

HEALTH DIPLOMACY MONITOR

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

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 Global Health Diplomacy Network

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A WORD FROM THE EDITOR

Historically, responding to the threat of infectious diseases has been a key driver of global health diplomacy, given the very visible nature of the cross-border transmission of these diseases. In recent years, we have seen an increased interest in cooperation to respond to non-communicable diseases like cancer, diabetes and cardiovascular diseases. This fall, the first UN summit on non-communicable diseases was held in New York in order to discuss the nature of such global cooperation. The concrete outcomes of the meeting are limited, but the experience may set the stage of greater mobilization and concrete measures in the future.

This issue of the Health Diplomacy Monitor reports on the outcome of the

summit, as well as the World Conference on the Social Determinants of Health which took place in Brazil under the aegis of the WHO. Rene Loewenson reports on how Ministries of Health, WHO, UNICEF, IOM, and UNDP affirmed commitments to accelerate action on social determinants of health to address the uneven distribution of resources for health, including through joint UN agency action. However she also noted the absence at the conference of officials from economic ministries or agencies or from large corporations who influence these determinants, and the failure to tackle the economic and trade determinants of health, including in the conference declaration.

In this issue we also report on negotiations and discussions which are receiving less global attention. Paolo de Tarso Lugon Arantes writes on the final stage of the negotiations of a Protocol on Illicit Trade within the Framework Convention on Tobacco Control. Bente Molenaar provides an update on discussions about the harmful consumption of alcohol; as one of the four key risk factors for NCDs, it was on the agenda of the NCD Summit in New York. However, alcohol producers and retailers have not been subjected to the same level of scrutiny as the tobacco or food industry.

Paul Gully writes on the latest meeting of the initiative "Toward a safer world," examining lessons learned from pandemic preparedness efforts, especially the recent experiences with influenza preparedness. This issue also includes coverage of regional health negotiations; Adam Karamdt-Scott reports on the discussions regarding the most effective strategies to tackle HIV/AIDS in the South East Asia region.

Major discussions are currently taking place on the global health governance front. The WHO is in the midst of major rethinking of its role; Priyanka Kanth describes the state of the debate, as member states are meeting in a special session on reforming the WHO on November 1-3, 2011. In contrast, the Global Alliance for Vaccines and Immunisation (GAVI) has risen in the global health architecture as a central and effective actor. Bente Molenaar reviews the outcome of the last pledging conference and the nature of the discussions on the future of GAVI.

As always we welcome your feedback on this issue of the Monitor and your suggestions on emerging and ongoing diplomatic processes warranting coverage in future issues.

- Chantal Blouin

EDITORIAL

THE PAN AMERICAN FORUM FOR ACTION AGAINST CHRONIC DISEASES: A PIONEERING MULTI-SECTORAL INITIATIVE

Diego Bernardini

"The burden of non-communicable diseases (NCDs) on our societies has been described by Dr. Mirta Roses, Director of the Pan-American Health Organisation (PAHO), as a "tsunami." In the Americas Region, NCDs are the leading cause of death, especially those related to cardiovascular disease, cancer, chronic obstructive pulmonary disease, and diabetes. Three of every four deaths in the region are due to NCDs. There are some 145 million smokers and 139 million overweight people in the region, the burden is the largest amongst women, the poor, and the least educated populations.

To meet the challenges presented by NCDs, Member Countries are already working on a series of initiatives such as public awareness about the importance of prevention, the promotion of healthy lifestyles including proper diet, regular physical activity, moderate consumption of alcohol, and not smoking. Today we know that with only a 20% reduction in the consumption of tobacco, a 15% reduction in salt intake, and an increase to 60% of patients with high cardiovascular risk on a simple drug regime, we could prevent nearly 3.4 million deaths in the next 10 years. In addition to saving lives, economic losses in the billions could be prevented.

On September 21, 2011 in New York during the United Nations High Level Meeting on Non Communicable Diseases, PAHO launched the

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Pan American Forum for Action Against Chronic Diseases (PAF). The Pan American Forum is a pioneering and innovative initiative looking to achieve the type of strong multi-sector collaboration needed to scale up the initiatives already underway such as the advocacy and communication campaign as Get the Message, implemented by the Healthy Caribbean Coalition, the “Act now!” campaign in Canada, the health promoters in Mexico, and the Ciclovias project in Columbia.

The Pan-American Forum is a multi-stakeholder platform where the public sector, the private sector and civil society can share information and best practices. It is a space for exchange and dialogue. The participation of the private sector as a strategy for improving health has not been free from debates and controversies. For the PAHO and WHO, the main challenge is the fine balance between opportunities and risks associated with the participation of public and private interests. The mandate given by member countries stipulates that credibility, independence, objectivity, integrity, and impartiality must be assured at all times. Private sector engagement will be considered on a case-by-case basis by our legal department to prevent any real or perceived conflict of interest. While the Forum aims to be inclusive in its partnerships, there are some sectors that are excluded from engagement. These include tobacco, alcohol, arms and armament industries.

One of the great strengths of the Pan American Forum is the potential for the integration of various sectors to a single platform that concentrates on the development of better ways to translate policies into action. The PAHO’s regional plan of action for Chronic Disease adopted in 2006 is one such policy the Forum could help to move from policy into action. Based on this alliance with non-traditional partners, the Forum will be more than a place of dialogue, but also a platform for joint action on specific projects and issues such as workplace wellness or salt reduction. We hope that the Pan American Forum against Chronic Diseases will be an effective mechanism to implement the “whole-of-society” approach, as was re-affirmed in the political declaration adopted at the UN high-level meeting on NCDs.

Dr. Diego Bernardini is an officer at External Relations, Resources Mobilization and Partnerships at PAHO.

MISSED OPPORTUNITY AT THE FIRST UN HIGH-LEVEL MEETING ON NON-COMMUNICABLE DISEASES



UN Photo by Rick Bajornas

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BACKGROUND

THE ISSUE

The UN General Assembly held a High-Level meeting on non-communicable diseases (NCDs) in New York from September 19-20, 2011. This is the first time that the world’s leaders have convened to discuss potential concerted action to address the challenges posed by NCDs, and the second time ever that the UN General Assembly has focused on global health, following its Special Session on HIV/AIDS in 2001.

Until recently, chronic diseases such as cancer, diabetes, and cardiovascular problems were considered afflictions of affluence and not of concern to the developing world. However, evidence clearly shows that these NCDs have become a truly global problem, further burdening the health-care systems of emerging markets and low-income countries. [1] They have also become an economic burden, with the World Economic Forum ranking them as one of the main risk factors for the global economy, given their impacts on productivity and health-care costs.[2] The economic losses for developing countries are estimated at USD 500 billion per year.[3]

GLOBAL HEALTH IMPACT

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

THE ROLE OF DIPLOMACY

The proposal to convene a summit on NCDs, an initiative driven by the Caribbean countries, was motivated by the need to raise awareness at the highest political level and to mobilize agencies and organizations outside the health

sector. With the UN General Assembly, not the WHO, holding the meeting, 34 world leaders speaking in New York on NCDs during the plenary meeting, and with world media providing more coverage than ever on the global health and economic consequences of this epidemic, the objective of putting this health challenge on the global agenda has been achieved.

INTRODUCTION

After several months of active negotiations facilitated by the Jamaican and Luxembourgish ambassadors, the UN General Assembly unanimously adopted on September 16, 2011 a political declaration that acknowledges the scope of the crisis and identifies the key components of a “whole of government and whole of society” response.[4] Most parties agree that this consensus document is only a first step in terms of mounting a global response to the epidemic, but all tended to portray the 13-page document in a positive light. Civil society responses also tended to stress the achievements of the declaration and the importance of having a summit to put this challenge on the global agenda, rather than the shortcomings of the agreement. For instance, the NCD Alliance, the formal coalition of four global federations of NGOs working on cancer, diabetes, and lung diseases, noted that the declaration “provides a strong foundation that will accelerate international efforts to prevent and control NCDs.”[14] However, several experts analyzing the outcome of the summit found the declaration “lacking in targets, funds and action”[6] and therefore, a missed opportunity.[12]

NO FINANCIAL COMMITMENTS

During the negotiations, one could note a North-South divide on two main issues, including the need for financial support. The declaration did not establish a special funding mechanism devoted to improving access to treatment of NCDs globally, nor did it commit donors and international organizations to invest more resources in that area, as was requested by developing country members of the Group of 77. A number of the G-77 States stressed this gap during their interventions at the High-Level Meeting. For instance, during the plenary session, the Minister of Health from Jamaica deplored that the Declaration “failed to commit the international community to increased and sustained resources” to achieve [the prevention and control of NCDs].”

Given the current economic and fiscal position of most donor countries, there was no appetite from industrial countries to discuss new health funding in their development budget. Rather, leaders committed themselves to exploring paths toward more predictable and sustained domestic and international financial resources, including through “voluntary innovative financing mechanisms” (article 45 (d) and 49). This difference of views was evident earlier on in the process leading to the Summit. For example, in the declaration resulting from the WHO consultations in the African region in April 2011, African health ministers urged

“development partners and civil society organizations to provide new and adequate financial resources to address NCDs without jeopardizing [the] current and future funding of the prevention and control of communicable diseases.”[13]

We should note that during the meeting itself, Australia nevertheless announced financial commitments (AUD 25 million) to tackle NCDs in the Pacific islands. [5] Another initiative known as Pink Ribbon Red Ribbon was launched by the George W. Bush Institute, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), Susan G. Komen for the Cure, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to leverage public and private investments to combat cervical and breast cancer in Sub-Saharan Africa and Latin America through funding currently focused on HIV/AIDS;\$75 million have been committed for the next five years. [11]

ACCESS TO TREATMENT AND INTELLECTUAL PROPERTY

Another issue where disagreements among UN delegations tended to split along a North-south divide related to intellectual property rights and how they can affect access to treatment of NCDs. Throughout the process, the G-77 stressed the importance of the full use of the flexibilities provided by the Agreement on the trade-related aspects of intellectual property rights (TRIPs) which was signed at the World Trade Organisation (WTO) in 1995. Since its signature, public health advocates have expressed strong concerns that the TRIPs may impede access to affordable drugs by offering a strong protection of patents. In response to these concerns, WTO members agreed to the Doha Declaration on TRIPs and Public Health adopted in 2001 which re-affirmed the right of governments to adopt measures to protect health. The final document did not include a reference to the Doha declaration, but does refer to TRIPs flexibility when discussing access to treatment and care of NCDs.

The divergent views about intellectual property were also at the centre of the disagreement as to whether the rise of NCDs should be named an epidemic or not. Indeed, given the language in the Doha Declaration, such a term would imply greater flexibilities when governments wish to facilitate the production of generic drugs. “Developing countries with large generic drug industries clearly favored the move. Washington, [and other partners] opposed the measure, a view clearly in line with the interests of its large pharmaceutical industry.”[9] The compromise was to use the expression “a challenge of epidemic proportions.”

LACK OF SPECIFIC TARGETS

The political declaration adopted in New York does not include new specific targets in terms of reduction of the prevalence of NCDs or in terms of concrete measures to be undertaken by governments. Instead, it refers to prior commitments and strategies, like the Framework convention on tobacco control or the WHO Global

Strategy to reduce the harmful use of alcohol. Civil society organizations, especially the coalition of the main federations of civil society groups focusing on NCDs, the NCD alliance, had been asking for very specific targets such as the reduction of the NCD death rates by 2% per year or the reduction of salt intake to less than 5g/day/person by 2025. [7]

The United States, the European Union, and Canada generally opposed mandatory or binding targets during the negotiation process, preferring voluntary actions to a regulatory approach. [9] The outcome was a new mandate for the WHO to develop voluntary targets and a global monitoring framework mandated to be presented by the end of 2012. Importantly, this process has been criticized by observers as another unfunded mandate for the WHO, which is “in the midst of a major reform precipitated by funding cuts.”[8]

PRIVATE SECTOR INVOLVEMENT AND CONFLICT OF INTEREST

Nevertheless, as acknowledged by officials, the private sector is “part of the problem, and will have to be part of the solution;” the tobacco industry is the exception and the Declaration clearly bans the involvement of the tobacco industry. In this context, several business organizations have highlighted the actions they have already undertaken to contribute to NCD prevention. In various side-meetings during the Summit, companies vocally presented their preferences for an approach that focuses on voluntary guidelines rather than regulations of the industry practices. Moreover, certain companies have noted that industries such as medical diagnostics should be viewed as separate from food, beverage, and tobacco countries, and could be involved in addressing the prevention and control of NCDs without hazard. Finally, participants to these side meeting noted that the Summit should have involved a wider array of industries crucial to changing the social and physical environments which can prevent NCDs, such as the media, the transportation, and agricultural industry.

PRESSURES FROM TOBACCO INDUSTRY

During the speeches made by ministers during the summit, several officials raised the problems associated with the pressures and legal strategies adopted by the tobacco industry to counter tobacco control measures. NGOs welcomed this development positively. For instance, Sylviane Ratte, an advisor to the International Union against TB and Lung Disease, commented that it is novel to see officials publicly suggesting that governments join forces to confront such pressures; the Australian health minister invited signatories to the Framework convention on tobacco control to collaborate to push back against the pressures they are being subjected to. The Norwegian and Uruguay officials entered similar pleas during the meeting.

NEXT STEPS

Next steps include the development of targets and of a

monitoring framework by the WHO by 2012. A progress report on the commitments of the Political declaration will be presented at the sixty-eighth session of the UNGA in 2014. This comprehensive review will occur in time for the discussions concerning the next phase of the Millennium Development Goals, which will end in 2015 and has thus far excluded NCDs.

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ALCOHOL: ON-GOING EFFORTS TO REDUCE HARMFUL CONSUMPTION



Photo: <http://test-alcohol.com/>

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BACKGROUND

THE ISSUE

High consumption of alcohol is directly linked to increased illness and mortality. With the recent emphasis on non-communicable disease, alcohol is again featuring more prominently on the global health agenda. In the Declaration that came out of the recent United Nations high-level meeting on non-communicable disease prevention and control, Member States recognized that “...most prominent NCDs are linked to common risk factors, namely, tobacco use, harmful use of alcohol, an unhealthy diet, and lack of physical activity.”

GLOBAL HEALTH IMPACT

The World Health Organization estimates that the harmful use of alcohol results in some 2.5 million deaths a year. The WHO further estimates that “globally, 6.2% of all male deaths are related to alcohol, compared to 1.1% of female deaths. One-in-five men in the Russian Federation and neighbouring countries die due to alcohol-related causes.”[1] Additionally, 76 million people around the world suffer from alcohol related disorders.[2] Alcohol is a risk factor in NCDs. Abuse of alcohol has far-reaching health effects on the drinker, and can also have a negative effect on the health of people around them.

THE ROLE OF DIPLOMACY:

In May 2008, in adopting resolution WHA61.4, the WHO Member States requested that the WHO develop a “global strategy to reduce the harmful use of alcohol.” After developing a draft document, several rounds of consultations, and further debate at the Executive Board meeting in January 2010, the World Health Assembly adopted the Global Strategy to Reduce the Harmful Use of Alcohol (the Global Strategy) in May 2010.

INTRODUCTION

There is nothing new about international efforts to reduce the harmful consumption of alcohol; the League of Nations’ Health Organization began working on alcoholism in 1928. [3] Today, we have the WHO Global Strategy to Reduce the Harmful Use of Alcohol as well as regional plans. Since

the adoption of the Global Strategy in 2010, alcohol has also featured on the global health agenda in the context of non-communicable disease. The harmful consumption of alcohol is one of the main risk factors in a range of NCDs, including cardiovascular disease, various forms of cancer, and liver disease.

Coming out of the recent NCD Summit, the question for many was “are doing enough to reduce the consumption of alcohol?” Given what we know about the risks associated to consumption of alcohol, and the trend towards increased consumption, should we not be doing more? Members of the WHO have recently held their regional meetings, and reduction of alcohol consumption was on the agenda in the European region, in the Americas, as well as in the Western Pacific region. While excessive alcohol consumption is a problem in many parts of the world, the EURO region self-describes as being “the area of the world with the highest levels of alcohol consumption and alcohol-related harm.”[4]

The Declaration that came out of the NCD Summit does recognize the need to reduce the risk factors, including alcohol, but beyond reiterating the importance of the Global Strategy to Reduce the Harmful Use of Alcohol, does little more to further work towards reduced consumption.

NEGOTIATIONS: THE GLOBAL STRATEGY AND REGIONAL EFFORTS

The Global Strategy to Reduce the Harmful Use of Alcohol was adopted by the WHA in May 2010. The discussion that preceded the adoption showed the diverging views on the matter. For example, Thailand, speaking on behalf of the SEARO region, advocated the need for a binding strategy, along the lines of the Framework Convention on Tobacco Control (FCTC). Developing countries on the other hand, agreed that a strategy without any binding mechanisms is adequate to effectively reduce the consumption of alcohol.[5] In the end, the Global Strategy adopted non-binding approach.

Efforts to reduce alcohol consumptions are on-going at the regional level. The Directing Council of the Pan American Health Organization (PAHO) recently adopted a plan of action to reduce the harmful consumption of alcohol. The plan of action “proposes measures ranging from increased taxes on alcohol sales and restrictions on marketing, to training for primary health care workers in screening, and treatment for risky drinkers.”[6] The regional committee meeting for the WHO Euro region, which concluded September 15, also adopted a regional action plan covering the period 2012-2020.[4]

The European policy is aligned with the Global Strategy, although it is more detailed in some areas. It diverges from the Global Strategy in one important area: the European

plan of action contains a specific reference to conflict of interest. Paragraph 115 holds that “[r]ecognizing the role that NGOs can play in supporting alcohol policy, the Regional Office will strengthen its processes of consultation and collaboration with NGOs and relevant professional bodies that are free of conflict of interest with the public health interest.”[4]

The recent Summit on NCDs brought the issue of alcohol consumption to the forefront of the international health agenda, as it is recognized as a major risk factor in a range of NDCs. The reactions to the Summit have been mixed. Professor Rehm of the Centre for Addiction and Mental Health in Canada notes that “[w]e were happy about the idea of the NCD summit and the recognition of alcohol, but the way it was discussed wasn’t optimal.”[7] He further noted that we shouldn’t under-estimate the importance of international meetings to help bring attention to the issue.

The Global Alcohol Policy Alliance (GAPA) released a statement welcoming the Summit and the Political declaration that resulted. They feel that while the Summit and the Declaration represent a positive step forward, there are several short-comings. Chief among the short-comings was the failure to tackle the issue of the impact of WTO policies on health. GAPA notes that several WHO regions, including SEARO and EURO, have stated “the hindrance to implement effective alcohol policy is due to trade liberalization.”[8] Derek Rutherford, chairperson of the board of GAPA, observed that “the political will is missing” from the efforts to reduce the harmful consumption of alcohol.[12]

CONTENT OF THE GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL

The Global strategy is an important tool in aiding countries develop, or further strengthen their own policies, strategies and national plans to reduce alcohol abuse. Lars Møller, Programme Manager of Alcohol and Illicit Drugs, Life Style Determinants Division of Non-communicable Diseases and Health Promotion of the WHO’s regional office for Europe, emphasised that even though the Euro region has had an alcohol strategy in place since 1992, the adoption of the Global Strategy to Reduce the Harmful Use of Alcohol was a major step forward, bringing important attention to the issues around harmful consumption of alcohol.

The strategy offers a wide-ranging menu of policy and intervention options, recognizing that the measures should be implemented at the discretion of Member States, depending on their national context and availability of resources. Amongst other recommendations, the Global Strategy urges Members to develop and strengthen

alcohol policies; introduce measures on drinking and driving, marketing on alcohol, and selling to alcohol to minors.[5]

When it was adopted by the World Health Assembly in 2010, the accompanying resolution WHA 63.13 requested that the Director-General “...give sufficiently high organizational priority, and to assure adequate financial and human resources at all levels [...]” to ensure effective implementation. In the context of WHO restructuring and tough financial times, money is a challenge. Lars Møller confirms that there are very few resources available for the work in the WHO’s regional office for Europe, noting that while Member States have been asking for more work on the reduction of harmful alcohol consumption “little money has been forthcoming.”[11]

DOING MORE TO MAKE PEOPLE DRINK LESS: A FRAMEWORK CONVENTION ON ALCOHOL CONTROL?

It has been argued that the movement to reduce the consumption of alcohol could learn from the Framework Convention on Tobacco Control. Over the years, many have called for the creation of a Framework Convention on Alcohol Control.[9] The international community has flirted with such a Framework Convention, but ultimately failed to agree on the measures that would be contained within it. Professor Rehm notes that “to get a Framework Convention, there would have to be a huge majority supporting it at the World Health Assembly, and we simply aren’t there yet.” He further notes that reaching the Framework Convention of Tobacco Control took decades, “we are only in about year 10 on alcohol!”

Despite this push and despite the fact that alcohol and tobacco are relatively equal in terms of global disease burden, the international community has been less willing to be tough on the alcohol industry. A letter to the editor by medical professionals in *The Lancet* draws attention to the lack of action on alcohol, stating that “[d]espite clear evidence of harm from excess alcohol, there is little will to prioritise the problem in the global health agenda.”[10] Speculations and analysis of why this is the case has focused on three factors: there is a significant industry lobby at work; alcohol plays an important social and cultural role in many countries; and, the discussion is about reducing rather than eliminating the use of alcohol, which makes it less clear cut in terms of policy.

There is little argument that the industry represents a powerful voice. In a recent statement, GAPA notes that “policies concerning alcohol need to be formulated by public health interests without interference from commercial interests.”[8]

The debate around alcohol is less clear in some ways than work on tobacco. In the case of tobacco, the efforts have focused on eliminating use. In terms of alcohol, the debate is about reducing the harmful level of consumption. In many countries, consumption of alcohol is acceptable and forms part of many cultural events. Professor Rehm notes that we need to pay increased attention to the harm alcohol consumption can inflict on others. He argues that often the debate is framed in terms of the individual right to have a drink, neglecting the true extent of the level of harm others can be exposed to by the drinker: "I believe that the harm done to others by drinkers is as large as the effects of second hand smoking." [7]

NEXT STEPS

Work will continue on a national, regional and international level, in the context of Regional strategies, the Global Strategy to Reduce the Harmful Use of Alcohol and the Outcomes of the NCD Summit. Progress made on the implementation of the Global Strategy will be assessed at the 66th World Health Assembly (2013) through the Executive Board (January 2013).

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CLARITY AND CONTRADICTION AT THE WORLD CONFERENCE ON SOCIAL DETERMINANTS OF HEALTH



Photo: World Health Organization

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BACKGROUND

THE ISSUE

Delegates from 125 countries at the World Conference on Social Determinants of Health (WCSDH) debated inequities in the distribution of power, money and resources underlying wide avoidable inequalities in health. They also debated governance: community leadership; health sector roles; global action and monitoring needed to close the gap.

GLOBAL HEALTH IMPACT

The 2008 report of the Commission on the Social Determinants of Health showed that dramatic and avoidable social gradients in health exist within and between countries and that closing the gap by improving living conditions will not only improve health, but will bring wider societal benefit. [1]. Economic, energy and climate crises are argued to raise, not reduce, the urgency for attention to the distributional effects of policies. [3]

THE ROLE OF DIPLOMACY

Despite persuasive evidence, health equity has been a marginal consideration in trade, economic or climate forums. Public health advocates argue that equity should be included at the centre of wider economic, trade and development agendas, including the UN Conference on Sustainable Development in June 2012 (Rio+20) and the UN Millennium Development Goals (MDGs). While a task force of UN agencies was set at the WCSDH, key economic and trade agencies were not present.

FROM SANTIAGO TO RIO

At the launch of the World Health Organisation (WHO) Commission on the Social Determinants of Health (CSDH) in Santiago Chile, J W Lee, then Director General (DG) of the WHO noted that the WHO's establishment in 1948 and the 1978 Alma Ata Declaration were moments of great clarity around health in the world. He called for the Commission to contribute to another such moment. The final CSDH report in 2008 backed, with evidence, two clear statements: First, that "Social injustice is killing people on a grand scale," and secondly that underlying this are wide inequities in the distribution of power, money, and resources.[1] Expectations were high that the WCSDH held in Rio de Janeiro Brazil 19-21 October 2011 would be another moment of clarity. Dr Alexandre Padilha, Minister of Health of Brazil, the host country, noted at the opening "This is the largest world health conference organised outside the WHO headquarters since Alma Ata," aspiring for it to be the Alma Ata of the 21st century.

The background documents and case studies for the conference outlined both the need and opportunity for action, a call for 'health in all policies', and analysis of five strategic areas that were used to frame the conference themes [2, 3, 4, 5]. The host country seemed appropriate: Brazil has prioritised social rights in public policy.[6] Dr Paulo Buss, Fiocruz and chair of Brazil's National Commission on SDH noted that to do this, Brazil "implemented anti-cyclical policies, against the current of neoliberal policies,"(7p22) choosing a growth strategy that integrates poverty eradication, equity, and security of social needs like water, food, and income.

THE DEBATES IN RIO

The conference had a three part process: i) plenary roundtables primarily involving the UN, government and academic speakers; ii) a ministerial track of country reports; and iii) sessions with government, academics and civil society on the five strategic areas: governance to tackle the causes of health inequities: community leadership for action on Social Determinants of Health (SDH); the role of the health sector; global action on SDH; and monitoring progress.

The reports from countries indicated a range of actions being taken, including actions to assess or monitor equity and SDH, measures to plan and review action on SDH, as well as actions to strengthen constitutional protection of the right to health and to strengthen intersectoral action and comprehensive primary health care. The case studies demonstrated interesting models, such as Iran's allocation of 10% of the mandatory motor vehicle insurance to the health sector to provide free care after road traffic injury and support community-based approaches such as improved

road safety education for school children, or Jordan's introduction of simplified food labeling on the front of packages and menus to support healthier food choices.[5]

However, few countries reported on actions on economic determinants. Hence the growth of the fast food industry, trade in tobacco and other hazardous products, the lack of integration of health in economic policies, and the migration of health workers were raised as challenges to improving health equity. Dr Margaret Chan, DG of the WHO observed that "globalisation creates benefits but has no rules that ensure the distribution of these benefits", with consequences in terms of "disruption, disasters and insecurity". Countries that have regulated commercial interests for public health reasons, such as introducing taxes on foods high in fat or sugars, or in implementing legal controls over tobacco, have faced counter litigation from companies. Ironically, given her position at the helm of the lead global public health agency, Dr Chan claimed that "public health loses its power to influence" against powerful commercial interests.

Two contradictions emerged within the conference process.

Firstly, the initial communications indicated that the conference would be attended by ministers of health, foreign affairs, environment and other sectors; and by representatives from the private sector. Brazil in its preparatory seminar brought together different ministries and civil society to debate the five themes of the global conference.[6] However these other state sectors and the private sector were absent at the WCSDH, reflecting that WHO's mandate is limited to convening Ministries of Health. The absence of an invited representative of a large food corporation on a panel—after their very visible presence at the processes for the UN Summit on Non Communicable Diseases—was notable and unexplained. This suggests that the global policy dialogue on health equity and SDH should be convened at higher levels of the UN, including at the UN's General Assembly.

Further, while the heads of WHO, UNAIDS, and UNICEF explicitly pointed to the central role of public and social pressure as a countervailing force when commercial interests conflict with public health, the very vibrant community of civil society actors at the WCSDH were not present when the country reports were being made and excluded from the drafting group of the final Rio Political Declaration. In response, one group, the International Federation of Medical Students' Associations (IFMSA), pointed out that "Governments should value the voice of civil society as these groups, having been working on reducing health inequities for many decades, have the capacity to see these defects and propose innovative solutions.[8]

ONE CONFERENCE, FOUR DECLARATIONS

A political declaration adopted by member states present was made at the end of the conference, the 'Rio Political Declaration on Social Determinants of Health', to build high-level international backing for national policies addressing the social determinants of health.[9] The detailed seven page declaration makes political commitments to act on SDH, to position health equity as a national, regional and global goal, to do more to accelerate progress in addressing the uneven distribution of resources for health. It further clarifies clear commitments against which states and global institutions can be held accountable, including to strengthen universal access to social services and international co-operation on transfer of technology; to include communities and civil society in decision making; to use health impact assessment, policy and legal measures to raise and address practices harmful to health; to accelerate implementation of the WHO Framework Convention on Tobacco Control (FCTC); and, provide disaggregated evidence to measure societal progress, beyond indicators of economic growth.

Drafted in Geneva by member states and diplomats prior to the WCSDH, and finalised at the conference, there were some changes in the drafts. Reference in earlier drafts to rejection of health as a commercial good were not found in the final draft, and the language on implementation of the FCTC, on transfer of technology, and on economic determinants or power relations that underlie health inequities was toned down. A final clause committing the WHO to integrate the SDH approach in its reform almost did not make it to the final declaration. The political declaration stands as a non binding commitment, with a recommendation that the 2012 World Health Assembly endorse it by resolution.[9]

However, frustration over the declaration process and content ran high and no less than three alternative declarations were also circulated on the final day, one from the People's Health Movement, a global civil society movement,[10] one from the Latina- American Association of Social Medicine,[11] and one from IFMSA.[8] These declarations were all insistent in demanding confrontation with the free trade agreements, unregulated capital markets, and restricted intellectual property rules underlying health inequities. They called for further explicit measures, including progressive taxation, which would include a financial transactions tax, to raise resources to address inequalities in health; for universal, public health, and social security systems; for measures to strengthen social participation and power in decision to deal with the existing unequal power relations and for participatory monitoring.[8, 10, 11]

GLOBAL DIPLOMACY ON SOCIAL DETERMINANTS AND HEALTH EQUITY: NEXT STEPS

Kathleen Sebelius, United States Secretary of Health and Human Services observed in relation to global platforms that "...things cannot go on as is – equity is the key issue and must be at the centre of the agenda". There are opportunities in global diplomacy to see whether this is implemented, including the forthcoming UN Rio+20 in June 2012, also being held in Rio de Janeiro, or the debates on the UN MDGs towards and beyond post 2015. It raises a spotlight on the UN system itself.

Dr Paulo Buss, Brazil, observed that "The UN is crucial but somewhat fatigued", pointing to the need for a rethink in global governance to avoid the contradictions of policies in one institution that protect health, and in others that protect patents or profits margins at the cost of health (7p26). The May 2009 World Health Assembly Resolution WHA62.14 charged the WHO DG to report back in 2012 on the effectiveness of existing global governance mechanisms in addressing SDH.[12] Marie Paule Kieny Assistant DG WHO told the conference that the UN agencies present—UNDP, WHO, UNICEF, UNFPA, and IOM—would immediately form a task force led by WHO to strengthen internal coherence on health equity within the UN. However, the global environmental, trade, and finance agencies were not present.

Discussion of the conference themes suggested that beyond policy coherence, there was a call for a more assertive global health leadership to raise recognition and action on features of the global economic regime that drive inequalities in health. While WHO DG Dr Chan spoke forcefully of 'people over profits' at the conference opening, delegates raised that health leadership has been weakened by some critical trends. For instance, Maria Guzenina Richardson, Finland's Minister of Health and Social Services and host of the next Global Conference on Health Promotion in 2013 noted that commercialisation of health and erosion of the welfare state has weakened the institutional basis for addressing inequality. Professor David Sanders, University of Western Cape South Africa noted that member states not making contributions to the WHO has made it susceptible to the influence of private funding. PHM criticised the label of 'civil society' mixing public interest groups with privately funded foundations and organizations and Dr Padhilo, Minister of Health for Brazil noted that to be a whistle blower for health the WHO must be independent of any other interest than public health.

FROM RIO 2011 TO RIO 2012

The Rio WCSDH and the processes towards Rio+20 in 2012 both point to “sustainable economies” that are just and enable long-term social and well-being, especially for marginalized groups, as central to the response to social injustice and ecological crisis. In one session of the WCSDH, Brazil and South Africa, the host and chair of Rio +20 respectively, both spoke about the co-benefits of integrated action and proposed changes to economic growth paths, including through expanding internal markets, employment and social protection. This, they indicated, is an agenda that the BRICS (Brazil, India, China, South Africa) countries will bring to global platforms.

Brazil pointed to the role of foreign affairs as a key actor in framing this relationship between social, economic, and environmental dimensions for Rio+20 and other platforms. So while the multilateral/ UN level continues to reflect the debates and contradictions found at the WCSDH, the conference also pointed to the role of emergent alliances such as the BRICS countries and the role of south-south international co-operation in building ‘moments of clarity’ in global diplomacy on health equity and social determinants of health.

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FINAL NEGOTIATIONS FOR A PROTOCOL TO ELIMINATE ILLICIT TRADE IN TOBACCO PRODUCTS



Photo: World Health Organization

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BACKGROUND

THE ISSUE

During the negotiations of the Framework Convention on Tobacco Control, one of the issues where there remained unresolved disagreement among delegations was the illicit trafficking of tobacco products. It was dealt with in general terms under article 15 of the FCTC, but no further details were agreed upon for the issues such as control of supply chain, judicial criminal cooperation, sale via the internet, stock information and greater transparency on the part of legal tobacco producers.[1]

The negotiations of a protocol in illicit trade of tobacco products started in 2008 held by the Intergovernmental Negotiating Body (INB), mandated by the Conference of Parties (COP) of the FCTC.

Since the creation of the INB for this protocol, four sessions have been held. Although significant progress has been reached in these four sessions, a number of issues remained inconclusive, such as supply chain control, financing of the protocol, mutual legal assistance and extradition, and protection of personal data.

GLOBAL HEALTH IMPACT

More than 11% of the global cigarette market is illicit. Tobacco products are made available at lower prices, increasing their consumption and frustrating demand reduction strategies (e.g. through taxation). Illicit products also escape from national quality control, in further detriment to consumers' health.

Moreover, governments sustain massive income losses by illicit trade. In 2006, this lost was estimated to be between USD \$40-50 billion. [2]

THE ROLE OF DIPLOMACY

The COP, in its fourth session in Punta del Este (Uruguay), in December 2010, decided in favour of the continuation of the negotiations of the protocol until a fifth and final session, to be held between 29 March and 4 April 2012.

The COP also decided to create an informal working group to facilitate the works of the upcoming session and the conclusion of the text of the protocol.¹

This informal working group (IWG) is composed of five members of each region.² The members were nominated by the respective WHO regions. Both meetings were chaired by Dr. Nuntavarn Vichit-Vadakan (Thailand).[3]

INTRODUCTION

The Informal Working Group (IWG) held its second meeting this year to advance the negotiations of the protocol to eliminate illicit trade in tobacco products to the Framework Convention on Tobacco Control (FCTC) from 19-23 September 2011 in Geneva. Overall, while the negotiations on technical issues have advanced, provisions regarding financing of the protocol and mutual legal assistance and extradition, have not gathered considerable agreement among the negotiators.

CONTROLLING THE SUPPLY CHAIN

The July meeting had finally reached an agreement on the provisions regarding the control of supply chain for tobacco products. The importance of overseeing supply chain is based on the need to keep a clear record of both origin and destination of tobacco products, through licensing, record-keeping, control of duty free and internet sales, and legality analysis (“due diligence”).

There was consensus in prohibiting the manufacturing, import, and export of tobacco products without prior license (or equivalent approval) and control systems in place.

Licensing, however, is bound “to the extent considered appropriate,” giving leeway to the signatory State on this issue. However, the licensing requirements include a long list of requirements such as establishing a competent national authority, periodic review and renewal of the license, information on acquisition, disposal or destruction of any manufacturing equipment, and transparency on information and procedures.

The parties also agreed to the obligation of a due diligence procedure to be conducted before and during the course of a business relationship through the entire supply chain. The group also agreed on the compulsory record keeping of all relevant transactions, including date of shipment, mode of transportation, intended shipping routes and destination and details of the products shipped.

FINANCING THE PROTOCOL, MUTUAL ASSISTANCE AND EXTRADITION

On financing the functioning of the protocol (secretariat, extra personnel, meetings’ costs), no agreement was reached. The working group requested that the WHO Secretariat update the anticipated costs.

The European group proposed that the parties to the FCTC finance the protocol, regardless whether some members have ratified the protocol or not. Concurring proposals are that (a) only the parties to the protocol bear the relevant costs, or (b) all parties to the FCTC bear the costs for a period of five years, when then the COP would decide on a financial mechanism thereafter.

The African and South Asian groups defended strong wording on mutual legal assistance and extradition. Even though the other regions did not expressly agree with this wording, it was agreed that similar provisions should be incorporated in the text. A conciliatory proposal was that the language resemble as closely as possible the relevant provisions of the United Nations Convention against Transnational Organized Crime (UNTOC). However, the criteria for “organized criminal group” from the UNTOC is not to be used in the future protocol.

Another option is to establish a clause, allowing a signatory State to extradite only in case the wanted person is subject to a lesser penalty than the equivalent under its jurisdiction, or a penalty stipulated in the UNTOC’s Article 2. Moreover, an “opt-out” clause would be adopted, which would not require States to use the future protocol as legal basis for extradition, referring it instead to their own domestic law.[3]

NEXT STEPS

Despite the considerable advancement of the IWG on a number of issues, one has to consider that this group has a limited mandate. In fact, the COP established it with the sole purpose of facilitating the work of the Fifth Intergovernmental Negotiating Body (INB5), next year.

As such, the agreements reached by the IWG are of a merely assisting—and thus informal—nature. The issues agreed to in the IWG may be revised by the INB5, which is the competent body to negotiate the protocol. However, IWG deliberations are expected to be accepted by the INB5 at their next meeting 29 March – 4 April, 2012), since the issues agreed to under the IWG enjoy a wide acceptance of the parties involved.[5]

¹ Decision FCTC/COP4(11), held at the 4th Conference of the Parties, in Punta del Este, Uruguay, December, 2010.

² Specifically, (a) from the African Region: Algeria, Kenya, Nigeria,

Senegal and Swaziland; (b) from the Region of Americas: Brazil, Canada, Mexico, Nicaragua and Panama; (c) from the Eastern Mediterranean Region: Egypt, Iran, Pakistan, Saudi Arabian and United Arab Emirates; (d) from the European Region: European Union, Georgia/Israel (taking turns), Poland, Russia and Turkey; (e) from the South-East Asia Region: Bhutan, India, Maldives, Nepal, and Thailand; and from the Western Pacific Region: Australia, China, Cook Islands, Japan and Mongolia.

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GAVI ALLIANCE: EXPANDING ITS REACH



Photo: Wikimedia Commons

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BACKGROUND

THE ISSUE

The core business of GAVI is to provide life-saving vaccines to poor and under-served populations. The Alliance is a unique partnership that brings together developing country and donor governments, UNICEF, the World Health Organization, the World Bank, civil society, the vaccine industry, research agencies and the Bill and Melinda Gates Foundation and other private philanthropists. The success of GAVI and its growing reach has introduced a need to consider how it approaches Health Systems Strengthening (HSS), its relationship with key partners, and future financial strategy.

GLOBAL HEALTH IMPACT

Since its foundation in 2000, over 5 million child deaths have been prevented through an increased focus on providing vaccines in low-income countries, where an estimated 85 percent of the world's unvaccinated children live.[1] Providing immunizations is a significant factor in lowering child-mortality and can help achieve the Millennium Development Goals. GAVI is also involved in funding health system strengthening.

THE ROLE OF DIPLOMACY

GAVI represents a unique public-private partnership, which has successfully used innovative finance mechanisms to achieve its goals. In difficult financial times, GAVI succeeded where others have failed: it exceeded its fundraising targets at its first pledging conference (June, 2011). Donors are committed, putting pressure on GAVI to continue to perform well.

INTRODUCTION

Donors spared no praise for the work of GAVI at the first pledging conference in the history of the Alliance. The June 2011 meeting heard from UK Prime Minister David Cameron that “GAVI was one of the very top performers in our root-and-branch review of all agencies that deliver British aid because it demonstrates tangible results.”[3] The Alliance exceeded its fundraising target of USD 3.7 billion, with donors committing some USD 4.3 billion for future work. While there is overwhelming support and a promise of expanding the number of children vaccinated, some have called this a time of questions for the future strategy of the Alliance. As the reach and budget of GAVI grows, the need for consideration of strategy, finances, and partnerships also grows. A detailed analysis by the Centre for Strategic and International Studies finds that although GAVI has been very successful it suffers being relatively unknown. In order to achieve its goals in the future, they recommend that the Alliance craft a powerful brand, a strategic direction and raise the profile of the Alliance. In order to achieve this, changes are required at the level of the GAVI secretariat, as well as in its partnership work.[4]

EXPANDING GAVI'S REACH RAISES QUESTIONS

Critics of GAVI recognize the success of the Alliance, but have often claimed that it can be even more effective. The environment in which GAVI operates is more complex now than it was at the time of the foundation of the Alliance. For example, GAVI has found it necessary to fund health systems strengthening (HSS) efforts. To effectively deliver vaccinations, a country needs a health system that works. In many poor countries this can be a challenge. Problems identified by a 2004 GAVI study include, “unpredictable funding for salaries, transport, and outreach, shortage of adequately trained human resources at all levels, and management issues at the peripheral levels.”[5] The challenge is even more complex with the introduction of more vaccinations, some of which might require multiple shots to be fully effective.

In 2008, GAVI announced that it would spend a total of USD 800 million on health system strengthening. [6] GAVI is working with the Global Fund and the World Bank, with support from the WHO to develop a joint funding platform for health systems strengthening. The Platform was established in 2009 and has a dual mandate of advancing progress towards the health related MDGs and streamlining international resources to support national health strategies.

GAVI is a partnership organization, and how it works with partners will continue to be an important question. In a paper by the Centre for Strategic and International Studies, they recommend that GAVI “systematically and routinely revisit GAVI’s core partnership relationships to achieve the full potential of GAVI’s partnership format and continually assess what skills are needed to serve the mission and which partners can provide those skills and resources.”[4]

Médecins sans frontières (MSF) UK asks if GAVI is getting the best possible price when they purchase their vaccinations. MSF argues that GAVI could, in fact, get a much better price and that the big pharmaceutical companies are still making huge profits. MSF notes that manufacturers in India, for example, are matching the quality of the established pharmaceuticals such as GSK, Pfizer and Merck, and producing at a much reduced cost.[7] UNICEF now publishes the purchasing price for vaccinations they acquire, which has made oversight easier. In a recent editorial in the British Medical Journal, Finoa Godlee notes that this step “revealed substantial profits, in one case of around 180%.”[8] Clearly, prices could be lower, enabling the purchase of more vaccinations. The CEO of GAVI, Seth Berkley, notes in a recent article that he expects prices of the newly introduced rotavirus and pneumococcal vaccines will be reduced as pharmaceutical companies from India and Brazil enter the market.[9] The program and policy committee of the GAVI Board reported to the July 2011 Board meeting that they “...continued to deliberate on a vaccine supply and procurement strategy and expected to table a recommendation to the Board in time for the November 2011 meeting.”[10] Exactly how GAVI procures their supplies, and what they pay for the vaccines will be important in the years to come.

The GAVI alliance focuses on the provision of both new and under-used vaccinations. Godlee, editor of the British Medical Journal asks if “it is right to focus on access to new vaccines against rotavirus and pneumonia for children in countries that can afford to contribute financially? Or should it help the very poorest countries [who are]

building their health systems so their children can get basic vaccines against diphtheria, tetanus, and pertussis [whooping cough]?”[8] MSF has a strong in its critique of the GAVI alliance, noting that both the pneumococcal and rotavirus vaccines being sold to GAVI initially were designed for use in the developed world. They note that the rotavirus vaccination requires refrigeration and can only be given to children under nine months old, which will limit the ability of GAVI to reach the most vulnerable children.

NEXT STEPS

At the pledging conference in June 2011, it was agreed that stakeholders would meet again in two years time to review progress.[3] The Executive Board of the GAVI Alliance is meeting in Dhaka, Bangladesh on November 16-17, 2011 where they will continue discussions of, amongst other issues, a procurement strategy. The Alliance itself is keenly aware of the challenges that exist, especially in light of the overwhelming support at the pledging conference. The minutes of the board meeting that took place in July following the pledging conference emphasize that fundraising momentum must be maintained.

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Photo: news.xinhuanet.com

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BACKGROUND

THE ISSUE

On November 17-19, 2011, the Leaders of all ten member states that comprise the Association of South East Asian Nations (ASEAN) are due to meet in Bali, Indonesia, for the 19th ASEAN Cooperation Forum on HIV/AIDS. The meeting will commemorate the 10th anniversary of the ASEAN Declaration on HIV/AIDS [1], and Leaders are expected to renew their commitment to this strategy and launch a new report on the progress made to date. It is expected that Leaders will use the meeting to outline new measures for tackling HIV throughout the region, but what is less clear is whether the meeting will address any new strategies to prevent HIV infections amongst the three most vulnerable population groups in Asia – injecting drug users (IDUs), men who have sex with men (MSM), and sex workers and their clients.

GLOBAL HEALTH IMPACT

According to the latest UNAIDS report, in 2009 some 4.9 million people in Asia were living with HIV, representing approximately 15 percent of the world's 33.3 million cases. [2] Although the national epidemic in each Asian country has different characteristics, the primary source of new infections overwhelmingly remains IDUs, MSM, and sex workers and their clients. [3] Unless leaders of ASEAN countries agree to new measures to help prevent new transmissions amongst these vulnerable populations groups and support access to treatment, it is likely that earlier gains made throughout the region will begin to be reversed.

THE ROLE OF DIPLOMACY

Diplomacy has been central in developing a regional strategy for ASEAN countries to respond to HIV, and it will continue to remain critically important. The diplomacy-by-consensus approach utilized by ASEAN has several key benefits for developing and implementing regional strategies as countries agree to targets and programs they are already committed to implementing. At the same time, issues that are deemed to be too controversial, such as strategies for addressing disease transmission in IDUs, MSM, and sex workers – three population groups that remain criminalized in many ASEAN countries – can be sidelined. Diplomatic intervention by those ASEAN member states who have witnessed success in reducing HIV transmission amongst these three vulnerable population groups will thereby be important for ensuring a comprehensive and effective regional strategy for HIV.

INTRODUCTION

The spread of HIV in South East Asia was first identified as a concern by ASEAN member states at the 4th ASEAN Summit in 1992. At this meeting, the organization's 10 member states agreed to establish the ASEAN Taskforce on AIDS (ATFOA), which met for the first time in 1993 to begin developing the first regional strategy for tackling the disease – the ASEAN Regional Program on HIV/AIDS Prevention and Control (1995-2000). In collaboration with UNAIDS, ATFOA developed an implementation plan to give effect to the strategy that identified several priority areas including building links with non-health sectors, improving HIV surveillance, identifying vulnerable population groups and population movements, and engaging religious leaders throughout the region. [4]

In November 2001, the leaders of ASEAN met in Brunei Darussalam to endorse the ASEAN Declaration on HIV/AIDS. Reflecting the organization's core principle of non-interference [5], the declaration emphasized the need to support national AIDS programs via education, prevention, and treatment, with joint regional activities to increase access to affordable drugs and testing, target mobile populations with information and prevention strategies, and monitoring and evaluation. [1] This year marks the 10th anniversary of the ASEAN Declaration on HIV/AIDS and the commencement of ASEAN's fourth work program (2011-2015). [6] On November 17-19, 2011, leaders will meet for the 19th ASEAN Cooperation Forum on HIV/AIDS where it is expected they will renew their commitment to the ASEAN Declaration on HIV/AIDS and set a target of "Zero" new HIV infections in line with UNAIDS' new strategy. [7, 8]

ASEAN'S PROGRESS IN COMBATING HIV

By its own admission, ASEAN's member states currently enjoy a mixed record in preventing and controlling HIV transmission throughout the region. At a meeting in Bangkok earlier this year, delegates at the Asia Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support, heard that while Malaysia and Thailand have recently been cited as "Global Superstars" in preventing mother-to-child transmissions, since 2001 two ASEAN countries have also witnessed new HIV cases increase by over 25 per cent. [7] According to the latest UNAIDS figures, the characteristics of HIV epidemics throughout Asia vary from country to country. [3] To some extent, the variation in national transmission rates across the region may be explained by the diverse economic status of ASEAN's members; however, as ATFOA recently acknowledged, "[c]onflicting laws and policies still exist, particularly for HIV prevention among people who inject drugs, sex workers and men who have sex with men." [7]

HIV experts in the region are also concerned about ASEAN's lack of progress in tackling some issues. In an interview for the Monitor, Dennis Altman, Professor of Politics and Director at the Institute for Human Security at LaTrobe University, Australia, recently noted, "ASEAN's record is spotty. Some states have certainly taken the lead in tackling transmission rates amongst vulnerable population groups. Some good examples here include Thailand and Cambodia's work with sex workers and Malaysia's efforts in allowing some forms of needle exchange." Professor Altman went on to say that "a mixture of denial and Puritanism means that some of the most vulnerable populations continue to be consistently overlooked," noting that, "homosexual men, sex-workers and drug users continue to be persecuted throughout most of the region." [9]

Moreover, ASEAN's mixed record in successfully addressing HIV prevention and treatment has also been noted at the global level. Kent Buse, Senior Adviser at UNAIDS, recently acknowledged that, "ASEAN has certainly been a catalyst for significant change in the region." The organization "has provided a critical platform for countries to collaborate—for example, to address HIV vulnerability associated with cross-border mobility or strengthening the capacity of health ministries to better understand the flexibilities inherent in the TRIPs agreement to ensure affordable access to ARVs—as you likely know, eight of the ten member countries now allow compulsory licensing," he said. Dr Buse went on to note though, "let us be honest, despite considerable success in some ASEAN countries, much remains to be done. Too many scarce resources are being spent on the wrong things while those populations most at risk—I am talking about men who have sex with men, sex workers and their clients and people who inject drugs—are crying out for access to services." [10]

ASEAN'S KEY HIV CHALLENGE: AGREEING TO A REGIONAL STRATEGY FOR ADDRESSING VULNERABLE POPULATIONS GROUPS

UN Secretary General Ban Ki-moon observed in 2008, "[in] countries without laws to protect sex workers, drug users, and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment, and fewer deaths." [11]

In 2001 ASEAN's Leaders did acknowledge the need to "promote the creation of a positive environment in confronting stigma, silence and denial; elimination of

discrimination" and addressing the needs of "vulnerable groups and people at risk, particularly young people and women." [1] Yet importantly, since 2001, no ASEAN member state has moved to enact anti-discrimination laws to protect those population groups identified as at most risk of HIV; [12] and homosexuality, drug-taking, and prostitution remains illegal in the majority of countries throughout the region.

In 2010, UNAIDS released a new strategy document "Getting to Zero" whereby it identified "Zero Discrimination" as one of three key objectives in preventing all new HIV infections by 2015. [13] In March 2011, ATFOA signaled a willingness to align ASEAN's work with the UNAIDS global strategy. [7] It would appear, therefore, that addressing discrimination of sex workers, IDUs and MSM may be on the agenda of the 2011 Bali Leader's meeting. Dr Buse from UNAIDS remains hopeful, stating, "I think that ASEAN provides a great mechanism to get traction on this agenda. Increasingly, leaders in the region acknowledge where the HIV problem lies and, while I do not want to pre-judge the proposed Bali Declaration, there has been encouraging talk of making a commitment to reviewing laws and taking action to ensure that legal obstacles do not block access to critical HIV services. This would be a great leap forward for HIV prevention in the region". [10]

Certainly, there is little question that the diversified nature of HIV epidemics in the region will continue to present a key challenge for ASEAN in developing a comprehensive regional strategy and program of work for HIV prevention and control. Nonetheless, several possible strategies – such as relaxing legal restrictions on the availability of sterile needles and syringes, and the de-criminalization of homosexuality – may assist in preventing new HIV infections in the region. [14] Political commitment at the highest level will be required, however, to enact these initiatives and measures. Understandably, all eyes will be on the outcome of the Bali Leaders' meeting in November.

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“TOWARDS A SAFER WORLD” FROM PANDEMIC PREPAREDNESS TO EMERGENCY PREPAREDNESS



Photo: www.rfa.org

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BACKGROUND

THE ISSUE

The response to the H1N1 pandemic of 2009 indicated that planning and preparedness had been of benefit. The pandemic also highlighted challenges in trying to ensure timely vaccine production and distribution. The review of the WHO's response under the International Health Regulations (IHR) concluded that there had been successes and failures and that global preparedness was not adequate.[1]

After the 2009 pandemic, at the same time as the results of evaluations and reviews emerged, resources for pandemic preparedness dwindled, partly as a result of the economic downturn. The UN System Influenza Coordinator, together with the World Food Program, which had developed a strong preparedness program, and with the support of USAID, launched the “Towards a Safer World” initiative, to look beyond pandemic influenza and translate learning into emergency preparedness for other disasters. This year-long process culminated in the release of a report and a meeting held in Rome on September 15 and 16, 2011.[2]

The meeting was an invited gathering of 170 people from government departments, including health, agriculture and the military, from almost 40 countries, as well as UN agencies, NGOs, The Red Cross/ Red Crescent movement, and industry. The goal of the meeting was to capitalize on pandemic investment. The formal report of the meeting is available at (<http://towardsasafeworld.org/>).[3]

GLOBAL HEALTH IMPACT

The TASW initiative seeks to encourage countries to engage multiple sectors in their emergency preparedness planning, and the TASW report demonstrates that those countries that were able to plan across sectors were best able to minimize the health impact of the last flu pandemic. The overarching goal of the TASW initiative is a world that is better prepared to face threats that impact all of society.[3]

THE ROLE OF DIPLOMACY

Planning and preparedness for pandemic influenza commenced in the 1990s in some countries, gaining a stimulus as the result of the appearance of H5N1 in 1996, and continued to develop until the 2009 pandemic. The WHO, along with donor support, provided guidelines, enhanced surveillance, and promoted vaccine capacity development.

Efforts were complemented by the activities of the office of the UN System Influenza Coordinator and there was a series of International Ministerial level Conferences on Avian and Pandemic Influenza, which demonstrated the continued concerns of the emergence of a pandemic from highly pathogenic avian influenza. The concept of “One Health” became incorporated into the discussions at these meetings at the Delhi conference in 2007 and was further confirmed as part of the collaborative thinking of UN organisations and the World Organization for Animal Health (OIE), with a strategic framework presented at the Sharm El Sheik conference in 2008. Pandemic planning eventually included the possibility of rapid containment followed by the use of anti-virals for treatment and vaccine, and non-pharmaceutical measures, such as isolation of cases, to contain spread.

INTRODUCTION: UNDERLYING THEMES

There have been two underlying themes related to pandemic preparation. First, an increasing emphasis on the need to link the animal health and human health sectors, i.e., the animal human interface, as exemplified in the One Health concept,[4] and, second the imperative that preparedness for widespread outbreaks of infectious diseases translate into a capacity to respond to other crises.

The first theme was a feature of the TASW meeting, but was limited to recognizing the necessity to strengthen veterinary services to prevent the spread of diseases in animals that might, occasionally, give rise to widespread outbreaks and possibly pandemics in humans. Past examples of the global human disease consequences of animal diseases are significant but not numerous; they do include, HIV infection, Nipah virus infection, SARS and influenza. One area of work is to prevent animal to human transmission at their source.

The second theme has morphed into the need to “advance” a whole of society approach, and this explicitly includes a “whole of government approach,” to address not only acute communicable disease events, but also ‘slow-onset, cross border disasters’ such as climate change.

MAIN ISSUES DISCUSSED AT THE RECENT TASW CONFERENCE

Whole of Society, including a local approach

A whole of society approach was confirmed, but it was recognized that this has to be complemented by a principle of inclusion of individuals, communities, and organizations at all levels, both global and local. Sustainability of preparedness and a capacity to respond to crises come from reinforcing community resiliency and recognizing the importance of local ownership of the problem. This requires consultation and negotiation, and as “urgency impedes consultation ... it must be done beforehand.”

How can countries work together to confront challenges that require multi-sectoral solutions? The response to complex crises that cross international borders needs to be sustainable for periods of time. For example, the need to pay attention to the adverse consequences on health resulting from climate change was mentioned more than once at the meeting. Similarly, non-communicable diseases have been described as a slow moving pandemic, and are also linked to factors outside the health sector.

Planning

Planning has to take account of the needs of vulnerable populations and those that will be most affected by disasters. These populations include those with chronic conditions and those living in remote and isolated communities away from quality health care as well as the socio-economically deprived. The response has to be risk-based and simulations are a necessary part of the planning process. The recent earthquake in New Zealand showed the importance of resiliency and self-reliance

in the short-term but that planning for recovery and rebuilding may not have been given enough attention.

Political support

“Disaster management is a core part of good government” and for this to be promoted, political support is necessary. Often there is technical level cooperation across government departments, but cooperation may be lacking at the political level. Organizational resiliency is dependent on the recognition that, in complex large events, governments, organisations, industry and society at large are interdependent and need leadership.

Funding

It was made clear that emergency funding cannot be used for long-term preparedness activities and so must be part of a development agenda. Financing arrangements should lead to a predictable flow of resources.

Private Sector Involvement

An adequate response by the private sector is fundamental to an effective community response. Coordination across government departments such as transport, finance, agriculture, telecommunications, as well as health, should be reflected in a coordinated private sector response and will aid integration. A successful societal response to a crisis, especially in a resource-constrained environment, has to include all sectors at all levels. The changing character of emergencies, such as those resulting from climate change or cyber-attacks, will serve to demand refinement of plans for priority sectors and industries.

Risk Analysis and Communication

Risk analysis should adopt a multi-disciplinary approach including economic analysis and social sciences. Communication of risk was also discussed as a challenge. The advent of new social media offers different approaches. If responses to an event are well coordinated across governments and sectors, then it will be easier to gain the trust of those who often feel most vulnerable, such as front line health workers.

NEXT STEPS

Plans for going forward from the meeting included the maintenance of the TASW network, encouraging a culture of preparedness, using the One Health approach, collaboration, implementation of best practices, and advocacy for funding.

It is not clear how these activities will be achieved; however, at a time when financial stability is an immediate preoccupation, and particularly as the response to the 2009 pandemic was viewed as successful in many ways and is now not considered to be “top of mind.” The absence of key members of the G20 including Brazil and the Republic of Korea was noted as being an important gap and the increasing influence of the “BRIC” economies may well be important in obtaining sustainable interest in advancing crisis preparedness.

Possibly the most important proposed next step of the network is the continued promotion of a whole of society approach. Sectors outside of health, such as the military and civil protection (first responders), play their part in emergency response and are collaborators in health related events. In addition, parts of other sectors, such as banking, have highly developed business continuity plans for pandemic influenza. These initiatives will have to be the basis for promotion of a whole of society view of disaster/ crisis preparedness.

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SPECIAL SESSION OF WHO EXECUTIVE BOARD TO DISCUSS REFORMS AT THE WHO



Photo: WHO/ Pierre Albouy

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BACKGROUND

THE ISSUE

Since 2010, the discussion of "future financing of [the] WHO" has expanded into an integral organizational reform, being overseen by the Director General (DG) Dr. Margaret Chan. During the 64th World Health Assembly in May 2011, Member States passed a resolution to proceed with extensive programmatic, managerial, structural, financial and governance reforms [1, 2]. Following the WHA, at the 69th Executive Board (EB) meeting in May 2011, countries gave clear guidelines to the DG to develop concept notes, on which comments were given through online consultations, and which will be discussed in-depth at the Special Session of the EB during 1-3 November 2011.[5-8]

GLOBAL HEALTH IMPACT

The intended reform package will examine the governance of the World Health Organization (WHO), the leading international organization responsible for global health issues. This will redefine the remit of the WHO's work and engagement in health, as well establish the kind of role the WHO should have in governing global health. As such, the WHO will reform its financing, its human resource policies and its leadership and managerial structure. The global health impact of this reform package will be significant, as Member States are pushing to narrow down the business areas of the WHO and give more power to country offices to work more closely with governments and other national organisations and address specific health needs at the country level.[8, 9]

THE ROLE OF DIPLOMACY

In the recent past, member states have expressed concerns that the WHO secretariat has acted autonomously on several important decisions and that member states were not always included. This criticism was also voiced at the 129th EB meeting in May 2011, following the WHA. Countries such as Ecuador, Brazil, India and Mozambique expressed concerns that the draft text under consultation was drafted by the Secretariat without consultation. Ecuador's proposed text then formed the basis for the 129th EB decision. In so doing, Member States have pushed to regain control of the reform process.[3]

SECRETARIAT'S PROPOSAL AND MEMBERS STATES' REACTIONS

UN Secretary General Ban Ki-moon observed in 2008, Following the Executive Board meeting in May 2011, three background papers were prepared by the Secretariat, which formed the basis of online consultations. The results of the consultations, now available to the public, highlight key comments from Member States. They ask for "next steps, a general action plan/time frame for phased implementation of the reform and to consider key metrics for monitoring progress on reform." [8] Member states also ask to show how the three areas of reform, namely managerial, governance and programmatic, are connected. The countries provide flexibility to DG Chan to oversee ongoing reforms that can be implemented at her discretion, and clearly distinguish these from the ones the countries need to discuss and endorse.[8,9]

At the European Regional Committee meeting in Baku, Azerbaijan, in mid-September 2011, the DG spoke about the reform package. She explained that the "proposed reforms are comprehensive, encompassing the technical and managerial work of WHO as well as the governance mechanisms that guide and direct this work." She added that while recognising the challenges, she remains "highly committed" to ensure "a WHO that is more efficient,

transparent, and accountable, stronger on areas where WHO is badly needed and sharper on priorities where WHO is uniquely effective.”[4]

The DG noted that to facilitate funding and fundraising, the WHO must do a better job at communicating their work since it is often difficult to tangibly measure the outcome of their technical work.[4]

The WHO has so far identified five core business areas: Convening for better health; generating evidence on health trends and determinants; providing health advice for development; coordinating health security; and strengthening health systems and institutions. These areas constitute the programmatic work of the WHO and will be presented to the member-states for endorsement. [9]

The managerial reform package is focused on six elements:

1. Increasing organizational effectiveness, including corporate decisions and decentralized implementation;
2. Improving results-based management and accountability;
3. A dynamic approach to human resource policy, planning and management;
4. Strengthening financing, resource mobilization and strategic communication;
5. Increasing WHO's effectiveness at the country level;
6. Strengthening WHO's role in global health governance.[9]

FINANCING

Due to domestic financial constraints faced by most traditional donor countries, the WHO will need to find new funding sources in order to extend core financial resources. At the WHA, emerging economies were asked to make commitments, however Dr. Chan noted that many of the emerging countries are not yet in a position to make commitments that would match previous years' funding. There was tremendous debate around this issue at the WHA, and is expected to ensue at the special EB session.

Countries such as Thailand called the WHO a donor-driven organization, which highlights the need for flexible, i.e. non-earmarked, funding. During the online consultations, Member States requested that the Secretariat to provide more details including an analysis of the current financial health of the organization and a realistic, pragmatic proposed budget, expressing concerns that increasing the percentage of WHO's predictable budget to 70% is over-ambitious and unrealistic.

Countries also call for a better management mechanism for overseeing the use of voluntary contributions. Additional concerns exist regarding accepting funding from private or corporate sources.[8, 9] An article by the Third World Network also highlights that while the reform discussions started with a need to address WHO's financial insecurities, the DG's report contains little discussion of new financing mechanisms to address this issue. Germany raised this concern during the EB meeting in May.[3]

WORLD HEALTH FORUM

Contentious discussions continued on the creation of the multistakeholder forum for global health- the World Health Forum. During the discussions at the WHA and online consultations, many Member States displayed unease due to the lack of information on how such a forum would be organised and funded, and the kind of relations it would engender between the WHO and the private sector.

The civil society organizations had very strong views on this issue and was supported by certain countries, notably Thailand, who altogether rejected this initiative. Most countries asked the Secretariat to prepare a concept note on how the DG views the forum. According to the concept note, the “purpose of the World Health Forum will be to explore, in an informal and multi-stakeholder setting, ways in which the major actors in global health can work more effectively together - globally and at [the] country level (...).”[5,7, 10] In online consultations, countries also asked the DG to consider alternative options to the World Health Forum, especially in the absence of guiding principles on how to interact with different actors.

The first forum is proposed to be held in Geneva over three years in November 2012, with an estimated cost of \$100,000 for preparatory activities and \$675,000 for the meeting itself, amounting to \$775,000. The financing of this initiative will most likely be an issue of contention at the Executive Board, since most traditional funders are under severe financial constraints.[10]

ORGANISATION EFFECTIVENESS, ALIGNMENT AND EFFICIENCY

Specific comments on the reform package also include strengthening of the country offices in order to render the organisation more effective and efficient to ensure improved health outcomes at the country level; heightened engagement with other UN organisations, NGOs, CSOs, and academics at the country level to avoid duplication; and ensuring regional level coordination since many health problems are shared amongst countries of the same regions.[8, 9]

In the context of improving human resource policies and management, the Member States highlight the need to place emphasis on having the right skills and competencies, while being mindful of the need for diversity; as well as improve secondment mechanisms with Member States.[8] In fact, during the 63rd WHA, France called on the WHO to apply the principle of subsidiarity and highlighted the importance of engaging country offices in a decentralised way.

Criticisms from Member States highlighted that priority-setting for the work of the organisation was not strategic nor selective, and that funding interests guided the work that the organisation undertook, as opposed to being needs-based or strength based.[8]

INDEPENDENT REVIEW

Furthermore, it was decided, in consultation with the member states, to undertake an independent evaluation of the “work of WHO.” The first report of this independent evaluation is to be presented to the member states at the World Health Assembly in May 2012.

Until now, the evaluation of the work of WHO has been undertaken at three levels: at the UN system level, by the UN Joint Inspection Unit; at the Organization level, by the office for Internal Oversight Services; and at the decentralized level (regional and country-level) by individual WHO programmes. External reviews have been conducted, but not through the WHO mandate, but through the UK Multilateral Aid Review, for example.[7,11]

In the DG’s report, there are suggestions as to how independent evaluations could be undertaken in the future: the EB would “commission and provide oversight for evaluations, approve terms of reference;” the Office of Internal oversight and Services could have a greater mandate and would report to and be supervised by the Board; and a separate Evaluation Unit which could be established.[7]

Several countries, including Norway, have raised concerns regarding the timeline and funding of the independent evaluation, as well as the scope and breadth of the evaluations.[3]

NEXT STEPS

Between 1-3 November 2011, Member States will come together for a special session of the Executive Board to discuss the reform package put forward by Director General Dr. Margaret Chan, in consultation with the countries. Member States will discuss the future financing of the organisation, the managerial and structural reforms that it must undertake, agree upon the areas of work most suited for the WHO, the World Health Forum initiative, and the governance of the organisation, as well as the role the organisation should have within the wider global health arena.

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HEALTH DIPLOMACY MONITOR

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