Department and co-author of the article, noted later that this idea had previously been tabled at the World Health Assembly three years ago, but it failed to gain support. Dr Raviglione suggested that if a change to the title were to take place, it would have to come from Member States or, “from a much higher level than WHO, like the United Nations” [7]. It is likely that these issues will be followed up at the International Union Against Tuberculosis and Lung Disease (IUATLD) conference on November 11-15, 2010 [8]. The WHO Secretariat has agreed to report on further progress at the 65th WHA, in May 2012.

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WHA ADOPT RECOMMENDATIONS FOR THE MARKETING OF FOOD AND NON-ALCOHOLIC BEVERAGES TO CHILDREN

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BACKGROUND

The Issue

Children's diets are influenced by food and beverage advertisements. Many of the products targeted at children are high in sugar, fat and salt.

Global Health Impact

High consumption of fat and sugar can lead to obesity. At least 20 million children under the age of five worldwide were overweight in 2005, and this number continues to rise [1]. Obesity is a significant risk factor for a range of noncommunicable diseases, including diabetes and cardiovascular disease. Noncommunicable diseases represent a heavy burden on health care systems, especially in countries where health infrastructure is weak.

The Role of Diplomacy

Resolution WHA60.23 (2007) called on the World Health Organization (WHO) to develop, "a set of recommendations on the marketing of foods and non-alcoholic beverages to children, in order to reduce the impact of foods high in saturated fats, trans-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector parties." The WHO subsequently established an expert group, and held a number of stakeholders' meetings and consultations with Members to establish guidelines for responsible marketing.

Introduction

At the recently concluded 63rd World Health Assembly (May 17-21, 2010), Member States passed a resolution on marketing of food and non-alcoholic beverages to children. The resolution endorses a set of guidelines on the marketing of food and beverages to children. The draft recommendations were discussed at the Executive Board meeting in January, and remained, with the exception of two minor amendments (see Health Diplomacy Monitor, Volume 1, number 1) [2].

The Guidelines

The main objective of the guidelines is to assist Member States to draft new, or strengthen existing, policies on food marketing to children. The guidelines include the following recommendations [3]:

- Governments should reduce the exposure to marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt.
- Governments should be the key stakeholders in the development of policy, implementation, monitoring and evaluation, but: "may choose to allocate defined roles to other stakeholders, while protecting the public interest and avoiding conflict of interest."
- Member states should cooperate to reduce the impact of cross-border marketing to children (in-flowing and out-flowing), of foods high in saturated fats, trans-fatty acids, free sugars, or salt.

The Resolution

The draft resolution put forth by Norway, had close to 30 co-sponsors, with most regions represented. In addition to endorsing the guidelines on food marketing, Member States are urged to, among other things:

- Identify the most suitable policy approach to address the marketing of food to children given national circumstances and develop new/strengthen existing policies that aim to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt;
- Establish a system for monitoring and evaluating

the implementation of the recommendations on the marketing of foods and non-alcoholic beverages to children; and,

- Take active steps to establish intergovernmental collaboration in order to reduce the impact of cross-border marketing

The resolution also stresses the importance of cooperation with all stakeholders in the implementation of the recommendations. They call on the Director-General to promote their implementation by providing technical support to Member States and by promoting cooperation with intergovernmental organizations, civil society and other stakeholders.

WHA Negotiations

Member states were supportive of the resolution and the need for the guidelines. A number of delegates, including those of India, Togo (for the African group), the US and Australia emphasised their support for the guidelines as well as the importance of continuing work on non-communicable diseases. The delegate of the United States noted that combating childhood obesity is a priority of the Obama administration. The delegates of Togo, Thailand and Suriname appealed for resources to work in the area of prevention and implementation. Norway stressed that childhood obesity is increasing rapidly worldwide and that food marketing to children is prevalent. The Norwegian delegate also commented on the process behind the drafting of the guidelines, noting that broad consultations and the work of an expert group were instrumental in producing the draft recommendations.

Reactions from other Stakeholders

While civil society groups have generally shown support for the guidelines, some have expressed the concern that the draft guidelines do not go far enough to protect children from marketing of unhealthy foods. In an editorial published just prior to the WHA, The World Public Health Nutrition Association (WPHNA), argued that the draft stressed the need for research, but, “omits the point that governments should make policy” [4]. The group also argued that the recommendations position governments

in a co-ordinating role, and, “allow the option of industry taking the lead with self-regulation” [4]. Moreover, the WPHNA is critical of the, “vague [...] mechanisms for audit” [4]. In an oral statement to the WHA, Consumer International called on Member States to move beyond self regulation.

Industry representatives expressed support of the guidelines. In a statement released by the International Food and Beverage Alliance, whose membership includes General Mills, Kraft Foods, Nestlé and the Coca-Cola company, expressed the opinion that the WHO recommendations: “Provide a set of flexible options which, once approved, will be a solid basis for moving forward. Member States will then need to begin the important and cooperative work of engaging relevant stakeholders to consider options on marketing to children, which encourage and promote balanced diets, physical activity, and healthy lifestyles” [5].

Next Steps

It will now be up to governments, with the support of the WHO, to implement the recommendation on marketing of food and non-alcoholic beverages to children. The resolution passed requests that the Director-General reports on the implementation of the guidelines as part of the progress report on the global strategy on prevention and control of noncommunicable diseases to the 65th session of the World Health Assembly to be held in 2012.

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WHA ADOPTS GLOBAL STRATEGY TO REDUCE HARMFUL USE OF ALCOHOL

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BACKGROUND

The Issue

High consumption of alcohol is directly linked to increased illness and mortality.

Global Health Impact

76 million people around the world suffer from alcohol-use disorders. The WHO estimates that the harmful use of alcohol causes up to 2.3 million premature deaths each year. Alcohol contributes to 3.7% of global mortality, and is the cause of 4.4% of the global burden of disease [1].

The Role of Diplomacy

In May 2008, the WHO Member States requested that the WHO develop a strategy to reduce the harmful use of alcohol (see Resolution WHA61.4). After consultations with various stakeholders, WHO presented a draft of the “Global Strategy to Reduce the Harmful Use of Alcohol,” to the Executive Board meeting in January 2010 [2]. The Board passed a resolution urging the World Health Assembly to adopt the Strategy at the upcoming WHA meeting [3].

Introduction

At the WHA in May 2010, Member States adopted the Global Strategy. There was consensus on the utility of the Strategy, and Member States recognized the strategy as an important step to reduce harmful effects of alcohol (see also Health Diplomacy Monitor, Volume 1, number 1).

Contents of the Strategy

The Strategy includes the following elements: It urges countries to develop and strengthen alcohol policies; establish agencies to supervise national alcohol policies; and raise awareness of the harmful effects of alcohol, especially amongst vulnerable groups. The strategy also references the importance of health services; community initiatives; strong drinking and driving policies; as well as regulations to regulate the availability of alcohol, such as the enforcement of minimum drinking age limits. The marketing of alcoholic beverages and pricing policies is also addressed by the Strategy.

The WHA Negotiations

While countries agreed on the need to have a strategy to guide national alcohol policies, certain countries preferred a binding strategy, along the lines of the Framework Convention on Tobacco Control (FCTC). This view was defended by Thailand, speaking on behalf of the SEARO (South-East Asian Region) countries. Acknowledging the influence of lobbying by the alcohol industry, the Thai delegate asked for evidence on how effective and successful industry self-regulation has been, stressing that SEARO countries have strong doubts regarding the effectiveness of self-regulation in this area. Similarly, Thailand showed concern over the effectiveness of community education initiatives in reducing the harmful use of alcohol. Thailand prescribed the need to have recommendations that focus more on cost mechanisms, including increased taxation of alcoholic products.

Turkey supported Thailand, arguing that concrete steps needed to be taken by the WHO to push for a treaty on alcohol, as the FCTC has shown good results. Turkey also suggested that the Secretariat prepare bi-annual reports on the implementation of the Strategy. India also endorsed Thailand’s concerns with the Strategy, and highlighted some alarming national

trends, such as a reduction to a younger age of initiation, which is worrying due to younger demographics. The Indian Secretary of Health, Ms. Sujatha Rao, advocated a FCTC-like model to ensure “holistic strategies.” She noted that the implementation at the country level will depend on the quality of the agreement at the global level, which would be highest under an international binding treaty.

South Africa reported a growing burden of alcohol abuse amongst school children. According to a survey, 29% of South African school students engaged in binge-drinking habits. The South African delegate also noted high consumption among vulnerable groups, especially those affected by HIV/AIDS; and highlighted South Africa’s elevated rates of Fetal Alcohol Syndrome (FAS).

Among developed countries, there was a consensus on the adequacy of current strategies in informing national alcohol policies. The EU, represented by Spain, emphasized that the EU supports community education and advocacy measures to promote reductions in alcohol consumption.

Norway shared its experiences of raising excise duties and strengthening regulations nationally, and highlighted the political challenges in implementing these measures. In response to country level interventions, the WHO Secretariat emphasized the difficulty in attracting donors to invest in programs to reduce the harmful use of alcohol.

Next Steps

The Strategy was adopted by the WHA, and Member States are now responsible for implementing it within their respective national contexts. It remains unclear whether those supporting a more binding strategy will advocate for this in future World Health Assemblies.

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