Health for All Now!
People's Health Movement

PHM daily briefing of the WHO 152 EB Meeting: Day 7 (February 6, 2023)
Report prepared by PHM's WHO Watch team

MORNING Session

The meeting started with discussion on agenda item **23.1 Matters emanating from the Working Group on Sustainable Financing: • Report of the Agile Member States Task Group on Strengthening WHO Budgetary, Programmatic and Financing Governance (Documents EB152/33, EB152/33 Add.1 and EB152/33 Add.2), • Secretariat implementation plan on reform (Documents EB152/34 and EB152/34 Add.1), • Sustainable financing: feasibility of a replenishment mechanism, including options for consideration (Document EB152/35)**. *The Chair* began the session by requesting members to avoid repeating any contributions that had already been made and to make focused contributions, so that the meeting could proceed through the heavy agenda before it. The chair of the PBAC read out the report, which highlighted that: **PBAC recommended the EB to note the report EB152/33 and adopt EB152/33 addendum 1**. *The AFRO region* asked WHO to ensure higher levels of allocation to regional and country offices. They were delighted to see high-level indicators in document 34 and added that objective 3 should be expanded and revised to increase the ability to exercise oversight of WHO HQ. Regarding Replenishment Mechanisms (RM), they thought it had been made clear in document 35, and so they were **in favour for the RM to be established before further deliberation**. *Russia* thought that PBAC as a body was not highly effective and that MS were not given an opportunity to thoroughly consider important issues. They **proposed that PBAC revised its working methods**. They questioned how MS were supposed to agree on increased assessed contributions (AC) without understanding how their money was spent. Regarding implementation plan, they **asked the Secretariat to share risk assessment with MS in the future and to focus on fighting fraud and corruption in the organisation, not only sexual harassment**. *Peru* echoed similar sentiment, adding that it was necessary to **elaborate on plans and present them in a way that was clear for MS** so that **MS could analyse them clearly and implement them properly**. They supported the RM proposal and hoped it would continue to work on the basis of the 6 guiding principles. *Botswana*, with regard to sustainable financing, expressed support for **incremental increases in AC, increased flexibility of voluntary contribution (VC)**. They added that MS must be consulted with MS, taking into consideration the FENSA. *The USA* added that **RM should be entirely voluntary** and that MS or **donors should be able to decide on long-term or short-term commitments**. *Colombia* said that **guidelines regarding allocation of voluntary contributions (VC) would be helpful** for sustainability of WHO without putting more pressure on the AC. They asked WHO to consider the continuing economic impact of Covid19 on countries when developing financing mechanisms. *Syria* thanked concerns for the earthquake and called on others' conscience in supporting the country, especially with regard to **blockades which had made disasters difficult to deal with**. *Maldives* called

for streamlining implementation. They requested **more accountability and transparency by WHO** going forward. *Australia* looked forward to considering specific reform proposals and was pleased to hear the plan would be a living document. They also **welcomed reforms to reconsider the structure of governing body meetings** to ensure they are effective and **supported sustainability of financing reforms, including in increasing AC**. *Namibia* said that reallocation of resources to countries and regions was a matter of urgency for the country. They supported the AFRO region call to **increase the budget allocations to countries and regional offices in programme budget 2024-5**. Regarding RM, they asked for **prioritising flexible funding and for it to cover the entire GPW period**, adding that the funding envelope for **RM should be on the base section of the budget**. *Germany* echoed the same sentiment. *Thailand* asked WHO to **ensure RM funds were not earmarked** and had high flexibility to be allocated to base programmes and other urgent needs. They reminded MS that WHO funding could not fill all countries' health budgets and called on **WHO to use its political, social and intellectual capital to organise MS and partners to fully finance health budgets**, adding that WHO could play an important role in encouraging MS to address political interference by industry. The same sentiment was echoed by *South Africa*.
Raoul Thomas clarified that on reporting, the Secretariat would **report through PBAC, EB, WHA and also intersessional sessions** consisting of deep-dives on a topic by topic basis. On prioritisation, he ensured that it should be a prioritisation of MS, as part of a consultative process. He informed us that **MS portal was up and password protected**. On coordination, he believed close coordination between Secretariat and MS was necessary. The portal was supposed to report on both dimensions. Regarding financing and budget, he confirmed that country allocation had been increasing but insisted that **increasing a ceiling alone would not address our problems**. *Bruce Elward* added he heard what had been said regarding RM and looking forward to consulting with MS. It's a big new direction for the organisation. They were committed to have intersessional sessions for more detailed discussions. They noted the emphasis of **ensuring those under earmarked contributions were directed in the right manner**, etc. *The Chair* asked EB to adopt the draft decision and as amended by Slovak representatives. Legal team read out the **2 specific amendments**. The (1) is in operative paragraph 1, there was an addition. The full sentence would read: **" to support the efforts of the task group co facilitators and the chair of the executive board, in consultation with member states"**. And (2) under operative paragraph 2, **"to request the task group co facilitators for consideration of the EB153 session in May 2023"**. Added with **",in collaboration with the Chair of the EB, former and in consultation with member states"**. The report was then noted and a draft decision adopted. *The Chair* concluded the session.

On Governance matters agenda item **23.2 Global strategies and plans of action that are scheduled to expire within one year: • WHO global action plan on promoting the health of refugees and migrants, 2019–2023 (Documents EB152/36, EB152/CONF./8 and EB152/CONF./8 Add.1) • WHO traditional medicine strategy 2014–2023 (Documents EB152/37, EB152/CONF./9 and EB152/CONF./9 Add.1)**. With regard to the health of refugees and migrants (R&M), *Canada*

wanted to underscore equity at the heart of the efforts, meaning to **recognise the specific needs of vulnerable and marginalised people, women and girls**, especially if they were displaced and needing humanitarian assistance. They emphasised the need to **advance access to services for all LGBTQI+ community** who experienced specific forms of marginalisation. They supported extension and noted progress, but urged **WHO to step up attention on priorities in action plans, particularly those neglected during the pandemic**. *Brazil* also supported extending action plans and suggested that health support should include **special support of migrants and refugees belonging to indigenous communitie**s. They welcomed the inclusion of traditional medicine in health interventions, noting the contribution it had shown in achieving UHC. They emphasised that indigenous peoples had the **right to preserve their minerals and plants** which were fundamentals to their traditional medicines. The same sentiment was echoed by *Colombia* later on. *Malaysia* supported the global action plan on R&M and supported traditional medicine and contributions to UHC. They appreciated WHO guidance in professionalising traditional medicine but asked for **more attention on how to integrate it into the health system**, especially in relation to workforce, financing, etc, adding that these should be included in the renewed plan. *The USA* co-sponsored recommendation to extend the R & M action plan and stressed the importance of coordination with other UN and humanitarian agencies. They added that, with regard to traditional medicine, it was: important to ensure scientific rigour in studying their safety. *France* and *Peru* also supported the extension of the R & M program. *India, on behalf of the SEARO region*, stated that traditional and complementary medicines were extensively used by many MS, therefore MS should **promote safety, quality and affordability** of traditional medicine which could be done by **integrating traditional medicine into UHC and PHC, as well as developing regulatory frameworks** for traditional medicine and practitioners. They asked WHO to support MS in developing traditional medicine strategies in achieving H4A. *Peru* suggested the development of **databases on R&M**, not for surveillance but to plan in order to deliver on health needs. They added that health systems were already at a breaking point in Peru post-pandemic, so to service an additional population of R&M required expansion of public health systems as well as financing. *Rwanda* appreciated the report & Secretariat's efforts to address specific needs of R&M in the African region. They said that a renewed global action plan would contribute to sustaining these efforts. They also recommended **integrating R&M health into regional and national initiatives**. With regard to traditional medicine, they thought there were still gaps, therefore WHO needed to support R&D to generate evidence to ensure safety, efficacy and quality of traditional medicine. *India* proposed to take steps in developing guidelines on traditional medicine. They would harness traditional medicine for preventative, geriatric, palliative, and NCDs care. *Yemen* admitted that they were struggling to care for R&M. They asked WHO to do more at regional and country levels. They needed support for hospitals, health centres, and all kinds of clinics now providing to migrants. *Botswana* proposed to **leverage IP potential and knowledge of traditional medicine in keeping with IPR under TRIPS by partnering with WTO, WIPO and private sector**. They supported the extension of the R&M health action plan and co-sponsored it. *Portugal* supported extension of R&M health and requested to

ensure non-discriminatory access including address language barriers. No new comment was brought forward. The draft decisions were adopted.

Afternoon Session

Item 25.1
The session after lunch started with the EB welcoming the new regional director for the Americas, Dr. Barbosa, who was in attendance. The DG and regional directors all made interventions expressing support for Dr Barbosa. Haiti on behalf of AMRO expressed appreciation for the incoming RDs insistence on promoting equitable access to Covid-19 countermeasures during the pandemic, and indicated that his expertise in managing health emergencies would be a valuable resource during the INB and IHR revisions negotiations. The EB also said farewell to the outgoing regional director for the Americas and wished her well. The incoming regional director emphasised that his focus would be on orienting primary health care interventions to address the epidemiological scenario that the region is facing, addressing health promotion, prevention and surveillance and control of non communicable diseases, providing care for mental health at the primary level, and accelerating the elimination of communicable diseases. He also mentioned his commitment to gender equity and to creating a zero tolerance environment for sexual harassment.

Item 23.2
Global strategies and plans of action that are scheduled to expire within one year

- **WHO global action plan on promoting the health of refugees and migrants, 2019–2023 (EB152/36)**
- **WHO traditional medicine strategy: 2014–2023 (EB152/37)**

WHO global action plan on promoting the health of refugees and migrants, 2019–2023 (EB152/36)

During the EB discussion on the global action plan on promoting the health of refugees and migrants all countries expressed support for protecting and promoting the rights of migrants. In its opening intervention

Many countries gave examples of the efforts they were making to honour this sub-populations right to health. *Uruguay* noted that refugees and migrants continue to be among the most vulnerable members

of society, are often exposed to xenophobia, discrimination, poor living working conditions, and they have inadequate access to health services with frequent physical and mental health problems. It mentioned that the WHO's health and migration programme had allowed it to take a more systematic approach to managing migrants' health, and that the country was now shifting from focusing on giving migrants access to Covid-19 vaccines toward more long term vision for realising refugee and migrant health.

However, many countries indicated the strain they were experiencing as a result of their efforts to provide inclusive and appropriate healthcare to migrants and refugees, and to particularly vulnerable sub-groups within this population. *Poland* mentioned that it had received a huge influx of refugees and migrants due to the war in Ukraine and were willing to share their experiences in order to contribute to global responses to the health needs of refugees. These included adopting a special act which allowed migrants free access to UHC and interventions aimed at facilitating the refugee community's understanding of how to access health care services. *Iran* pointed out that despite international sanctions, it continues to give migrants and refugees access to health services by giving refugees the option to enrol in national health insurance for essential secondary and tertiary public health services. It specified that any support by international organizations and other relevant stakeholders should be in line with national healthcare laws, policies and plans of host countries.

As evidence of its support for the global action plan, EMRO reported that its members had endorsed a new regional strategy to promote the health and well being of refugees, migrants and other displaced populations in October 2022 and indicated that Member states of the European region are currently consulting on a new regional action plan for possible endorsement in October 2023.

Uruguay noted that any future implementation of the global action plan should take into account the views and needs of those directly involved based on the principles of solidarity and equity and health as a right.

In its reply to countries *the Secretariat* mentioned that the extension of the global action plan to 2030 will allow WHO to continue to pursue strategic and structured work on refugee and migrant health, and ensure alignment with international frameworks. It would also enable it to provide technical assistance to countries in addressing the root causes of disease, create the conditions for good health and wellbeing for all, and reorient health systems with a primary health care approach to include integrated and inclusive health services and programs for refugees and migrants.

It stated that WHO will also continue to raise public awareness about the health of refugees and migrants and promote high quality research and information and build the capacity to support evidence informed policies and actions. It also pointed out that it would take into account the

countries' comments regarding the special attention and consideration that should be given to the needs of women and girls, and indigenous populations.

WHO traditional medicine strategy: 2014–2023 (EB152/37)

Many states supported the traditional medicines strategy and asked for WHO's support in incorporating the use of traditional medicines in the formal health system, with a view to achieving UHC targets. *Turkey* argued that the accessibility and affordability aspects of traditional and complementary medicines made them a potentially important component of achieving UHC and requested WHO support by giving technical guidance on how to go about integrating these medicines.

Singapore called for the strategy to include robust, **well designed clinical trials** that will help to strengthen the evidence base to assess the efficacy of traditional forms of medicine. It pointed out that a clinical trials registry for such trials, and open sharing of their results will be helpful to coordinate global efforts. Second, it asked that the **global strategy should encourage greater cooperation and knowledge sharing between member states and different traditions of traditional medicine or methods of traditional medicine treatment** and best practices that could upgrade skills or traditional medicine practitioners.

In its response to country comments the Secretariat specified that the WHO Global Centre for traditional measure would be to review and evaluate the scientific evidence and data for traditional medicine so that this could play a role in updating the global strategy. It also noted the issue of **active collaboration with indigenous knowledge and practices** and their links with the One Health approach. It indicated that there is ongoing work happening with member states on this, including with the WHO environmental health colleagues in relation to the Convention on Biodiversity. The Secretariat also spoke to the need to integrate its work on traditional medicines with that of other agencies, e.g. WIPO and WTO, especially in order to secure IPR for indigenous communities. In closing it noted that WHO will host the first traditional medicine summit in August 2023, which will be co hosted with the Government of India alongside the G20. The summit will focus on the latest evidence and data from all regions to inform the development of the new global traditional medicine strategy.

At the end of the discussion the EB noted both reports.

Agenda Item 23.3
WHO reform: Involvement of non-State actors in WHO's governing bodies (EB152/38)

India opened the discussion by requesting that NSAs should adhere to the regulations and norms provided by WHO to promote transparency and accountability in governing body meetings. It argued that **data sharing with any NSA should not be done without specifically securing the consent of the affected WHO member state.**

Several countries made inputs on the **issue of constituency statements**. The *AFRO* region commended the Secretariat's efforts to implement the decision to improve engagement with NSAs by giving them the opportunity to make group statements and have informal engagements with member states and the secretariat. It suggested that the practice of constituency statements be continued. However the **AFRO region noted the modalities in the report were still being piloted by the Secretariat and that it would look forward to feedback on the outcome of this experiment for decision-making at EB155.** Similarly, *Canada* suggested the practice should continue but proposed language that would ensure that the secretariat would on a regular basis survey NSAs and member states on their views on the continued effectiveness of constituency statements. It suggested that the EB should report back on this at its 156th meeting. The *UK, Peru, and Colombia* supported the Canadian proposal, with Colombia stating that It is particularly important that grassroots organizations be properly taken into account. It called on WHO to innovate and consider using remerge technology so as to guarantee the broadest level of participation possible. In closing it reminded the meeting thay **"What we don't want is for the participation just to focus on this one or two organizations which have the necessary influence and resources to be able to participate".** It proposed that the WHO consult on the new modalities and report back at EB154. *Bangladesh* proposed that the matter of constituency statements be referred to WHA76 for discussion.

India suggested that **constituency statements delivered by NSAs should be strictly focused on technical issues** and should be directly relevant to the agenda item. It specified that the work of NSAs should contribute significantly to the advancement of public health. It also said there is a need for stronger monitoring and evaluation of the performance of NSAs. *Canada* supported the continued use of constituency statements but also stated that they were **glad to see that NSAs will continue to have the option to deliver individual statements** should they not wish to join a constituency statement, as this would ensure that member states can benefit from a diversity of views amongst NSA.

Oman on behalf of EMRO requested that WHO go back to its standard practice of **accommodating statements of observer states, which includes Palestine**. It stipulated that WHO as a member state organisation should give equal consideration to Palestine as a member of the region. It also acknowledged the role of NSAs, whose participation and inclusion it pointed out "has always been always considered in our methods of work".

Ghana on behalf of AFRO also encouraged the Secretariat to **continue to organise informal pre-meetings with NSAs in official relations by WHO.** *Denmark on behalf of the Nordic and Baltic*

countries stated that governing body meetings were necessary but not sufficient for achieving active engagement with NSAs. it supported the idea of formal Health Assembly and EB pre-meetings with NSAs, including at the national level.

Some countries **suggested new modalities of engagement**. *India* said that besides improving the participation of NSAs in official relations with WHO governing bodies, WHO could also **engage with NSAs to implement health programs at country level**, making outreach to remote areas and population possible. *Slovenia* affirmed the importance of CSO presence at governing body meetings but also emphasised that it would be important to have their **feedback during the intersessional period,** a sentiment echoed by *Russia*. It also mentioned that CSOs could play a role at national level by assisting countries with policy implementation.

The ***USA*** **proposed considering additional ad hoc measures, such as opportunities to have contact with constituents in meetings on site, pre-meeting consultations, web based discussions**, and many of the different strategies and tactics that we've discussed as the board informally and that the Secretariat has been considering. Peru also emphasised that **pre-meetings in the run up to a governing body meetings could contribute to countries hearing the substantive contributions that NSAs have to make well ahead of the formal meeting.**

The USA also **noted that NSAs include philanthropic foundations, academia, civil society and advocacy groups as well as the private sector and it's impression was that none of these constituencies really felt FENSA has fully enabled their ability to engage with WHO**, including during the pandemic. It closed by calling on WHO and member states to make efforts to remove barriers faced by stakeholders across the spectrum of NSAs, including during the Governing Body process.

In its response to contributions from the floor the Secretariat indicated that it felt the constituency statements allowed NSAs to have a more concentrated impact while stuff allowing for an efficient meeting, that it was open to consulting NSAs about the items to be opened for constituency statements, and apologised for the lack of physical space for NSAs in the meeting room (blaming this to the space constraints of the new building). At the end of its comments, the secretariat affirmed the importance of hearing diverse NSA voices and that it in no way intended to limit these.

At the end of the discussion the EB noted the report. The chair decided to defer the question of adopting the decision since new amendments had been proposed.

Item 23.4

Engagement with non-State actors: Report on the implementation of the Framework of Engagement with Non-State Actors (EB152/39)

The *PBAC* chair first took the floor on this item asking EB members to note the report and to consider adopting the decision in EB152/40.

The *USA* made the first intervention and asked for additional information on how WHO **tracks and compares NSA engagement across the organization, including regional offices and where to improve areas of outreach.** It also noted that the FENSA of proposal Review Committee held meetings to discuss cases that required senior management guidance, and requested the secretariat to explain how many cases were discussed in 2022, and what types of cases required that guidance. The USA again noted that there's still seems to be **significant problems with implementation of FENSA**.

Ethiopia cautioned that **having adequate capacity at regional and country level is key to ensuring quality due diligence on engagement with NSAs in order to avoid potential risks associated with such engagements**, including conflict of interest, sexual exploitation, abuse and harassment and other potential risks. It also stated that **having adequate capacity at regional and country level is key to ensuring quality due diligence on engagement with NSAs** in order to avoid potential risks associated with such engagements, including conflict of interest, sexual exploitation, abuse and harassment and other potential risks.

China argued that relevant decision making in WHO should be led by Member States and stated that **NSAs are not suitable to participate in WHO decision making.** It also stated **WHO should strengthen its supervision review and follow up of the NSA with official relations** with WHO to ensure that they are consistent with the spirit and principles of relevant debates or resolutions.

At the end of the discussion the report on item 23.4 was noted by the EB.

Item 23.5
Provisional agenda of the Seventy-sixth World Health Assembly (EB152/41)
Item 22
Update on the Infrastructure Fund: Geneva buildings renovation strategy (EB152/32)

One of the key issues discussed under this agenda item was whether the EB should consider electronic voting in future meetings. Senegal on behalf of AFRO stated that it **approves the use of the fund for the financing of renovation to the main building**. It also **endorsed the draft relating to adoption of an electronic voting system by WHO governing bodies**. However, the Africa region **emphasized the need to be sure that safety is guaranteed throughout the process before this is actually adopted.** It invited the EB to take into account **respect for modern energy** performanc, and

also additional requirements for persons with disabilities in implementing all of these project Maldives also emphasisd ensuring the security of an electronic voting system, and making provisions for people with disabilities.

France indicated that it is **not in principle opposed to electronic voting**. However, it recalled that the **general rule remains in person meetings**, and therefore that it's not desirable for votes to be taken remotely. It recommended that **electronic voting should not be any kind of substitute for the search for a consensus acceptable tool.** *Brazil* also called for consensus-based decision making to remain at the heart of WHO as a multilateral institution. It noted that electronic voting might increase conflict between delegations and expressed regret that there seemed to be an emerging turn to voting at EB. The *UK* noted that the EB **is by its nature, a more dynamic and interactive forum and with a smaller number of member states.** It therefore felt that **the efficiency arguments for an electronic voting system are less obvious in the context of the EB.** *China* too expressed concern about the practice of voting on technical issues, rather than settling them by consensus. It indicated that the Secretariat should **consider both the convenience and reliability of electronic voting, as well as its impact on member states' decision-making before making a final decision**. The Maldives called for provisions that would **allow for manual voting should member states wish to utilize** this option.

In its response, the Secretariat acknowledged the comments and undertook to do a financial and risk analysis on the issue and report back to the Board. The discussion concluded by the EB adopting the provisional agenda of WHA76 and the draft decision in EB152/42.

Agenda 12.1 (continued)

Resumption of discussion on the second and third bullet under item 12.1: Strengthening who preparedness for and response to health emergencies

The Board next resumed its discussion on Agenda item 12.1, i.e. strengthening clinical trials to provide high quality evidence on health interventions and to improve research quality; and coordination and proportional division of funds for the partnership contribution of the pandemic influenza preparedness framework for the sharing of influenza viruses and access to vaccines and other benefits.

Yemen made the first intervention and on behalf of its **region expressed appreciation for the framework and for the partnership contribution** and investments made in countries which have a need for external resources as it was helpful in building the essential capacities mentioned in the International Health Regulations. It recommended that the DG **temporarily amends the division of funds** because of the need to respond effectively to emergency situations. *Korea* echoed these sentiments on both sub-items. *Japan* agreed to the proposed split in the PIP funding but requested for the purposes

of accountability that the **DG report to the EB and the Standing Committee on HEPRR, and also inform the contributors on the temporary change.**

Japan further stated that if the scope of the pathogens covered by the PIP framework was going to be expanded beyond influenza viruses, or if an increase in contributions was going to be considered. Japan would like to **request the Secretariat to continue to share information frequently on the PIP framework, not only with member states but also the other entities concerned, including manufacturers.**

On the issue of clinical trials, *Colombia* called for the results of clinical trials to be given on a transparent basis, and for trials to take include special populations that might require special treatment strategies. It advocated for **communities and patients to be at the center of clinical trials and research and therefore be the first to benefit from the technology or drugs being evaluated.** It also stated that barriers to building local capacity for research and clinical trials should be dismantled, and called for these processes to strengthen health sovereignty and health equity. *Argentina* called for clinical trials to be supplemented by **studies to evaluate the economic and budgetary impact** of interventions, which is important to ensure interventions are sustainable from a financial and programmatic point of view.

Norway expressed support for the proposal to undertake a mapping of national infrastructures, and proposed that in order to do this the Secretariat could develop a standardized survey and invite both countries and international clinical trial networks to participate. It further recommended that **in order to include Primary Health Care levels, professional societies could be also invited to participate in the mapping exercise.** It also pointed out that in order to break down silos between clinical trials and implementation in clinical practice the Secretariat should **consider expanding the current mapping in order to form a more complete overview but should do this without making the exercise resource consuming.**

During the NSA interventions, the *IFPMA* argued against proposed modifications of the PIP Framework,

> "As a long-standing partner of the PIP Framework, industry is highly concerned about the recommendation by the PIP Advisory Group to the WHO DG to expand the Framework to include seasonal influenza viruses and to take this discussion to Member States. Industry strongly opposes this expansion as it would 1) not help improve influenza pandemic preparedness and response nor strengthen GISRS, the main mandate of PIP, 2) not effectively address the ABS challenges it aims to improve, and 3) negatively impact rapid development, manufacturing, and delivery of seasonal influenza vaccines. Moreover, this would mean a third negotiation process in parallel to the INB and IHR discussions. Industry also notes the PIP

> Framework should not be considered an ABS model for the Pandemic Accord as its transactional nature, among others, is not fit-for-purpose for rapid pandemic response."

In contrast, *MSF* argued for equity to be given more consideration in WHO"s discussion on clinical trials,

> "The WHO report on clinical trials outlines some of the challenges of generating clinical evidence. However, it fails to embed access considerations in its core. There is a need for access conditions and principles, and transparency of clinical trial data and costs, as highlighted by Member States at the intergovernmental negotiating body (INB) and the International Health Regulations (IHR) Review Committee, to enable access to technologies and know-how. Equally, a comprehensive system of access and benefit sharing for clinical trials is needed to facilitate timely sharing of pathogens and genomic sequences. These aspects should be central both in the best practices document to be developed by the WHO Secretariat, mandated by the WHA Clinical Trial Resolution, as well as the self-assessment tool that needs to be designed with broad participation and representation, particularly from LMICs, to improve clinical trial design across settings.

[close of afternoon session, before reconvening for evening session]

Evening session: 6.00 to 7.00 pm

Agenda 12.1 (continued)

Resumption of discussion on the second and third bullet under item 12.1: Strengthening who preparedness for and response to health emergencies

Japan proposes a revised language that aligns with the PIP framework after a consultation with the legal dept and the PIP framework secretary. The proposal is for section 6.14.6. After the word "shall", proposes to all "promptly". After "Member States", add "manufacturers and other stakeholders." Mike Rayn confirms that it's in line with the PIP framework.

"To provide decided; that in order to ensure that the proportional division does not hinder the necessary response measures during pandemic influenza emergencies the director general shall continue to be able to modify temporarily the allocation of partnership contribution resources as required to respond to such emergencies and that the director general shall promptly report on any such modifications to member states and manufacturers and other stakeholders."

John (secretariat) responds to the clinical trial resolution. MS mention about the work needed to improve their own clinical trials capacities. Sometimes only 1 MS is involved in CTs. But more often, these are multi-country endeavours. The efforts put during Covid-19 should continue during normal period too. Secretariat noted the request of mapping of the baseline of CT ecosystem. This is a deeper plan. Also desire for high-quality multi-country CTs.

Mike Rayn responding to CTs issue: WHO's open platform was funded by PIP. So, PIP benefits are building for everybody. It's a challenge to bring experimental stuff to the market during emergency. PIP received 250 million dollars in the last years for supporting preparedness. This led to things like massive expansions of GISRS around the world to support surveillance, laboratory, training, equipment supplies etc. 7.5 million people trained around the world during Covid-19, 49 courses on Covid alone in 69 languages. This was wholly funded by PIP.

No plan to review PIP right now.

Chair: Reports contained in EB 152/13 and EB 152/14 are noted. Amended decision adopted. 12.1 done.

19. Behavioural Sciences for better health

Malaysia brought a resolution on this issue. It has many co-sponsors. While some member states support it fully, quite a few spoke in favour of making it a much broader topic which will include SDH, mental health etc.

Canada: Advocates behavioural science as a multi-disciplinary approach. Was helpful during Covid-19. BS can be applied to antimicrobial stewardship, mental health and public health.

India: BS can help in individual, organizational and community change towards seeking health services. Health promotional aspects are a part of addressing NCDs etc. India used this during Covid-19 too. Setting standards in BS and proper training can help. More research and capacity building is needed.

China: Support Malaysia's resolution to use BS for public health needs. Healthy behaviours cannot be separated from healthy environment and safe water and sanitation. China is concerned about Japan's recent announcement that it will release nuclear contamination from Fukushima nuclear plant into the ocean. This is very irresponsible.

Peru: Multidisciplinary approach needed. There should be a team with knowledge and experience in public health which includes psychologists, teachers specialising in adult education, anthropologists, sociologists, among others.

Maldives: SDH should be a part.

Uruguay: Published an article in November 2021 in the WHO Bulletin describing the country's initiative to improve health using behavioural science. The article described the work of socio-economic and behaviour laboratory and Uruguay's experience during Covid-19. The laboratory was created to producing and disseminating the knowledge regarding the behavioural dynamics, socio-economic impacts and mental health effects of Covid-19 on the Uruguayan population.

Singapore: There should be PPP in the field. Strongly supports digital health technologies. An example is smart nudges. Worked with Apple to create a tech-enabled integrated health journey to create personalised challenges and financial rewards for participants who engaged in sustained healthy behaviours. Health authorities collected data which is otherwise not easily available.

WHO secretariat, John Reader: The idea is to create a methodologically high quality sound science of behavioural science. Covid-19 has highlighted the need for behavioural as well as biomedical interventions. Behaviours are driven by the environments within which people make choices, not just the focus on individuals. BS must be context specific, so regional offices must adapt the evidence tools and lessons learnt according to specific contexts. Need to build capacity of the health workforce. We will use the WHO Academy to strengthen capacity in this space.

Tedros: There was a concept note on BS and the work is based on that. We also have a technical advisory group.

Chair: The report 152/25 is noted

152/conference paper 6: decision is adopted

Item 19 concluded.

Item 23.3 Involvement of NSAs in WHO Governing Bodies Document 152/38:

Oman and Canada proposals can be accommodated in the decision points.

Japan responded to China's statement on Fukushima's nuclear waste going into the sea: Japan is doing everything within international law.

China responds: There's too much contamination and it will continue for the next 30 years. Our future generations' health is at risk.

Japan responds again. Same points.

China responds. Similar points.