As has been our tradition, the Monitor team covered the World Health Assembly (WHA) in May. The team in Geneva consisted of Adam Kamradt-Scott, Priyanka Kanth, and Miriam Maria Sangiorgio. In this current issue, you will find articles on some of the key areas that were covered during the WHA, including Universal Health Coverage, the Pandemic Influenza Preparedness (PIP) Framework, WHO reform, the International Health Regulations, health in the post-2015 development agenda and noncommunicable disease. Also in this issue, an editorial from Yoswa M Dambisya commenting on the first review on progress in implementing the WHO Global Code of Practice on International Recruitment of Health Personnel. Adam Kamradt-Scott also reported by twitter throughout the WHA, and the tweets can be accessed at https://twitter.com/adamkams.

Our sister publication, the Journal of Health Diplomacy, has started publishing on-line first content. Please visit http://www.ghd-net.org/journal-of-health-diplomacy/online-first for a preview of Volume 1, Issue 1 of this new, peer-reviewed Journal.

As always, we welcome your feedback and.

- Bente Molenaar Neufeld
At the recently concluded World Health Assembly (WHA 66) member states reviewed progress in implementing the WHO Global Code of Practice on International Recruitment of Health Personnel (the Code). This was the first review report since the adoption of the Code three years ago. The Secretariat report tabled at the WHA showed that few African countries have designated authorities for monitoring and reporting on the Code, and that only one African country submitted a report on implementation. This low response was commented on in April 2013 EQUINET newsletter.

When the report on the health workforce, which included a progress report on the Code, was tabled at the WHA, the discussion was somewhat muted. Only fourteen member states commented on the report, and only eleven made reference to the Code. African countries generally speak as a group on issues through a nominated delegate. This time, Burkina Faso spoke for the 46 WHO-AFRO member states, and Ethiopia spoke in support of Burkina Faso. Those who attended the WHA in 2010 when the Code was adopted observed the contrast between this muted responds and the exciting atmosphere of intense debates and the large number of voices that were heard at the time of adoption.

So what has happened over the last few years? At a side event at the WHA, participants took stock of the progress, or lack thereof, in the implementation of the Code. The side event was organised by Medicus Mundi Internationales together with the Governments of Malawi and Belgium, EQUINET and The African Medical & Research Foundation (AMREF). Participants raised various challenges that member states faced in getting the implementation of the Code off the ground, including their lack of preparedness, the poor mobilisation of national level stakeholders and limited engagement of civil society since the Code was adopted. Ministries of Health were also reported to be overwhelmed with other issues. The WHO and some countries reassured the audience that despite low reporting, work was underway. The fact that many countries had reported was seen as a positive sign, given the voluntary nature of the Code, as was the commitment of Northern countries (USA, EU) and the WHO Secretariat to support its implementation.

The muted African member state reaction to the report at the WHA by the Secretariat may, as raised above, be explained by the diplomatic process of the Africa Group, where African ministers reach agreed positions, as they did on this issue, giving little added value in countries making further individual statements. While shared position and voice is an important feature and strength of African diplomacy, it is also common practice for countries to state/restate their position as they “align themselves with the statement made by the delegate for…… region”. This allows countries to give force behind specific areas and for country experiences to add weight to positions raised. African countries may also have been reluctant to raise their voice in the WHA process given lack of input to the Secretariat report.

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*This editorial first appeared in the June 2013 edition of the EQUINET newsletter.*
Whatever the reason, and this needs to be further explored, the low profile adopted by African member states on this occasion may have sent a message that the Code is not perceived to be a key policy instrument for the region to address its continuing challenges over the production, retention and migration of health workers. If so, then given the energy that went into its adoption, where are the shortfalls?

There are lessons to be learnt from other processes at the WHA. Voluntary codes may be side-lined as other issues demand more urgent government attention. If this is the case then the implementation of the only other WHO Code - on Breast Milk Substitutes - provides a lesson on the role of civil society to galvanise countries into action, particularly with technical support of the WHO. Civil society has kept the code on Breast Milk Substitutes alive and current and generated pressure within countries to ensure that it is implemented. Is this possible for the Code of Practice on International Recruitment of Health Personnel? In theory it is achievable. The loss of health workers in countries of highest health need is still a concern, and communities and health workers have an interest in the issue, as it affects their rights and services.

Civil society organisation on health worker issues has partly been through the Global Health Worker Alliance (GHWA). The fact that the GHWA currently has no executive director weakens its support for civil society input, and creates uncertainty about its future. The third global forum on health workers organised by the WHO and the GHWA will be held in Recife, Brazil in November 2013. It should provide an opportunity to review and give profile to the role of the Code in addressing health worker issues, and give new momentum to the role of civil society in its implementation. This however does require civil society, health worker organisations and academics within countries to ask questions on the implementation of the Code, to ask delegations for feedback from the discussions held at the WHA, and to know, share information on and support implementation of the Code.

It is also a matter of concern that reforms at the WHO Secretariat have diminished the capacity of the unit dealing with health worker issues. Fewer people are now contending with an increasing workload, weakening the capacity of that unit to play a leading role in support of member states and the wider community.

A number of civil society organisations, including MMI/Peoples Health Movement, and the International Federation of Medical Students Associations (IFMSA) spoke as observers at the WHA deliberations on the Code. Most of the presentations raised the issue of the weakening of these institutional capacities for supporting its implementation and called for a stronger Health Systems Policies and Workforce unit at WHO Secretariat and a stronger GHWA.

In a world of rapidly shifting policy attention, it seems to be important to organise and secure the resources, institutional roles and capacities for implementation when negotiating new instruments, particularly if they are voluntary as the Code is. The next few years will be a test of whether the slow implementation is a feature of countries preparing for a marathon rather than a sprint, or whether it is a feature of diminishing interest in the race. Issues are also sustained when they have a place in the current focus of policy attention. The focus of this year’s WHA and of much current global engagement in health was on universal health coverage (UHC). It was thus important that health workers were identified as a central element of that policy.

This then may be the important message that we need to send. Delivering on UHC is not possible without health workers, and one sign of that delivery at the global level is the extent to which countries are operationalizing the Code and implementing its intentions. The international agreements negotiated by member states at the WHO are instruments for achieving UHC, whether voluntary or not, as are the global and national capacities in governmental and non-state institutions for leading and being accountable on their implementation.

Please send feedback or queries on the issues raised in this briefing to the EQUINET secretariat: admin@equinetafrica.org. For more information on the issues raised in this op-ed please visit www.equinetafrica.org
The 66th WHA saw a remarkable victory for noncommunicable diseases with the adoption of an ‘omnibus’ resolution on NCDs, addressing some of the key commitments made at the UN General Assembly in September 2011 in the UN Political Declaration on the Prevention and Control of NCDs.

The omnibus resolution was unanimously adopted by all member states. It contains i) an endorsement of the ‘WHO Global Action Plan for the prevention and control of NCDs 2013-2020; ii) an adoption of the ‘global monitoring framework on NCDs’ including the 9 global targets and 25 indicators; and iii) a decision to develop a ‘global coordination mechanism’ by the end of year to coordinate efforts of all actors in the fight against NCDs.

During the statements made on the NCDs by member states, all countries unanimously supported the action plan and global monitoring framework but a number of the lower- and middle-income countries, such as Mongolia, Malaysia, Kenya, and other EMRO countries, expressed concern that the targets and indicators were too ambitious. A main cause of concern was capacity for accurate and wide-spread data collection at the national level. For example Ghana spoke about the difficulty to implement the recommended policies in light of lack of data on alcohol consumption, fat and salt intake and on availability of adequate medicines.

The Director-General, in her speech also highlighted the importance of cooperation of the private sector and also the threat they hold in seeing a fight against NCDs be successful. She noted that “[m]any of the risk factors for noncommunicable diseases are amplified by the products and practices of large and economically important forces. Market power readily translates into political power”. Amongst others, she mentioned the industry funding flawed research studies. She seemed hopeful to have cooperative relations with certain private sector outlets, that are willing to make their foods, beverages healthier or work on their marketing, but was very critical of the tobacco industry as she highlighted that “there are no safe tobacco products and no safe level of tobacco consumption.”

Background

Noncommunicable diseases (NCDs) was one of the key and expansive issues on the agenda for the 66th World Health Assembly (WHA) in May 2013. The NCD agenda item encompassed not only the draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases; the draft action plan for the prevention and control of noncommunicable diseases 2013-2020; but also a draft comprehensive mental health action plan 2013-2020; draft action plan for the prevention of avoidable blindness and visual impairment and a report on disability. NCDs also fit into agenda items on social determinants of health, World Health Organization (WHO) reform, the WHO General Programme of Work and Programme Budget 2014-2015, where NCDs and Mental Health are allocated US$318 million, and health in the post-2015 development agenda, where a African Union tabled resolution, adopted by the member states highlights the importance of NCDs.

Global Health Impact

NCDs account for 65.5 percent of all deaths globally, an increase of 30 percent since 1990. Of the top 10 causes of death, five are NCDs: ischemic heart disease, stroke, chronic obstructive pulmonary disease (COPD), lung cancer and diabetes. Nearly 80 percent of NCD deaths occur in low and middle-income countries. Main risk factors for NCDs are tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets.

The Role of Diplomacy

Policies that have the significant impact on reducing the burden of NCDs are in sectors outside of health, such as trade, agriculture, housing and energy. A key role of diplomacy is to promote policy cohesion across sectors, in both international and national-level policy. As some drivers of NCDs include the private sector (food, alcohol, tobacco), there are also broader questions for avoiding conflicts of interest and how the WHO deals with partnerships. Finally, NCDs are recognized as a serious challenge to social and economic developments, and the challenge remains to fit them into the post-2015 development agenda.
THE WORK OF THE DRAFTING GROUP
As discussions started on the NCDs at the WHA, it was decided that the Global Monitoring Framework on NCDs (GMF)- item 13.1 on the WHA agenda and the Global NCD Action Plan 2013-2020- item 13.2 would be discussed together. Before the discussion of the omnibus resolution, a drafting group was established. This drafting group, co-chaired by USA (Colin McIff) and Pakistan (Sania Nishtar) undertook the task to complete the action plan and negotiate the wording of what later became the omnibus resolution on NCDs. Areas that needed negotiating included bringing the text to a point where it would resonate with the post-2015 development agenda and echo the messages of social determinants of health like equity and inclusivity. The drafting group also worked at addressing the link between NCDs and children, which also links to a previous resolution on the marketing of unhealthy foods to children. Compromises were made on issues pertaining to intellectual property and importance of the generic medicines in meeting treatment demand for these chronic diseases, notably by Canada.

The drafting group also took into consideration recommendations made by member states on devising context-region- and/or country-specific recommendations so that each country could accordingly craft their policies. Member states, such as Botswana on behalf of the African Union, highlighted the immense global disparities in efforts to control, prevent and treat NCDs as well as the more obvious disparities in the levels of development of countries. In other examples, Iran on behalf of EMRO echoed the same concerns and also pointed out that due to various constraints, not all suggested policies may be implemented at the national levels. They also called for greater financial and technical support and capacity building efforts in these countries.

MENTAL HEALTH AT THE 66TH WHA
As part of the discussions on NCDs, the member states of the WHO adopted a ‘Comprehensive mental health action plan 2013-2020’ [7]. An initial version of the plan was discussed and approved by the Executive Board of the WHO at the 132nd session of the Executive Board in January 2013. One of the decisions of the EB was to host web consultations, which were held for the entire month of February 2013, to help finalize the plan. Mental health came on to the fore during the 65th WHA in 2012, when member states adopted a resolution wanting to address mental health disorders through a concerted global response and called on the Director-General to develop a comprehensive mental health action plan. Countries welcomed and agreed with the importance of addressing mental health issues at national levels. In fact, India went on to say that all disabilities have mental health impact and an EMRO country mentioned the need to also curtail the illegal drugs and alcohol markets which impact mental health.

DISABILITY
The World Report on Disability [9], jointly produced by the WHO and the World Bank has brought the issues of disabled people to the fore and also emphasized the need to see disability as a development issue. As a subset of NCDs, the member states also adopted a resolution on Disability [10], which reinforces the actions points and recommendations highlighted in the World report on disability and sets out ways for nations to implement the ‘Convention on the Rights of Persons with Disabilities’. In September, later this year, there will be a UN General Assembly high-level meeting on disabilities and development. In preparation for this, the WHO also held a lunchtime briefing on the 23rd of May. The UN high-level meeting will also set forward areas of work for the WHO secretariat to take up, as it did in the case of NCDs.

The support for the resolution on disabilities was also unanimous. Several countries such as Kuwait and Iraq highlighted the need for better pre-natal screening of disabilities. Other countries such as Mongolia requested additional funds to carry out the ambitious recommendations set forward, while Thailand highlighted the importance of de-stigmatization. Sweden asked for better data on disability as part of the role of the World Bank and the WHO.

NEXT STEPS
As WHO Assistant Director-General, Dr. Oleg Chestnov said, “the adoption of the global action plan moves the process from the political to the practical realm”. This means the onus is now on the countries to implement the policies set out in the action plan. That said, there are a number of follow-up tasks for the Secretariat:
to develop the terms of reference for the global coordination mechanism through informal consultations with Member States, UN agencies, NGOs and relevant private sector, followed by a formal Member State consultation in November 2013;

• to develop action plan indicators to inform progress reporting on NCDs and are capable of application across the six objectives of the action plan, to be submitted to WHA in 2014, through the Executive Board for approval;

• to update Appendix 3 of the global action plan in light of new scientific evidence, to be considered by the World Health Assembly through the Executive Board;

• to report on progress in implementing the action plan in 2016, 2018 and 2021, and on progress achieved in attaining the 9 global targets in 2016, 2021. 2026;

• to provide technical support to Member States to implement the global action plan, establish or strengthen national surveillance, and engage/cooperate with non-health government sectors and non-state actors;

• to recommend the formalisation of a United Nations Task Force on NCDs in July 2013 to intensify a joint UN response and to galvanise global support for NCDs. [8]

REFERENCES


The International Health Regulations: Update

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BACKGROUND

THE ISSUE

Under the terms of the revised International Health Regulations (IHR), member states were obligated to develop certain core capacities in disease outbreak surveillance and response by mid-2012.[1] Importantly, however, almost two-thirds of member states have requested extensions allowable under the framework agreement due to the lack of progress in developing the eight core capacities and it is anticipated that many of these countries will apply for a further two-year extension in 2014. In addition, following the independent IHR Review Committee findings[2], a number of key priority areas such as training, strengthening WHO internal capacities, and implementing organization-wide communications policy, remain outstanding.[3]

GLOBAL HEALTH IMPACT

The IHR core capacities and related technical and human resources are essential for enabling the rapid detection and response to disease outbreaks before they spread internationally. Implementation of these capacities has slowed in the wake of the 2008 global financial downturn, resulting in significant delays for member state compliance. The WHO is leading efforts to assist countries meet their obligations, however, sustained resourcing will be critical to meeting agreed global targets.

THE ROLE OF DIPLOMACY

Diplomacy will remain critical to the successful implementation of the IHR framework agreement, particularly in securing the requisite financial resources to build and strengthen disease surveillance capacities (e.g. laboratory capacity) as well as supporting the development of key human resources in low- and middle-income countries.

INTRODUCTION

The revised IHR were adopted in May 2005 and officially entered into force on June 15, 2007.[1] From this date, member states were given an initial period of five years in which to develop, strengthen and maintain eight “core capacities” in disease outbreak surveillance and response. Since then, however, 110 countries – or almost two-thirds of the WHO’s 194 member states – had formally applied for the first of two 2-year extensions allowable under the IHR framework.[3] In addition, in April 2011 the independent IHR Review Committee handed down its findings on the WHO’s management of the 2009 H1N1 influenza pandemic. The report outlined some 15 recommendations to accelerate implementation of the IHR, streamline the guidelines and advice provided by the WHO, improve communications, and strengthen global capacity to defend against new disease threats.[2] The 66th World Health Assembly (WHA) provided the WHO Director-General with the opportunity to update member states on the progress made to date in implementing the IHR Review Committee recommendations, as well as provide the annual report on IHR implementation as required under resolution WHA61.2.

THE 66TH WORLD HEALTH ASSEMBLY

Throughout the duration of the 66th Assembly member states were repeatedly observed to declare their strong support for the IHR, often citing the recent H7N9 influenza outbreak in China and the outbreak of the Middle East Respiratory Syndrome novel coronavirus (MERS-CoV) as important examples demanding their rapid implementation. Indeed, at the commencement of the agenda item 16.6, the Saudi Arabian Deputy Minister of Health, Dr Ziad Memish, and Dr Keiji Fukuda, the WHO Assistant Director-General for the Health Security and Environment cluster, provided an update and overview of the MERS-CoV outbreak, noting the challenges that had been encountered in managing the situation.[4] At the conclusion of this presentation and in response to the announcement by the Saudi Deputy Minister for Health that his country’s management of the outbreak had been hampered by patent issues, the WHO Director-General, Dr Margaret Chan, encouraged member states to share all new information and virus samples with WHO Collaborating Centre laboratories and announced her firm intention to ensure that intellectual property considerations should not be permitted to interfere with global health security.[5] The Director-General’s announcement was met with widespread applause, and member states moved on to discuss their progress in implementing the IHR. Multiple countries including Azerbaijan, Barbados (on behalf of CARICOM), Botswana, Cameroon, Iran, Nigeria (on behalf of the African region), the Maldives (on behalf of the South East Asia region), Morocco, Pakistan, and Papua New Guinea called on the WHO and partners...
for further assistance in developing and strengthening one or more of the eight IHR core capacities, while several high-income countries including the Russian Federation, Canada, the United States, Ireland (on behalf of the European Union), and Australia declared their continued commitment to assisting countries meet their obligations.[6] In recognition of the fact that 110 member states had formally requested a two-year extension for implementing the IHR core capacities[3], and that many of these countries were expected to request a further two-year extension in 2014 thereby further delaying full implementation of the IHR, governments repeated their request for the Director-General to develop assessment criteria to inform the approval process for any extensions. [7] This suggestion appeared to be welcomed by all countries attending the Committee A discussions, including those member states such as Papua New Guinea that expressly indicated they would be seeking a further 2-year extension.

Related to the discussion surrounding the IHR core capacities, member states also noted the progress achieved to date in implementing the 15 recommendations of the independent IHR Review Committee with several countries such as Bahrain, Botswana, and Thailand calling on the WHO Director-General to provide additional technical and financial support in developing the requisite legal frameworks, standard operating procedures, and additional human resource capacity to meet the review panel’s recommendations.[6] Dr Fukuda observed that while the WHO remained firmly committed to supporting member states meet their IHR obligations, he also stressed the need for ongoing financial support to be provided to the WHO, stating “the engine is there but it needs gasoline.”[6] In closing the agenda item, Dr Margaret Chan joined Dr Fukuda’s call for further financial support by calling on high-income countries including the Russian Federation, Canada, the United States, Ireland (on behalf of the European Union), and Australia declared their continued commitment to assisting countries meet their IHR obligations. Indeed, given the acknowledged financial circumstances of the WHO and the fact that approximately 70 percent of the PIP Framework partnership contributions have been allocated to strengthening disease identification and surveillance capacity in low-income countries [8], the resources derived from the PIP Framework will likely have several related flow-on benefits for IHR implementation. Additional financial pledges from high-income countries – such as Germany’s announcement of an additional €500,000 to support the WHO’s management of the H7N9 and MERS-CoV outbreaks – combined with further technical or in-kind support such as Brazil’s announcement to support further South-South collaboration [6], will likely have further additional benefits in overall implementation of the IHR. Given the acknowledged likelihood that the majority of member states will be seeking the additional 2-year extension, further consultations will be required to assist the Director-General develop a set of criteria that all countries – those receiving assistance as well as those countries providing financial or in-kind support – will be comfortable with. As such, although the WHO has already indicated that member states will need to formally apply for an extension four months prior to the June 2014 deadline and that such a request must be accompanied by a detailed implementation plan, it is still likely to prompt considerable debate at the 134th Executive Board due to be held in January 2014.

REFERENCES


The 2011 PIP Framework: Progress & Challenges to Implementation

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BACKGROUND

THE ISSUE

Two years after the 64th World Health Assembly (WHA) endorsed the 2011 Pandemic Influenza Preparedness (PIP) Framework in May 2011, the World Health Organization (WHO) continues to confront major obstacles in implementation. Challenges include negotiations with pharmaceutical manufacturers over the Standard Material Transfer Agreements (SMTA-2) that facilitate virus-sharing and vaccine supply, pre-qualification of the vaccines produced, equitable division of partnership contributions, logistical concerns over vaccine distribution during a pandemic, and the limited number of dedicated WHO staff to oversee the implementation and roll out of the Framework.

GLOBAL HEALTH IMPACT

Ultimately, the effectiveness the PIP Framework will not be fully realized until the next influenza pandemic. In the interim, however, the funds generated under the PIP Framework (otherwise described as ‘partnership contributions’) are channelled to strengthening global pandemic preparedness (70 per cent) and emergency response (30 per cent) thereby making a significant contribution to global health security.[1] In 2012, partnership contributions equated to US$18.121 million[2], and while this was far less than the annual anticipated US$28 million it is expected that PIP Framework partnership contributions will contribute a further US$78.4 million to strengthening global preparedness and US$33.6 million towards pandemic response over the next four years.

THE ROLE OF DIPLOMACY

To ensure the successful implementation of the PIP Framework diplomatic engagement with private industry and member states is essential. To date, the WHO Secretariat has successfully negotiated one SMTA-2 agreement with GlaxoSmithKline (GSK), and negotiations with a further three pharmaceutical manufacturers are advanced. Equally, however, there remain over 40 other vaccine and diagnostic manufacturers that the WHO is yet to even initiate pre-negotiations due to limited human resources.

INTRODUCTION

The 2011 PIP Framework was established in May 2011 after four years of intense negotiations.[3] The purpose of the Framework is to facilitate the “fair, transparent, equitable, efficient, effective” sharing of influenza virus samples with human pandemic potential while improving access to vaccines and other benefits.[4] Since 2011, however, progress in implementing the Framework has been slow. In large part, the lack of progress has been attributed to the limited human resources within the WHO Secretariat that is responsible for the Framework’s implementation. At the 65th WHA in May 2012, member states expressed their frustration at the lack of transparency over negotiations with pharmaceutical manufacturers and the slow progress in implementing the Framework’s objectives.[3] In March 2013, an Advisory Group established under the auspices of the PIP Framework met in Geneva to review progress made to date and provide strategic advice on furthering implementation. The recommendations of the Advisory Group and the WHO Director-General’s biennial report on the PIP Framework (documents A66/17 and A66/17_Add.1) were then reviewed by the 66th WHA.[2, 5]

THE 66TH WORLD HEALTH ASSEMBLY

Discussion on agenda item 15.2 Pandemic influenza preparedness commenced on Friday May 24, 2013, in Committee A of the 66th WHA with several countries expressing their thanks and appreciation to People’s Republic of China for its transparent handling of the H7N9 influenza outbreaks. As discussions progressed, the assembled member states resoundingly welcomed the WHO Secretariat’s report on the PIP Framework and noted the recommendations of the PIP Advisory Group. In particular, several member states including the United States of America, Indonesia, Brazil and Switzerland commended the Director-General’s biennial report on the PIP Framework (documents A66/17 and A66/17_Add.1) were then reviewed by the 66th WHA.[2, 5]
noted that there was an urgent need for the WHO Secretariat to finalize the SMTA2 agreements with other pharmaceutical manufacturers, with Australia announcing an additional donation of US$250,000 to help conclude negotiations for the supply of pandemic influenza vaccines. In this context, several countries such as Malaysia and Costa Rica also repeated their requests for the Director-General to ensure greater transparency in industry negotiations. Other member states such as Tanzania (on behalf of the WHO African region) and the Maldives noted their countries currently lacked the means to respond effectively to influenza pandemics, and called on the WHO to provide further technical and financial assistance to strengthen local influenza detection and laboratory capacities – calls that were further echoed by other countries such as Egypt, Bahrain, and Thailand that appealed to the Director-General to also help facilitate further technology transfers to enhance global vaccine manufacturing capacity. Yet other countries reported specific challenges, such as Paraguay that was experiencing difficulties in exporting influenza virus samples to the WHO Global Influenza Surveillance and Response Network (GISRN) due to funding shortages, and countries like Bahrain noted a lack of human resource capacity to respond to influenza outbreaks. In response to member states’ interventions the WHO Assistant Director-General for the Health Security and Environment cluster, Dr Keiji Fukuda, took the floor to outline the various measures undertaken to implement the PIP Framework and assist member states in their efforts to facilitate virus-sharing and gain access to related benefits. In particular, Dr Fukuda identified that a shipping fund has now been developed using partnership contributions to assist countries such as Paraguay forward virus samples to WHO laboratories. Dr Fukuda also explained that in response to member states’ requests new guidelines on pandemic influenza preparedness were soon to be released, and that further efforts will be taken to ensure greater transparency negotiations within pharmaceutical manufacturers. [6] Discussion on the agenda item concluded by the Chair of Committee A inviting member states to note the report.

NEXT STEPS

As per the decision taken 131st Executive Board in May 2012, 70 percent of all PIP partnership contributions have been earmarked for strengthening global pandemic influenza preparedness. [1] It has subsequently been agreed that these funds – an estimated total of US$78.4 million over the next four years – will be further divided to support key priority areas including, strengthening laboratory and surveillance capacity in low-income countries (70 percent or approximately US$52.36 million), enhancing risk communications (10 percent or approximately US$7.84 million), strengthening regional capacity and coordination (10 percent), and conducting disease burden studies (10 percent). [5] The remaining 30 percent of all PIP partnership contributions – an estimated US$33.6 million over the next four years – will be set aside to help support global response efforts. It is expected that these funds will assist the WHO support low-income countries gain access to critical supplies of pandemic influenza vaccines, antivirals, and diagnostics in the event of another influenza pandemic. [5]

Importantly, however, in noting the report member states at the 66th WHA have also endorsed the PIP Advisory Group’s recommendation to allocate – from 2013 onwards – up to 10 percent of all partnership contributions towards strengthening the WHO PIP Secretariat. These funds, which if fully realized would equate to approximately US$11.2 million over the next four years, will enable WHO headquarters and its regional offices to scale up their implementation of the PIP Framework and, according to the WHO Secretariat, be used primarily to help conclude the outstanding SMTA2 agreements with pharmaceutical and diagnostic manufacturers – including negotiations surrounding the equitable distribution of partnership contributions and the prequalification of vaccines. In addition, it is expected that these funds will allow the WHO Secretariat to facilitate other deliverables such as data collection, training for member states, and develop new measures to ensure logistical challenges in vaccine distribution during a pandemic can be overcome. The WHO Secretariat’s progress in implementing the PIP Framework will continue to be closely monitored over the next 12 months by the WHO Executive Board and PIP Advisory Group, ahead of a further progress report to the 67th WHA in 2014.

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In May 2011, member states of the World Health Organization (WHO) requested the Director-General, Dr Margaret Chan, to undertake a major restructuring and reform process of the organization. Over the past two years and following extensive consultations, a comprehensive plan has emerged that identifies three priority reform areas: programmatic, governance and management. Underpinning these are further reforms to the WHO’s financial arrangements and budgetary needs, which will be discussed again in further detail mid-2013 and will be essential to the WHO’s continued leadership in global health.

**BACKGROUND**

**THE ISSUE**

In May 2011, member states of the World Health Organization (WHO) requested the Director-General, Dr Margaret Chan, to undertake a major restructuring and reform process of the organization. Over the past two years and following extensive consultations, a comprehensive plan has emerged that identifies three priority reform areas: programmatic, governance and management. Underpinning these are further reforms to the WHO’s financial arrangements and budgetary needs, which will be discussed again in further detail mid-2013 and will be essential to the WHO’s continued leadership in global health.

**THE ROLE OF DIPLOMACY**

To date, several high-level diplomatic fora and consultations have been held to discuss and develop the comprehensive plan for WHO reform. Diplomacy will continue to remain critical to this process, particularly surrounding the organization’s financial arrangements and budgetary needs, which will be discussed again in further detail mid-2013 and will be essential to the WHO’s continued leadership in global health.

**REFERENCES**


INTRODUCTION
Two main changes in global health governance have led WHO member states to rethink the Organization’s work and position: the proliferation of global health actors and initiatives leading to a greater complexity and fragmentation of the global health landscape; and the WHO’s increasing reliance on voluntary contributions, now accounting for three quarters of the Organization’s budget[2] that continue to raise concerns over the predictability and sustainability of funding, as well as the donors’ influence on priority setting. In response to member states’ request, the WHO Secretariat has embarked on the most extensive reform process since the organization’s creation in 1948. The objective is to reposition the WHO as the leading and coordinating agency in global health, guided by the principles of efficiency, transparency, and accountability. In this regard, three main areas of reform were identified: priority setting for improved health outcomes, governance to achieve a greater coherence in global health, and management for an Organization pursuing excellence.[1]

At the 65th WHA in May 2012, member states requested the Director-General to report on the implementation of the WHO reforms via the development of a monitoring and implementation framework.[3] The report was subsequently reviewed at the 66th WHA together with the General Plan of Work 2014-2019 and the Programme-Budget 2014-2015, which is the first budgetary plan to be released that aligns with the reforms approved by the Executive Board (EB). The reform implementation plan outlines a series of actions to be taken in each reform area and provides an update on the status of the outputs identified to assess the WHO’s performance in the reform process. As of March 2013, one quarter of outputs had been completed or mainstreamed into the work of the WHO, while the remaining reform indicators are expected to be achieved by the end of 2015.[1] The reform process is therefore in a transitional phase, but its outcomes increasingly guide the WHO’s work and functioning.

THE 66TH WORLD HEALTH ASSEMBLY
Member states noted their widespread appreciation of the Director-General’s efforts to date in reforming the WHO, but also observed that much work remained outstanding. Given the extent of high-level consultations in the lead up to the WHA over the programmatic reforms, little contention emerged amongst the assembled member states over the WHO’s proposed programme of work and leadership priorities. Indeed, countries voiced their strong support for the WHO’s six priority areas that include communicable diseases; noncommunicable diseases; promoting health through the life-course; health systems; preparedness, surveillance and response; and, corporate services and enabling functions.[1] Having said this, some governments were observed to make specific additional requests, such as Canada and the United States encouraging the WHO to place more emphasis on antimicrobial resistance or Nigeria requesting that the WHO explicitly highlight neglected tropical diseases. It was in this regard that several member states emphasised the need for a “bottom-up priority-setting process”, and an implementation of the Programme-Budget that takes into account countries’ specificities. It was also in this context that the countries of the WHO South-East Asian Regional Office (SEARO) expressed their disappointment at the proposed reduction in regional office finances, which they maintained would have a negative impact on countries in the region achieving improved health outcomes. [4]

In terms of the WHO’s proposed management reforms, member states were again supportive, particularly in relation to the proposed support provided to member states, new financing arrangements, and the improved accountability and transparency mechanisms as outlined in the Secretariat’s report. [1] Significantly, however, several countries including Barbados, Brazil, and the Philippines observed that the WHO’s reforms needed to ensure closer coordination and integration across “the three levels of WHO” (headquarters, regional offices and country offices). High-income countries were also observed to support these proposals with the United Kingdom noting that while the reforms were “tough” the organization needed to “keep going, keep it real”. [4] Several low-income countries also stressed the need for the WHO to improve its performance at the country level by improved coordination and communication, while Argentina called for the WHO to release the methodology it had used to develop the strategic allocation of resources. In this context, China, Canada and the United States were observed to highlight the need for the WHO to promote a culture of evaluation and accountability by remaining committed to human resources reform.[4]

By way of contrast, one of the key areas where member states raised some concern related to the
proposed WHO governance reforms. Germany, China and Canada, for example, observed that governance was the most neglected area of the reform process, and called upon the Secretariat and member states to fully engage in reviewing the WHO’s relationship with external actors and especially private industry. In response, Director-General Chan confirmed that further consultations on the WHO’s engagement with private industry were scheduled to be held later this year, but stressed that while the Organization would never work with ‘Big Tobacco’ there was a need to engage constructively with other industries such as food and alcohol in setting nutrition standards.

Arguably, one of the most significant developments to emerge from the 66th WHA was the passage of resolution WHA66.2 relating to the WHO’s budget. In passing this particular resolution member states authorized the Director-General to take account of both assessed and voluntary contributions in developing an overall operational budget. While the status of voluntary contributions is unchanged (i.e. they will remain voluntary), this decision conceivably grants the Director-General greater oversight of the WHO’s activities while also increasing the level of transparency and accountability of the organization’s overall spending. Further, under the terms of the resolution the Director-General is also – for the first time – permitted to transfer up to 5 percent of funds from one program to another, if one area is confronted with a funding shortfall. This change marks a significant departure from the previous arrangements around voluntary contributions, and was widely welcomed by member states, the WHO Secretariat, observers, and non-governmental organizations in official relations with the WHO.[5] At the conclusion of discussions, the Director-General thanked member states for their interventions and publicly noted that she had “never witnessed such high-level engagement” from member states as on the issue of WHO reform.[4] The Director-General further noted that the passage of resolution WHA66.2 was significant as it will conceivably allow for better priority setting, transparency and accountability.

NEXT STEPS
Following on from the 66th WHA’s endorsement of the proposed financial reforms, a special meeting will be convened to bring together the WHO’s member states and major donors to examine the organization’s financial circumstances. This meeting, which is otherwise being referred to as the “Financing Dialogue”, is due to be held on June 24, 2013 and will aim to address identified funding gaps in the organization’s programme of work. It will also be a further opportunity for the Director-General to report back to member states on the progress of the reform implementation process. Member states have, for example, also requested the Director-General to undertake a series of reviews examining such issues as the nature and extent of the WHO’s engagement with non-governmental organizations and private industry. These themes, which were identified as a critical part of the organization’s governance reforms, were subsequently discussed at the 133rd EB meeting that was held immediately after the 66th WHA[6]. It is anticipated that the Director-General will provide a further update at the Financial Dialogue meeting to be followed by a more detailed progress report submitted to the 134th Executive Board scheduled to take place in January 2014. In addition, the Executive Board has agreed to form an Evaluation Management Group (EMG) comprising a sub-set of officers currently serving on the EB that will oversee an independent evaluation of the WHO’s overall reform process.[7] The EMG will then submit its findings of the independent review to the 134th EB ahead of the 67th WHA in May 2014.

REFERENCES


INTRODUCTION

The concept of universal health coverage emerged in the 20th century to describe the health systems in Western European countries such as in the United Kingdom, France, Germany and Sweden when they generalized access to basic healthcare services and recognized access to care for all citizens as a right.[5] Although the term emerged in a specific context, in the last decade countries throughout the world have taken steps to modify their health systems to improve access to health services and provide financial protection.[5] In parallel, recent international processes have highlighted universal health coverage as a unifying goal for health systems development, and WHO’s Director-General Margaret Chang sees it as the “single most powerful concept that public health has to offer”. [6]

Universal health coverage includes coverage with quality health services and coverage with financial risk protection for everyone. Access to required health services allows people to improve their health and earn incomes, while financial risk protection prevents people from falling into poverty due to out-of-pocket payments for health services. [1] Universal health coverage is, therefore, a component and determinant of sustainable development.[1] Its universal component is also an expression of the concern for equity and the right to health, which has gained momentum in the health community in the past decade. [7]

Member states recognized the links between universal health coverage and development and human rights, at the 66th WHA, as they reviewed a report on progresses towards the achievement of this public health goal.[1] Two main components of universal health coverage were highlighted: financing and human resources.
FINANCING

Health financing is one of the major challenges for the achievement of universal health coverage and is one of the main areas of focuses of the WHO’s work on UHC. The World Health Report 2010 outlined how countries could modify their financing systems to move towards universal health coverage. The report was complemented by a Plan of Action to support member states in the development of financing strategies in 2012. Three main financial obstacles were identified: the lack of resources, inefficient and inequitable use of resources, and the over-reliance on direct payments at the time health services are needed.[8]

At the WHA, three main factors for success were pointed out. The first was the need for inter-sectoral collaboration. In this regard, the joint WHO/World Bank high-level meeting held in February 2013, convening health and finance ministers from 27 countries, highlighted the importance of linking actions in the field of health to financial reforms and considerations of financial sustainability. The delegate from Costa Rica also underlined the importance of adopting a broader social perspective, bringing its national example of linking social and health policies targeting indigenous populations.

The second element noted was the importance of political commitment. Low- and middle-income countries have achieved remarkable progress on achieving universal health coverage thanks to their strong political engagement. Turkey’s representative described the success of their health system reform addressing performance problems and inequalities in the allocation of resources as the result of a broad and continuous political support. The delegate from Thailand also shared a lesson regarding the importance of political commitment. Its 2001 universal coverage reform was launched against concerns over fiscal sustainability raised by the World Bank. In part due to the political determination of Thai’s health leaders, the country saw a reduction of 300,000 in the number of Thai people suffering from catastrophic healthcare costs between 2004 and 2009.[9]

In her intervention, the Pan American Health Organization (PAHO) Director Carissa Etienne observed that few countries have adequate human resources to achieve universal health coverage in terms of level of staffing, training and distribution, with rural areas particularly concerned by these issues. Representatives of the health workforce (International Council of Nurses and International Federation of Medical Student Associations) called for a more comprehensive approach to health workers, including education, practice, policy and regulation. Indeed, improving access to services by tackling the health workforce is a multi-faceted endeavor, including considerations on planning and investments to improve availability; incentives to retain health workers in remote areas; training, regulation and supervision to ensure quality; and adequate infrastructure, equipment and management to improve performance.[11]

In recognition of the importance of access and health resources, a resolution was negotiated during the 66th WHA on transforming the health workforce education in support of universal health coverage.
The document urges member states to conduct an assessment of the current situation of health workforce education. It calls upon WHO Secretariat to develop a tool for assessment and provide technical support to member states. The resolution also calls for intersectoral collaboration between ministries of health, education and finance in the implementation of national policies and strategies to strengthen health workforce education in support of universal health coverage. The Director-General is mandated to report on the implementation of the resolution at the 69th WHA in 2016.

NEXT STEPS

Universal health coverage will remain at the top of national and international health agendas, as it was one of the emerging themes identified at the health consultations for the post-2015 development agenda. The hope that UHC will feature in the post-2015 agenda was expressed by several delegates at the 66th WHA.

Universal health coverage – and more specifically the importance of scientific research to achieve universal access to quality health services and financial risk protection – is also the subject of the next World Health Report to be released by WHO in September 2013.[8]

REFERENCES


SHORT UPDATE

For the better part of the last three years calls have been growing to ensure that improved health outcomes remain integral to the post-2015 United Nations development agenda. With the 2015 deadline for the Millennium Development Goals (MDGs) fast approaching, these calls have progressively grown in both strength and number. This year, the 66th World Health Assembly (WHA) joined the chorus of non-governmental organisations, civil society, and industry leaders by passing a resolution that urges all 194 member states to ensure that health remains central to the post-2015 development agenda[1]. Member states have also been encouraged to re-double their efforts to achieve the 2015 health-related MDG targets, while the WHO Director-General has been requested to escalate resource mobilization to assist countries meet their obligations. In addition, the resolution charges the Director-General to actively engage the UN Secretary General in further discussions to safeguard the centrality of health within any post-2015 targets, ensure that member states are kept fully briefed and able to participate in these deliberations, and report back to the 67th WHA in May 2014 via the 134th Executive Board meeting scheduled for January 2014. [1] This resolution, which preceded the release of the Eminent Person’s post-2015 development report “A New Partnership” by mere days [2], is indicative of the global concern that the advances gained under the health-related MDGs, particularly in maternal and child health, will be lost if pressure is not maintained to keep health issues high on the political agenda. The next 12 months will be critical to seeing these concerns addressed, and further high-level diplomacy combined with grass-roots support via dedicated civil society campaigns will arguably be essential to seeing health remain a central feature of the post-2015 development agenda.

REFERENCES


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