

HEALTH DIPLOMACY MONITOR

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Health Diplomacy Monitor

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

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 Global Health Diplomacy Network

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A WORD FROM THE EDITOR

The Health Diplomacy Monitor is completing its second year of publication. With now more than 2000 subscribers around the world, we deemed it timely to conduct a readership survey to ensure that we are achieving our goals of improving transparency in global health negotiations and making information about them more readily available.

More than 120 readers responded to the survey conducted earlier this fall; we are very pleased to see that our readers generally find the Monitor useful and relevant to their work. Some of the recommendations on how to improve the publication included: increased frequency of publication, wider distribution, more coverage of regional perspectives on global health negotiations, more on the ground reporting, and a greater focus on non-WHO negotiations. In terms of the themes covered, several respondents suggested that we provide more coverage of health and security related discussions, as well as of global negotiations related to non-communicable diseases and to

access to medicine. In the coming year, we will seek to implement changes in our work to reflect each of these suggestions.

Since our launch in 2010, we have had the opportunity to receive financial support from the Disease Surveillance Network Program of the Rockefeller Foundation, in the context of the Global Health Diplomacy Network. This support will end in June 2012 and we are now seeking support from our readers to ensure the financial sustainability of the Monitor.

We hope to find several sponsors who are able to provide annual support. If you, or your organization, are interested in being one of these sponsors, please contact me for details on sponsorships opportunities.

In this issue of the Monitor, we review some of the latest developments in the debate about the future of the WHO; Rachel Irwin and Priyanka Kanth report on the special session of the WHO Executive Board which was entirely devoted to this topic.

It will be interesting to see how this debate on a more focused role for WHO may contribute to the issue of fragmentation in global health governance, an issue that has been raised by several observers and public health actors. Bente Molenaar provides us with the latest information on the Global Fund, as it announced its decision to cancel its latest call for project proposals. Priyanka Kanth also presents the reflections from the heads of the WTO, WHO and WIPO about the impact of trade rules on intellectual property and access to medicine, ten years after the adoption of the Doha Declaration by trade ministers which reaffirmed the rights of WTO members to adopt policies to protect public health. This debate is still very lively one, as issues related to intellectual property rights and access to treatment remain a core component of the health diplomacy agenda. In another article, Bente Molenaar examines the current debate about the emergence of new donors on the international stage, focusing on the BRICs and their approach to global health cooperation. Finally, in preparation for the upcoming meeting of the Executive Board of the WHO, Paolo de Tarso Lugon Arantes reviews what are some of the key agenda items for discussion next month.

- Chantal Blouin

WHO REFORMS DISCUSSED AT A SPECIAL SESSION OF THE EXECUTIVE BOARD



Photo: news.daylife.com

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BACKGROUND

THE ISSUE

At the 64th World Health Assembly in May 2011, member states passed a resolution to proceed with extensive reforms to the WHO in terms of programmes, management, structure, finance and governance. The member states asked the WHO secretariat to call a special session of the WHO Executive Board (EB) from 1-3 November 2011, to oversee and discuss the reform package proposed by the Secretariat.

GLOBAL HEALTH IMPACT

“The intended reform package will examine the governance of WHO” and WHO’s role in governing for global health. [1] According to Mexico’s intervention during the special session, the implications of this exercise need to be well understood by all member states, since these reforms will pave the way for WHO’s future role in health issues at the global, regional and national levels.

THE ROLE OF DIPLOMACY

The formal impetus for reform began in budget-related discussions within WHO’s governing bodies in 2009. These discussions quickly broadened to include issues about alignment between WHO’s objectives and its funding priorities – a task that begins with clarifying the role of WHO in the contemporary architecture for global health governance.[2] Member states agree on the importance on having a transparent, comprehensive and inclusive process without haste, to ensure that national voices are heard and their needs addressed.

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INTRODUCTION

At the Special Session of the EB, held 1-3 November 2011, WHO member states discussed background papers prepared by the Secretariat as well as the outcomes of consultations held with member states on these papers. Overall, member states expressed firm support for the WHO and its reform process, and the aims of: 1) building upon WHO's core strengths to better equip it for addressing 21st century public health challenges;^[3] and 2) committing to its core work in a manner flexible enough to respond to emerging health threats. There was also broad consensus that the WHO's five areas of work should include health development, health security, strengthening health systems and institutions, generating evidence on health trends and determinants, and convening for better health.^[4] Member States also stressed that this continues to be a transparent and member state-driven process.

FINANCING

Financing has been a long-standing issue for WHO, especially recently with the on-going financial crisis and its effect on restricting donor countries' budgets. In addition, the earmarking of donor funds to WHO's budget has negatively affected the flexibility of its programmes, while the increased value of the Swiss franc – the currency used for many of WHO's costs - has decreased the value of member state donations which come in the form of US dollars.

At the EB meeting, member states requested the Director General (DG) to create a set of proposals to be discussed at the next EB meeting in January ; these proposals include mechanisms to increase the predictability and flexibility of income, and to ensure that spending is in line with the priorities set by Member States. It also includes proposed plans to establish a contingency fund for dealing with public health emergencies.^[5] The EB has also requested the DG to implement minor reforms, not needing approval from the governing bodies, to strengthen financial controls and streamline both administration and management costs.

WORLD HEALTH FORUM

The Secretariat's report to the 64th World Health Assembly had proposed the creation of a World Health Forum, which would have been a multistakeholder forum bringing together representatives from WHO member states, civil society, private sector, academia and other international organizations. The Forum would have had a "role in identifying, from the different perspectives of its participants, future priorities in global health."^[6] However

there was little support for the Forum and plans for it were abandoned on the first day of the EB meeting. Both civil society and member states voiced concerns over the potential for conflicts of interests and undue influence by the private sector. Also, because the forum would have been held in November 2012, there were concerns from civil society groups that this would have been too late in the policy cycle to contribute meaningfully to the following EB meeting in January 2013.

Having discarded the proposal for the Forum, questions remained about how to involve non-governmental actors in the WHO's work, while maintaining WHO's independence. To achieve this the WHO is expected to use existing mechanisms such as consultations or the Standing Committee on Nongovernmental Organizations, and to find ways of improving these mechanisms.

ORGANISATION EFFECTIVENESS, ALIGNMENT AND EFFICIENCY

Both the report by the Secretariat and the DG's opening speech stressed the need for the WHO to better integrate itself amongst its constituent entities. This involves: 1) establishing closer linkages between the Regional Committees, World Health Assembly and Executive Board; and 2) strengthening the role of the Programme, Budget and Administration Committee of the Executive Board. At the Secretariat level, this means clarifying the role of headquarters, regional and country offices. To this end, the DG will submit to the 130th EB a report on ways to increase coordination amongst the governing bodies. The DG was also requested to map out the activities carried out by different levels of the organisation along with a description and understanding of the relationship between priority setting mechanisms.

INDEPENDENT REVIEW

During the WHA in May 2011, member states asked the Secretariat to undertake an independent review of WHO and its work. The independent review will highlight the current financial and organisational difficulties being faced by WHO. Historically, the evaluation of WHO has been done at three levels, at the UN System level by the UN Joint Inspection Unit, at the organisational level by the Office of Internal Oversight Services and at the decentralized level by individual WHO Programmes. The review will: 1) examine existing information about WHO and the reform process (with a focus on budgeting, human resources and internal governance of WHO by member states); and 2) assess coherence between WHO's headquarters, regional and country offices. Stage one of the independent review is to be completed for the 65th World Health Assembly in May 2012 and stage two is to be completed the following year.

NEXT STEPS

The EB will meet next for its 130th session from 16-23 January 2012 and will consider WHO reform with “a view to deepening and consolidating the range of work on programme and priority setting, governance and managerial form.” [8] Between now and then, the DG has been asked to produce a report to guide discussions. The EB will review a proposed mechanism to increase the predictability and flexibility of financing, and will give guidance to the Secretariat in reporting to the 65th World Health Assembly in May 2012 on the reform process. [4] A proposal for a new resource allocation mechanism will also be discussed by the 131st EB meeting following May’s WHA.

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FUNDING SHORTFALL FORCES DIFFICULT DECISIONS FOR THE GLOBAL FUND



Photo: <http://www.asbmb.org>

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BACKGROUND

THE ISSUE

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Fund) is a global public/private partnership that has become the main source of funding for programs to fight AIDS, tuberculosis (TB), and malaria since its creation in 2002. However, at the Fund’s 25th board meeting in Accra, Ghana (November 21-22) its funding round 11 was canceled; it was also announced that a new general manager position would be created to oversee implementation of some of the changes proposed by the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms.

GLOBAL HEALTH IMPACT

AIDS, tuberculosis, and malaria are significant obstacles to reaching the Millennium Development Goals (MDGs). In 2008, there were an estimated 243 million cases of malaria causing 863,000 deaths, mostly amongst children under five years of age.[1] Similarly, TB continues to pose a global threat. According to WHO estimates, 9.4 million people were infected by TB in 2008, while 1.8 million people died of the disease.[2] The number of AIDS-related deaths worldwide is steadily decreasing from a peak of 2.2 million in 2005 to an estimated 1.8 million in 2010, while an estimated 34 million people are living with HIV. [3] A reduction in funding will adversely affect the gains that have been made in recent years, at a time when we have seen unparalleled global progress.

THE ROLE OF DIPLOMACY:

The board of the Global Fund will play an instrumental role in implementing changes to fiduciary controls and oversight mechanisms over the coming months. The board of the Global Fund consists of 20 voting members, representing donor and recipient countries, as well as representatives from non-governmental organizations, the private sector (including businesses and foundations), and affected communities. Additionally, donors will have a role to play in terms of ensuring funding levels.

INTRODUCTION

After what has been described as a “stressful” meeting in Accra, Ghana, the board of the Global Fund made public their decision to cancel funding round 11.[4] In addition to a funding shortfall in a harsh financial environment, concerns have also been raised about the management and oversight functions at the Fund, making an already difficult situation tenser. The announcement of the cancellation comes around the same time as UNAIDS, UNICEF and the WHO announced significant progress in the fight against HIV/AIDS, and just a few weeks before World AIDS day, held on December 1.

GLOBAL PROGRESS IN HIV RESPONSE

In a joint press release the WHO, UNICEF and UNAIDS presented their latest report: Report on the global HIV/AIDS response. The report shows that increased access to HIV services is working, and that the world has seen a 15 percent reduction in new infections over the past decade. AIDS-related deaths have seen a 22 percent decline in the past five years. According to Paul De Lay, deputy executive director of programmes at UNAIDS, 2011 has been a game changing year, with “new science, unprecedented political leadership and continued progress in the AIDS response”. [5] It is a disappointing coincidence that this progress follows on the heels of financial difficulties at the Global Fund.

FUNDING SHORTFALL AND CANCELATION OF FUNDING ROUND 11

The US\$ 11.7 billion pledged at the funding round in October 2010 did not meet even the low end of the three different funding scenarios outlined by the Global Fund. As outlined by the Global Fund, US\$ 13 billion would merely ensure continued support for program implementation. In a press release dated October 5, Michel Kazatchkine, executive director of the Global Fund, noted that “We need to recognize that this amount is not enough to meet expected demand. It will lead to difficult decisions in the next three years that could slow down the efforts to beat the three diseases.” [6] Since those remarks, the situation has become more challenging, and some of the money pledged has not yet been received. Italy, for example, pledged 130 million Euros between 2009 and 2010, but due to their financial situation, they have not made the payments. Spain has reduced its pledge, and has not made a pledge for 2011-13. [7] Kazatchkine, meanwhile, has come under increasing pressure to step down.

The Board was forced to make a number of adjustments, including the decision that China, Russia, Mexico and Argentina would no longer be eligible for grants from the Global Fund.

INDEPENDENT REVIEW PANEL RECOMMENDATIONS

In light of allegations of misappropriation of funds, the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanism was established to carefully consider and make recommendations for reform that would improve financial safeguards.[8] The allegations of fraud, led some donors to temporarily hold back their pledges. Some of the main findings of the Independent Review Panel included: 1) implementation and management capacity in a number of recipient countries is uneven; 2) oversight is inadequate to prevent fraud; and 3) insufficient scrutiny of budgets in proposals allows for exploitation after approval.

NEXT STEPS

The Fund is undergoing major changes, and it has a challenging year ahead. It is likely that a new general manager will be named soon, to help implement some of the internal changes recommended by the Independent Review Panel.

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10 YEARS AFTER THE DOHA DECLARATION ON THE TRIPs AGREEMENT AND PUBLIC HEALTH: THE FUTURE AGENDA AT THE INTERFACE OF PUBLIC HEALTH, INNOVATION AND TRADE



Photo: www.medicusmundi.org

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BACKGROUND

THE ISSUE

In a historical move on 14 November 2001, the Member States of the World Trade Organisation, passed a declaration on the Trade-Related Intellectual Property Rights (TRIPs) Agreement and Public Health in Doha, Qatar. The “Doha Declaration,” as it has come to be known, reaffirmed the public health concerns, especially with regards to access to medicines and “...agree[d] that the TRIPs Agreement does not and should not prevent members from taking measures to protect public health.” Additionally, they “reaffirm[ed] the right of WTO members to use, to the full, the provisions in the TRIPs Agreement, which provide flexibility for this purpose.” However, to this day, intellectual property and health, especially the role of intellectual property in promoting or preventing access to medicines, has been one of the most controversial and polarizing issues both in and outside the health forum.

GLOBAL HEALTH IMPACT

The estimated global health impact of the TRIPs Agreement and the debate regarding access to medicines is critical. Generic drug companies in emerging economy countries, such as India, currently provide the bulk of affordable medication to treat diseases such as HIV/AIDS, TB and Malaria, diseases that are endemic in many low- and middle-income countries. Approximately 75-80% of Medecins Sans Frontières (MSF)’s procurement in HIV/AIDS medication is from Indian generic companies. The global health impact, perceived or genuine, is not confined to HIV/AIDS. With today’s growing double disease burden in communicable and non-communicable diseases, the need for safe, efficacious and affordable medications to address the major non-communicable diseases is immense and medical costs are draining to most nations, low- and middle-income and high-income alike.

THE ROLE OF DIPLOMACY

The Doha Declaration was a landmark achievement in how global diplomacy was conducted to meet health needs. The Doha Declaration, which emanated from nearly ten years of negotiations, brought to the fore the importance of various stakeholders, notably key NGOs such as MSF and key emerging economy governments, such as South Africa, India, Brazil, Thailand and others. It assisted in changing, to an extent, the power-ratios in the multilateral negotiations by increasingly incorporating civil-society voices and counter-balancing private sector agendas. Many issues around the intellectual property and public health debate are still unresolved and new issues are arising, but the Doha Declaration remains one of the cornerstones which current discussions build on.

INTRODUCTION

On the 23 November 2011, the Graduate Institute of International and Development Studies, hosted a symposium at the World Trade Organization entitled “Ten years after the Doha Declaration: The future agenda at the interface of public health, innovation and trade.” The event, held under the auspices of Ms. Ruth Dreifuss, former Chair of the Commission on Intellectual Property Rights, Innovation and Public Health, brought together major players, leaders and heads of several international organizations engaged in these issues.

DIRECTOR-GENERAL’S OF WHO, WIPO AND WTO SHARE THEIR THOUGHTS

The event opened with a dialogue between the World Intellectual Property Organization (WIPO) Director General Mr. Francis Gurry; World Health Organization (WHO) Director General Dr. Margaret Chan; and World Trade Organization (WTO) Director General Mr. Pascal Lamy. The Director Generals explored the current challenges and possible solutions to address these challenges now and in the future. A key point of discussion, started by WIPO DG Gurry, who took the example of the recently launched ‘WIPO Re:Search Consortium’, was the potential to make considerable progress in ‘non-treaty’ areas at the multilateral level. The WHO agreed with this perspective and quoted their work on pandemics and on substandard/spurious/falsely-labeled/falsified/counterfeit drugs. Treaty-making, ratification and implementation is an extremely lengthy process, and some of the actions that these organizations need to take are much more immediate in order to address urgent needs. Currently at the WHO there is a recommendation, put forward by a WHO working group on financing research and development (R&D), to

start drafting a binding treaty or convention in R&D. The Director-Generals' dialogue highlighted the continued importance of multilateralism and the need for mechanisms to further enhance coherence-building work at the interface of intellectual property, trade and public health. This call for sustained multilateralism takes place in the context of the challenges currently facing the WHO and WTO. The WHO is going through an organization-wide reform, including financial and budgetary restructuring.[1] At the WTO, the current round of trade negotiations is at a standstill with low certitude of conclusion.[2]

Lamy stressed the importance of building on the Doha Declaration and the TRIPs Agreement multilaterally, as the TRIPs Agreement acts as a 'floor' and not as a "ceiling." Countries bring many concerns to the discussions at the TRIPs Council on patentability, data protection and other issues, but flexibly negotiate them away in bilateral- and regional free-trade agreements, undermining the success of multilateralism. An efficient way to address these concerns is to work on building coherence at the different levels: amongst the multilateral organizations, between the organizations and the countries, within the countries between different ministries, and between other stakeholders including civil society, the private sector and academia. Efforts to make their policies are underway between the three international organizations working in this area through trilateral cooperation. They produced a study whose preliminary findings show that, ten years after the Doha Declaration, access to medicines is still a huge problem.[3]

MANAGING PRIVATE SECTOR RELATIONS AND PROFIT MARGINS

Another core issue in the provision of new drugs and new research is that market forces have largely failed to provide incentives to fuel private-sector research, especially for diseases affecting the poor.

WHO DG Chan highlighted the importance of putting health concerns first and managing profit margins of the private sector. Her comments focused on the tobacco industry. Recently, the tobacco industry has come under fire for intensive lobbying at the WTO and with countries to stop national governments from taking actions against tobacco packaging to reduce smoking.

Other speakers spoke of concerns at the national level, which differ significantly between countries. Kenyan Ambassador Tom Mboya Okeyo reinforced that "innovation in the pharmaceutical industry is facing a serious crisis." He supported a proposal to introduce a financial transaction tax as a means to raise additional

funds directed towards boosting R&D for new drugs.

Eduardo Pisani, head of the International Federation of Pharmaceutical Manufacturers and Associations, also reiterated this gap in R&D for new drugs. He spoke of creating an environment that promotes new research. He spoke of product-development partnerships and other corporate social responsibility initiatives to illustrate attempts to address the absence of market-driven solutions.

WIPO DG Gurry also highlighted the need to collaborate and cooperate with the private sector, which is a direction that the organization is adopting. This is not possible for the WHO due to many member-states being against collaboration with the private sector. Challenges are bringing about new thinking, and as Ms. Ruth Dreifuss said in her final words, the IP system does not need to be replaced, but completed.

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BACKGROUND

THE ISSUE

'New' donors are emerging, and countries such as Brazil, China and India are increasingly contributing to global health. Moreover, private philanthropists, such as the Gates Foundation, are also making significant contributions to aid for health. These emerging donors operate outside, although sometimes in collaboration with, the Development Assistance Committee (DAC): a fifty year old club for selected members of the Organization for Economic Co-operation and Development (OECD) to discuss and coordinate aid.

GLOBAL HEALTH IMPACT

Developing countries benefit from new sources of donor aid. For example, Brazilian contributions are helping train medical staff from countries like Mozambique, Nigeria and Angola, while Chinese contributions are helping build malaria centres in Africa. These new donor countries are increasingly involved in global health policy; especially Brazil, which has actively engaged in global health negotiations. These events are prompting important questions; in particular, how these new actors are different from DAC donors, and how this impacts work in the area of global health.

THE ROLE OF DIPLOMACY

DAC countries' aid is guided by the Paris Declaration principles, which strive to make aid more effective by ensuring country ownership, harmonization, mutual accountability and a focus on measurable results.[1] Now, more donors operate outside the DAC framework, making aid for health more complex. For example, emerging donors such as Brazil and Russia are channeling some of their aid through multilateral organizations, but much of it also occurs bilaterally.

The fourth High-Level Forum on Aid Effectiveness in Busan, South Korea (November 29-December 1) represented a move forward in terms of collaboration on aid effectiveness by bringing emerging donors, including China and Brazil, into the partnership.

INTRODUCTION

Much has been written on 'emerging' donors and how these non-traditional donors are changing the landscape in which aid is delivered. Some have pointed out that there is in fact nothing new about South-South collaboration and aid, with India and China traditionally leading the way. Other countries, such as Brazil, Saudi Arabia and South Africa are also increasingly investing in aid for health. One perception that still exists is that these new donors are also less transparent, potentially undermining aid agreements arrived at by traditional donors through the Paris Declaration.[2]

MANY 'NEW' DONORS ARE NOT NEW

Many 'new' donors to global health are not new. However, what has changed is that these 'new' donors are becoming more strategic in their delivery of aid. In the last year, China has released white papers on its foreign aid program, with clear objectives and approaches to aid. Health features as one of the priorities in the white paper. [4]

The economies of countries like Brazil and China have grown dramatically over the past few decades, spurring their ambition and ability to contribute more aid. Brazil has been particularly successful at using its engagement in global health as an entry point for taking a leadership role internationally. Over the years, Brazil has positioned itself as a powerful actor, and played an instrumental role, in for example the establishment of the World Trade Organization's Doha Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement of Public Health in 2001, and the WHO Framework Convention on Tobacco Control, as well as playing a critical role in the debate around access to essential medicines.[7]

HOW MUCH DO EMERGING DONORS CONTRIBUTE?

While it is undisputed that the volume of aid from emerging donors has risen, there is little certainty about how much these donors are giving to global health work. While some report their figures to the Development Assistance Committee of the OECD, others do not. For example, statistics are not readily available for China.

Multilateral organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, offer a glimpse into the rise of emerging donors. Countries that announced contributions at the latest Global Fund pledging conference included China, India, Nigeria and Saudi Arabia.[8] The GAVI Alliance has also

seen more diversity in its funders; Brazil pledged (and has paid in full), US\$ 11.7 million for the 2011-15 period while Russia has contributed US\$ 80 million (2010-19).

In the period 2005-9, Brazil spent the equivalent of US\$ 1.6 billion on technical cooperation (this figure excludes debt relief and other forms of financial cooperation). Of this, some 17 percent went to health. [5] In April 2011, China issued its first White Paper on its foreign aid program. In it, public health is identified as a priority area, with an emphasis on building infrastructure for health, and tackling the challenge of malaria. According to the White Paper, China has built 30 malaria prevention and treatment centers in African countries, and provided artemisinin anti-malaria medicines worth 190 million Yuan in the last three years.[7]

IS EMERGING DONORS' AID DIFFERENT?

The number of bilateral donors per recipient country (not to global health specifically) has increased from 12 in 1960 to 33 in the early parts of this century. [3] There is little doubt that the increased number of donors, and donors that operate outside the DAC framework, contribute to more complexities and challenges in terms of coordination.

Some authors have raised concerns over the lack of oversight, and potential overlapping mandates. Brian Atwood argues, “[t]his increase of activity has overwhelmed partner nations and increased transaction costs.”[10] Others have pointed out that the DAC donor’s aid effectiveness agenda lacks buy-in from emerging donors.[4] Non-traditional donors like Brazil, India and China, have framed their aid for health in terms of South-South cooperation. “This is not surprising” says Kent Buse because “they want to play by a new set of rules more consistent with the seismic geopolitical shift that is unfolding—not rules developed by the DAC that they had no say in creating.” China has actively engaged with African countries and it has emphasized the “no strings attached” policy in offering financial aid and technical support to less developed countries. China has focused its efforts on building infrastructure, health practitioner training and curbing infectious disease.[11] China has come under criticism that their involvement in African countries is a thinly veiled attempt to gain access to natural resources available there. China has responded to this critique by emphasizing its first principle of development assistance, ‘equality and mutual benefit.’[12]

Brazil has similarly stressed cooperation and solidarity with recipient countries. The basic principles for South-South cooperation are, amongst others, that there should be no imposition of conditions; that there shall be no association with commercial interests or profit, and that there shall be no interfering in domestic issues.[5] Many programs have focused on technical cooperation, and examples include a 23 million US dollar donation to Mozambique for the construction of a plant to produce generic drugs for the treatment of HIV/AIDS.[13]

Emerging donors have in common a desire to develop relationships with neighbouring countries sharing similar history and language. For example, Saudi Arabia gives primarily to Arab countries, and Russia to countries like Tajikistan and Armenia. Brazil and China are actively involved regionally, but have also focused much of their attention on African countries. Emerging donors are increasingly making contributions to multilateral organizations too, although precise numbers are not readily available. “What we will likely see emerge,” speculates Buse, “is the development of mini aid clubs. We saw this in action in July this year with the first meeting of BRICS Ministers of Health—they agreed new commitments on south-south cooperation around drug innovation and technology transfer. I think that we will see these new blocks begin to set alternative development agendas and pursue these in a way that was not conceivable just a few years ago.”

NEXT STEPS

Although there was limited discussion on health at the recent High-Level Forum on Aid Effectiveness in Busan, Korea, the meeting will have an impact on aid for health. The outcome document from Busan demonstrates that there is recognition of the complexity of new actors in the aid architecture, and the outcome document starts the process of creating a more inclusive system. The Busan meeting was highly political and a priority was to bring China, and other large new donors onboard. The compromise solution that made this possible was the insertion of paragraph 2, which noted that South-South collaboration is different from traditional aid, and that the “principles, commitments and actions agreed in the outcome document in Busan shall be the reference for the South-South partners on a voluntary basis.” There are still details missing from the agreement, for this reason paragraph number 35 indicates that partners will meet again in June to come up with monitoring standards.[14]

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HIGHLIGHTS FROM THE AGENDA OF THE UPCOMING WHO'S EXECUTIVE BOARD

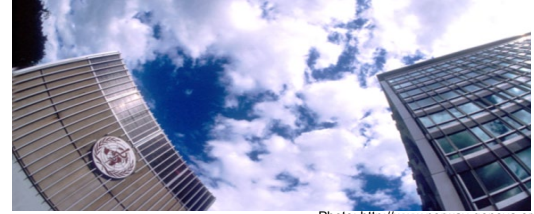


Photo: <http://www.norway-geneva.org>

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BACKGROUND

THE ISSUE

The World Health Organization's Executive Board (EB) will hold its 130th session from 16 to 23 January 2012. Key topics on the agenda for the upcoming meeting include the WHO reform process, a possible treaty on biomedical research and development (R&D), strengthening of health systems, and the Director General's report on noncommunicable diseases (NCDs).

GLOBAL HEALTH IMPACT

Many of the items on the upcoming EB agenda have the potential to bring about structural changes in the WHO.

THE ROLE OF DIPLOMACY

The EB is the organization entrusted to give effect to the decisions and policies of the World Health Assembly (WHA). It advises the Assembly, submits advice and proposals to the WHA, prepares the Assembly's agenda of meetings.[1] The discussions at the board meeting provides direction to the World Health Assembly and signals which topics will be controversial, or will require further work.

INTRODUCTION

Perhaps the most critical issue on the EB agenda for January 2012 is the continued discussion of WHO reform. Starting in 2010 under the title of "Future Financing of the WHO," this process has triggered a debate about broader reforms of the organization, under the supervision of the Director General (DG). In May 2011, Member States passed a resolution at the World Health Assembly (WHA) giving the DG guidelines to develop concept notes, followed by online consultation and a Special Session of the EB, which took place in early November 2011 [see article from Irwin and Kanth in this issue].

Consensus among the Member States that the reform process should be member-driven has prompted delegations to have a Special Session of the EB to discuss the reform agenda. Among the discussions, a number of delegations expressed their dissatisfaction with the fact that the Secretariat was leading the reform process, and reducing the role of the Member States in this process.

At the January 2012 meeting, the Board is expected to further consider the process of the WHO's reform.

After the January discussions, the Board will provide guidance on the aspects of the reform to be considered during the 65th World Health Assembly in May 2012. According to an Indonesian diplomat to the WHO, a key issue to address at the EB session in January 2012 is the decision to establish a Member State-driven process, with a view to providing recommendations on methods for programme and priority setting for the WHA's upcoming May 2012 session.[3] Such a process would allow States to gain a greater say in the reform discussions, leading to a more open process, with the necessary support of the WHO Secretariat.

RESEARCH AND DEVELOPMENT FINANCING AND COORDINATION

The EB is expected to consider the update of the Consultative Expert Working Group on Research and Development Financing and Coordination (CEWG) meetings' outcome and to make recommendations to be submitted to the World Health Assembly in May 2012. The CEWG was created in 2010 [4] with the mandate to examine R&D financing and coordination proposals for diseases that principally affect countries with lesser resources. It was set up in response to insufficient resources applied globally to R&D on diseases that mainly affect developing countries.

The proposals received by the CEWG included patent pools, pooled funds, precompetitive R&D platforms, open sources and access, direct grants to companies in developing countries, and the establishment of an internationally binding instrument. On a legally binding instrument, four developing countries [5] have proposed the negotiations of a biomedical R&D treaty.

The CEWG also recommends the negotiation of a convention for R&D related to Type II and III diseases and to the specific needs for developing countries in Type I diseases.[6] It proposes that the following principles guide the convention: global coordination mechanism, increased public investment, mechanisms for redistributing resources, and the pooling of funds. The CEWG is expected to finalize its report by the first quarter of 2012, which should contain its complete analytical work and a proposal for the establishment of an intergovernmental body and a technical committee to begin the formal negotiations of a convention. Reacting to this proposal, Pascal Lamy, the Director-General of the World Trade Organisation, declared his preference for a non-binding system to regulate R&D financing and coordination.[7]

As the CEWG has not concluded its final report, the EB is to consider the progress report of the Group only and no concrete steps are expected until the final report is available. The creation of working groups for a possible treaty will wait until then. However, a number of delegations favouring strong measures on this agenda item are likely to lend their political support to the process; indeed,

developing countries are expected to defend a binding instrument for R&D financing and coordination.

NONCOMMUNICABLE DISEASES

Under agenda item 6.1, the EB will discuss a series of actions on prevention and control of noncommunicable diseases. The outcomes of the United Nations High Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and the First Ministerial Conference on Health Lifestyles and Noncommunicable Disease Control will be discussed. The WHO DG has submitted a report on each of the meetings to the EB's consideration.

The Board will also consider the progress regarding the implementation of the Global Strategy for the Prevention and Control of Noncommunicable diseases and the Action Plan. The DG is mandated, by resolution WHA61.14, to report every two years to the Health Assembly through the Board on this strategy.

In the January 2012 session, it is likely that the host countries of the NCD summits will table a resolution proposing that the EB follow-up on the relevant declarations, recommend that the WHA adopt them and incorporate the contents in the WHO's work, or request the DG to take appropriate measures to implement the declarations. Given the technical nature of the EB discussions, it is possible that, within the NCDs, some priority is given to this issue, in terms of diseases or means to tackle the challenges. No delegation has appeared to present proposals for specific targets or the creation of a funding mechanism. The latter matters, of a more political nature, are more likely to be discussed during the 65th WHA meeting in May 2012.

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