Health for All Now!
People's Health Movement

PHM daily briefing of the WHO 152 EB Meeting: Day 3 (February 1, 2023)

Report prepared by WHO Watch, PHM

There was a tumultuous start of the day when NSAs were not allowed into the overflow room as confidential discussions by the European region did not finish on time and the EB proceedings had already started. As a result, civil society missed some essential discussions on item 12.1.

Continuing previous day discussion on agenda item **12.1 Strengthening WHO preparedness for and response to health emergencies – Strengthening the global architecture for health emergency preparedness, response and resilience (EB152/12)**, Observers and NSAs read their individual statements. Then AFRO RD underlined that initiatives have to consider the critical role of PHC and UHC. *Palestine* encouraged **transparency and equity as criterias** to select work and *Iran* speaks of the **importance of having an inclusive discussion** on these matters. Responding to statements *Dr. Michael Ryan*, Executive Director of WHO's Health Emergencies Programme, said that Global Health Security begins from bottom - up with an **agile clinical system that could be scaled up**, **connected with financing and governance.** He maintained that the global architecture of HEPRR was not about trickle-down systems. *DG Dr. Tedros* affirmed that **the proposal was not meant to go ahead of INB and IHR discussions.** He was using the momentum of the many reports produced assessing failures of Covid-19 so that when the INB and IHR discussions conclude, the plan for global architecture of HEPRR would be ready to start.

Moving on to agenda item **24.3 Standing Committee on Health Emergency Prevention, Preparedness and Response Documents (EB152/45, EB152/54 and EB152/54 Add.1)**. The Standing Committee (SC) discussed the misalignment between the terms of membership of the Standing Committee, because of the timing of nominations in December, vis-à-vis the normal cycle of committee membership that usually aligns with the Health Assembly schedule. Two options were presented (for more details see document EB152/54): 1. to **extend** the current terms of **3 members of the SC until the closure of WHA78 (2025)** and to **extend** the current terms of the **Chair and Vice-Chair of the SC until the closure of WHA77 (2024)**; 2. to **shorten** the current terms of the **3 members of the SC to expire at the closure of WHA77 (2024)** and to **shorten** the current terms of the **Chair and Vice-Chair of the SC to expire at the closure of WHA76 (2023)**. *Rwanda, Paraguay, Peru, US, EU, Brazil, Japan, Maldives, Yemen, Malaysia, UK, China, Colombia, Norway, Singapore* chose **option 1** because it ensures consistency with the committee's cycle every year, but also maintains a balance between continuity of the committee and the regular rotation of members among the MS. *The EU added* that SC should establish links with other bodies including the One Health high level expert panel and the quadripartite alliance to ensure a fully operational One Health approach. **Option 2** was considered the most appropriate by the *Russian Federation* and **asked for an actual voting procedure**. After some deliberation, the session was postponed until after lunch. The voting was done in the afternoon session and

Option 1 was adopted with an amendment that **some members were given an additional 6 months to their terms.**

Agenda item **5. Universal health coverage (UHC) •** Reorienting health systems to primary health care as a resilient foundation for universal health coverage and preparations for a high-level meeting of the United Nations General Assembly on universal health coverage (EB152/5, EB152/CONF./3, EB152/CONF./3 Add.1, EB152/CONF./4, EB152/CONF./4 Add.1, EB152/CONF./7, EB152/CONF./7 Add.1, EB152/CONF./10 and EB152/CONF./10 Add.1 Programme of Work No.2). There was a **general agreement of the importance of PHC to achieve UHC.** *The EU* opened by stating that "Primary Health Care (PHC) is the first line of defence against epidemics and pandemics". *Botswana* committed to UHC for health for all, while the *Russian Federation* reminded everyone that The **ALMA ATA Declaration was still relevant to guide us towards UHC**. *Slovenia* emphasised social participation and civil society involvement. There were some comments regarding **access to medicines and care.** *The Netherlands* pointed out a growing gap in access to medicine between poor and rich. The *47 MS African Regio*n asked **technological and financial support** to develop and help countries to achieve UHC and elaborate national services. *The EU* affirmed that **social determinants** should be considered a priority. Social protection should guarantee that everyone should access health systems without a catastrophic out of pocket spending (OOP). *Timor Leste* on behalf of the *SEARO Region* stated that **revitalising PHC will require resources and financing** with regard to workforce and medical supplies and proposed that 'unmet need' be included as an indicator to measure UHC. *Korea* emphasised the usefulness of **data and information systems** and *Maldives* asked to be supported in establishing it. *The USA* mentioned the importance of access to medicine to vulnerable and marginalised communities. *The Syrian Republic* protested that their inputs regarding diagnostics were not taken into account in the proposal. **Shortages of health professionals** were mentioned. *The Netherlands* stated the need for more community nurses. *47 MS African Region* wanted to use reorientation towards PHC to become the foundation of health security and health system. Financing was also emphasised. *Brazil* stressed the need to strengthen international cooperation for financing. *Yemen* stated the need for a common funding system which could come from MS or partners. *France* championed multilateral funds.

Afternoon session

Programme of work

The afternoon session started with MS agreeing to a decision on Item 24.3, where Option 1 (with some amendments) was adopted. After this the discussion moved back to Agenda Item 5 on UHC, which was concluded. The chair then opened the discussion of Item 6. This was not concluded and at the end of the day the item was suspended until the evening of Day 4 (Thursday 2 February).

The fourth day of the EB will stretch from 10am - 9pm, and the chair specified that the agenda items to be covered first are **Infection Prevention and Control (9), Global road map on defeating meningitis by 2030 (10), Standardization of medical devices nomenclature (11).**

5.Universal Health Coverage
Reorienting health systems to primary health care as a resilient foundation for universal health coverage and preparations for a high-level meeting of the United Nations General Assembly on universal health coverage (EB152/5)

All member states expressed concern about the lack of progress on achieving the UHC-related SDGs. Many noted that the Covid-19 pandemic only deepened the slow progress that had been made on this front before the pandemic. Many developing countries again mentioned that stronger health systems were a national priority, and that any resources for strengthening health systems should be used to strengthen primary health care provision. In particular MS mentioned the need to improve health infrastructure (including but not limited to disease surveillance infrastructures). Zambia called on WHO to strengthen national plans to achieve UHC, to prioritise equity in WHO budget allocation, and to allocate budget where the need is greatest.

The DG in his comments framed PHC, which is one component of UHC, as a priority for developed and developing countries alike, if they wanted to ensure their health security terms. He described primary health care as the "ears and eyes" of health systems, and therefore as essential to the prevention, early detection and response to outbreaks in all countries. The DG noted that weak investment in PHC made even rich countries vulnerable to the Covid pandemic.

Many developing states also pointed to the need to expand the numbers and improve the training of the health workforce, with Haiti noting that developing countries faced the problem of brain drain, which amounted to a "waste" of their "resources". In their comments to the Board the Assistant DG pointed out that they were supporting countries in implementing WHO Global Code of Practice on the International Recruitment of Health Personnel. The DG in his comments to the Board framed the issue as a supply and demand mismatch that, in the context of global shortages of health workers, led to health workers migrating to wealthier markets. He proposed that the world should "come together" to train more health workers, describing an increase in the "supply" of health workers as something that could address their shortage to developing countries.

The legacy of the inequitable distribution of Covid-19 prevention, diagnostic and treatment technologies also showed up in the discussion. Decisions aimed at increasing access to medical oxygen and strengthening countries' diagnostics capacity were accepted by the meeting. Eswathini called on WHO to support countries in their goal of achieving equitable access to diagnostics to create guidelines that would facilitate this.

All the other draft decisions submitted under this agenda item were accepted. In summary:

- The board noted the report EB152/5
- Decision EB152/con3 was adopted

- Decision EB152/conf4 was adopted
- Decision EB152/con7 was adopted
- Decision EB152/conf 10 was adopted

Many countries were concerned with rising levels of catastrophic health expenditure, and most saw universal access to some kind of universal health insurance mechanism as an important tool to address this. Norway pointed out that to be successful UHC systems required broader social protections, a prevention orientation, and strong accountability, financial management and political leadership, including ensuring that it remains a priority on the global political agenda.

Poland argued that catastrophic health expenditure should be a priority issue for all governments. As part of addressing this, it called for the unequal relationship between state and buyers on the one hand, and medicines suppliers on the other, to be addressed. It indicated that it would be happy to further discuss fair pricing issues at WHA76. Bangladesh called for the Secretariat to look into how essential health services and other supplies can be delinked from political and commercial interests.

Many countries emphasised that UHC systems should ensure universal access to primary care, with some (like Norway) pointing out that achieving UHC required involvement at the community level. Similarly Haiti argued that unless countries engage in social mobilisation, UHC will remain unattainable, and that vertical care programmes disrupted countries' ability to achieve achieve their primary health care goals.

Argentina emphasised that transparency, solidarity, research and development, and local production are all elements of a fair UHC system. Kenya too called for greater support for regional production and procurement of quality products.Most countries referenced the SDG goals when speaking about UHC, which is understandable given that these are a primary reference point for the documentation on this item. However, the broader structural transformations highlighted by Argentina were typically not mentioned by developed states.

6. Non-communicable Diseases (NCDs)

Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and mental health (EB152/6); Draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases

Most countries expressed concern about the extent of people suffering from NCDs between and within countries. All countries expressed support for recognising mental health as a fifth NCD and integrating it into primary health care. Denmark noted the significant underspending on mental health in comparison to somatic diseases, and called for countries to undertake long-term investments to improve mental health (particularly to children and adolescent) and combat stigma

and discrimination. It also pointed out that there is a need for a stronger evidence base to produce quality research on mental health.

China also made an intervention on the issue of research and evidence-based policy-making when it asked the Secretariat to include it is notes whether its documents contain references to non-English language scientific publications.

In general, many developing countries mentioned the importance of sustainable access to the technologies required to diagnose and treat NCDs, and local production and technology transfer were identified as important mechanisms to achieve this. Botswana for example welcomed the updated appendix the WHO had developed in order to expand the menu of cost-effective interventions countries could pursue. However, it also issued an urgent call for investment in research and development, particularly in LMICs, to enable the development context-specific medical devices for the management of NCDs.

In its intervention Canada asked for further clarification on how the Secretariat plans to integrate the 5 by 5 NCD agenda, including interventions aimed at addressing air pollution, into updates on the Global Action Plan and related documents. Japan noted the report did not contain critical conditions such as gastric and skin cancer, and cautioned against this leading to disinvestment in these areas. It requested that the secretariat recommend interventions on these conditions. Slovakia called for more attention to be paid to childhood obesity and childhood cancer. India called for the development of age-appropriate fitness guidelines, and to promote holistic approaches to managing NCDs, including incorporating traditional medicine into primary health care.