



PHM daily briefing of the WHO 152 EB Meeting: Day 5 (February 3, 2023)
Report prepared by PHM's WHO Watch team

MORNING Session

Agenda Item 14.

Well-being and health promotion (Document [EB152/20](#)).

In this session, the EB was expected to provide guidance on the further development of the draft WHO framework for achieving well-being, particularly in respect of:

- the general approach taken;
- any changes that may be required in the emphasis dedicated to each section, including the implementation and monitoring plan;
- any important omissions.

How to promote wellbeing in situations of crisis

Many countries intervened by pointing out that the WHO's commitment to promoting wellbeing was admirable but complicated by the crisis conditions in which many people currently live. *Afghanistan* pointed out that **the world is experiencing multiple humanitarian crises and protracted conflicts, and that this requires new paradigms that can incorporate wellbeing promotion in humanitarian settings**. It called for the "humanitarian-development-peace nexus" to be developed. Palestine indicated that the Israeli occupation and war has negatively affected Palestinians' health and wellbeing, and that greater access to resources from the global community would enable it to move forward. The chair's comments on this topic at the end of the discussion picked up on the crisis situations many communities are facing, when she pointed out that a major takeaway from the conversation is that many people live in crisis situations where they are simply not able to "choose" wellbeing.

Guidance on doing multi-sectoral collaborations, clarification of terms

Botswana, on behalf of AFRO, opened by emphasizing the environmental, economical, commercial and political determinants required to achieve UHC (The EU made no joint statement on this agenda item). They affirmed that "health and well being is not a cost, it is an investment in our common future". They asked **MS to compliment each other instead of duplicate efforts**. Many countries (*Ghana, Malaysia*) called for WHO to offer **technical guidance and capacity building support for building effective multi-sectoral partnerships** aimed at eliminating SDH inequities. *India* stressed that well-being **interventions should also focus on social protection and welfare systems that address sexual health, nutrition, substance abuse and stress**, while *Germany* emphasised stronger integration of UHC, including sustainable and solidarity based financing, into frameworks aimed at promoting wellbeing. *France* also emphasized a **cross-cutting approach involving all sectors and made repeated references to human rights**. *China* requested a clarification on terms used in the document, requesting that WHO add a glossary to the document to define different terms and explain the linkages between them, e.g. wellbeing, welfare and social health. *Thailand* asked WHO to report

on the role of all stakeholders, within and beyond the health sector, with respect to the implementation of the framework.

Environment, substance abuse

Canada underscored the importance of **integrating environmental risk factors** like air pollution and the climate crisis and their impact on wellbeing, e.g. through climate anxiety. It encouraged the Secretariat to take a **stronger approach for mental health promotion** and paying particular attention to populations with complex mental health and substance use issues. *France* also asked to put more emphasis on mental health as an indicator and a goal. *Germany* welcomed the emphasis on climate change and the biodiversity crisis as determinants of health and wellbeing and suggested that the air pollution crisis also be included in the topic of health promotion. *Canada* further asked for a **clearer articulation of the long-term impact of infectious diseases on wellbeing** such as Covid-19, and its impact in the post-pandemic phase.

Digital health

France advocated for strengthening **digital health technologies as a mechanism for promoting wellbeing** and to ensure that they cover all communities while being adapted to national level and community level circumstances. *Brazil* called for WHO to address persistent challenges with digitalisation in its intervention.

Building collective understanding

Peru mentioned that **elections were an opportunity to build awareness on health promotion and long term consensus on health policy**. They also called on governments to focus on children who have experienced violence, and to include family care and guidance in the rehabilitation process. *Malaysia* called for countries to **move away from health awareness to health ownership**, and the importance of countries to adopt a whole-of-government approach in promoting wellbeing. *Finland* argued that interventions at the individual level won't be able to solve the current crisis. It **stressed the link between the economy and wellbeing and proposed closer collaboration with the Council on the Economics of Health for All** on this topic.

Recognition of diversity

Many countries mentioned respect for ethnic, racial, and gender diversity as a key element of promoting wellbeing. *China* for example called for WHO to consider that understandings of wellbeing are shaped by national, cultural, economic and political differences between countries. *Colombia* noted that ideas about "living well" in Latin America included caring for the earth and for humans. It emphasised that respect for indigenous communities is foundational to wellbeing, and that we need a more holistic, diverse and participatory conception of wellbeing that includes ending war, patriarchy, racism, decarbonising the economy, doing better on protecting the environment, and respecting traditional medicine. *Colombia* also emphasised that these interventions are essential to guaranteeing the rights to education, work and peace, which are important for overcoming inequality.. *Russia* used the idea of diversity to object to language on gender in the documentation on this item. It argued that WHO has very diverse member states and that it was therefore unacceptable for WHO to use gender terminology that had not been agreed to by all members in its documents.

New indicators, new forms of investment

Mexico called for new indicators of wellbeing to be developed that are different from existing ones like GDP. It also pointed out that international cooperation and investment in LMICs need more attention in order to ensure that LMICs adopt more appropriate policies for promoting wellbeing.

There were no more requests from floor; the Board noted the report contained in EB152/20.

Agenda item 15.

Ending violence against children through health systems strengthening and multisectoral approaches (Document [EB152/21](#)),

Oman said that we need a multisectorial commitment to ensure reporting and protecting children from violence. They asked to ensure training and capacity building, i.e. **training modules in the curriculum for doctors, nurses and dentists**. *Brazil* echoed the need to train health professionals, adding also the need to **build a collective social understanding** of this issue. *Yemen* informed that they often didn't have the data to introduce the policy they needed and there needed to be strengthening in training and capacity to improve their overall health strategy. *Malaysia* admitted that their MoH had yet to develop a national plan of action on this issue involving other ministries & stakeholders. They requested guidance for training in order to increase health care personnel's ability to **detect violence against children at PHC level**. *France* echoed the same sentiment, but added that there should be **specialized services accessible to young people**. *Ghana, on behalf of the AFRO region*, noted with concern the **uneven implementation of framework in the region**. They requested the Secretariat to support MS to create intersectoral bodies within MoH to help coordinate efforts. *Japan* planned to address the issue through national / municipal health nurses, but reminded us that the **health sector alone could not respond to violence against children (VAC)**. *India* stated the need to **address economic and social factors that foster a culture of VAC** complemented with strengthening health system capacity at all levels. They emphasized on prevention. *Korea* proposed the establishment of a medical advisory group and a system so health care givers can respond to VAC more effectively. *The USA* supported WHO's support to frontline health providers to recognize signs of neglect and intervene where needed, but emphasized on multisectoral approach including **legal reforms to respond to VAC**. *Colombia* reiterated **MS commitment to adhere to the UN Convention of the Rights of a Child and other Human Right instruments**. They asked these to be taken into account in order to develop a cross-cutting approach. They acknowledged the importance of reforming the health system, especially PHC, but emphasized that the **major component to prevent VAC must be done in family, community and educational settings** by ensuring early detection and response. *Russia* called for **proactive medical evaluation and law enforcement** and emphasized the need to inform the parents of children on how to use health systems and **incorporate the issue in medical education**. *Maldives* informed that **drug abuse had reached almost endemic levels** in Maldives and it drove VAC. They have strengthened national campaigns and multisectoral mechanisms such as helplines and parental support programs. *Yemen* was facing a challenge of **recruitment of children in arm conflict**. They asserted that health workers didn't know how to fight this issue and that there were gaps in the legislature. *Slovakia* noted the importance to **prevent stigma and secondary victimization** including between siblings and family members. They called on MS to support each other and emphasized the need for international support. *Monaco* emphasized the need to **train teachers**. Ecuador reminded us to **protect confidentiality of abused children** and to improve **collaboration between health and judiciary systems**. *Palestine* maintained that the VAC in their country was driven by illegal Israeli



settlers which required a deep reflection and response from the international community. **Palestinian children in occupied East Jerusalem continue to be detained and arrested**, including night arrests, painful hand ties, lack of access to a lawyer, and lack of adequate detention facilities for children. The Chair called for MS for more comments. There was no objection and comment, so the Board noted report EB152/21.

Next was agenda item **16. Social determinants of health (Documents [EB152/22](#), [EB152/CONF./2](#) and [EB152/CONF./2 Add.1](#))**. The Board was invited to take note of the report and make a decision for accelerating action on global drowning prevention based on the proposal brought forward by Ireland and Bangladesh. *India, on behalf of the SEARO region*, requested EB to adopt a draft resolution with consensus. *Peru* said that there was no technical support to countries with regards to social determinants of health (SDH). They attached **importance to monitoring mechanisms** - i.e. data to analyze health inequities, which was essential to formulation plans and policies. *Afghanistan* asserted the fact that we lived in a political world where our actions were connected to politics and that in such an environment the slogan of “**health is not politics is not realistic**”. They called on WHO and MS not to just invest in PHC as a path to UHC but **help politicians to end the current global conflicts**; that health sector actors must work across sectors to improve SDH which required diplomacy and political skills in health leaders. *The USA* emphasized more on **addressing structural discrimination and racial issues**. They called on MS to provide marginalized and excluded groups with access to PHC and highlighted the importance of multisectoral approach, particularly for sustainable financing of SDH. *China* endorsed the adoption of the draft and co-sponsored drowning resolution. *Canada* called on MS to **act collectively against SDH like racism, gender based discrimination and environmental inequities** and to uphold comprehensive sexual and reproductive rights. *Paraguay* reminded us that current multiple major crises, i.e. conflict, climate change, covid pandemic, had exposed and aggravated inequalities with an impact on health. Therefore they thought it essential to **make other sectors and institutions responsible for instilling a culture of health**. *Korea* wished to co-sponsor the draft resolution on drowning. They requested to develop indicators to monitor health inequities and to focus on groups (migrant or homeless people) suffering health gaps. *The UK* asked WHO to clarify how it would achieve a more multi-sectoral approach and encourage greater integration, more specifically on the plans to engage with others beyond the health sector to deal with the health impacts of climate change. *Brazil* acknowledged the need for social policy to recognize the **role of gender as a strong structural determinant of health**. *Japan* acknowledged that many interlinked crises were faced by the world including covid19, war and conflict, climate and the cost of living crisis. *Russia* co-sponsored the draft resolution on drowning. *India* highlighted **rural-urban inequity** and supported use of **digital technologies and CHWs to address SDH barriers**. *Ethiopia* proposed to **increase engagement with development partners** and called on the necessity of health diplomacy skills. *Maldives* reminded that differently positioned social groups had experienced the impact of multiple crises differently. They asserted that **disaggregated data** was required and cross referencing it with data in other sectoral programmes was necessary to improve SDH, measure health systems wastage, and address efficacy of policy. They co-sponsored the draft resolution on drowning. *Colombia* asked the EB to include issues like SDH and inequalities in health care into the agenda of the upcoming WHA. They emphasized the need to **guarantee the right to health above economic and commercial considerations**. The Chair called the meeting to adjourn until 14:30.

AFTERNOON Session

After lunch, discussion on **agenda item 16** continued. *Bangladesh* informed us that drowning was the major cause of mortality. In the context of worsening social determinants of health, climate change and flooding events, **drowning was preventable with scalable interventions and prevention**. They called on MS to support the resolution. *Norway* emphasized the link between SDH and health inequities and said that **PHC is key in the health sector** in strengthening health systems, global preparedness and response, as well as addressing mental health issues. As a cosponsor, *Monaco* extended wholehearted support for draft resolution on drowning and for implementation. *Namibia* asserted the need to **address barriers to health equity**, including economic inequality, war and conflict, structural discrimination, in order to achieve progress. *South Africa* reminded us that there was little progress in SDH in or between countries; in fact, it had worsened. They wanted to **address SDH in the context of COVID-19 and other health emergencies**. They thought it important to strengthen life saving skills for drowning, therefore they registered for co-sponsorship. *Indonesia* co-sponsored the draft resolution on drowning because as the largest archipelago in the world, the **risk of drowning was one of the highest among the hazards encountered on a daily basis**. *Fiji* supported the resolution because **disturbances with seasonal variation impacted their health system** and asked to be co-sponsor. *Thailand* still waited for resolution WHA74.16 to be implemented for a comprehensive global health equity. *Ecuador* co-sponsored the resolution and emphasized multisectoral collaboration. *Switzerland* was concerned about the lack of progress in overcoming health inequities within and between countries and **chronic underfunding of the SDH agenda**. *Eswatini* and *Sierra Leone* asked to be co-sponsor. *Palestine* stated that the drowning problem touched upon all regions. They highlighted the need for a **geopolitical solution** because war and conflict exacerbated diseases and mental disorders, whether rich or poor. *Slovakia* requested **value-for-money analyses**, akin to what had been done in the Euro region, **to support “investments” in SDH**. There was no objection or more comment, the EB noted the draft and adopted the resolution.

Next was agenda item 17. **The highest attainable standard of health for persons with disabilities (Document [EB152/23](#))**. *Denmark* stated that disability required specific specialized and differentiated services. Therefore they asked **to take into account experiences of persons with disability** and encouraged their participation in health planning and decision processes. *Madagascar* reminded us that **80% of persons with disability were in LMICs** and emphasized their protection in health emergencies through public health care. They urged **WHO to include disability in all its programs** and the sentiment was echoed later on by the UK and *Peru*. *Malaysia* called for person-centered integrated care and asked to **hire more people with more disabilities** at HQ, regional office and country offices (also echoed by Maldives and Argentina). *The USA* said that it was imperative to continue to go for the highest standard of quality of life for people with disability, including **access and information on sexual and reproductive health**. *Russia* pointed out again the **problem with gender specific terminology** and urged to use agreed terminology. *Peru* considered **care in the community essential** and it could be done and be promoted by WHO through regional and country offices. *India* said that **investing in local manufacturers and use of digital technology would enhance accessibility** and asked WHO to support MS to promote nutrition, training programs, and prevention of disability. *France* was concerned about the legal issues of Artificial Intelligence (AI) and asked for responsible use of digital tools and AI. *Brazil* pointed out that “in the discussion on the health of people with disabilities, most countries drew



attention to the need for people with disabilities to have access to rehabilitative therapies and assistive technologies. Few countries spoke of **disabilities as the product of inaccessible and discriminatory social and physical infrastructure and conscious political decision-making**. *China* asserted that governments had the highest responsibility to guarantee the highest standards for health for persons with disability and they were working to enhance prevention, treatment and rehabilitation. *Colombia* emphasized strengthening the health system in a way that bears in mind the needs and rights of persons with disabilities, taking into account gender, economic and geographical orientation. *Israel* was of the opinion that adjusting our health systems to address persons with disabilities needs normally considered a luxury was the wrong mindset. They asked that we put disability at the center. *Slovakia* appreciated the work of WHO on the issue but asserted that **scoping review was not a good enough analysis for evidence-based interventions** and asked for more robust evidence-based recommendations. *Norway* asked for inclusive approaches that target barriers. *El Salvador* requested WHO and its regional offices to provide support for **training multidisciplinary healthcare teams** who work with persons with disabilities. *Argentina* requested technical experts on issues of disability in WHO and noted the link with palliative care. *Palestine* informed that there were **over 96,000 persons with disabilities in the West Bank and Gaza Strip**, with at least 3000 reporting that their disability was due to direct Israeli Army military attacks. There was no more comment or objection, the report was noted.

Moving on to agenda item **18. United Nations Decade of Action on Nutrition (2016–2025) (Documents [EB152/24](#), [EB152/CONF./5](#) and [EB152/CONF./5 Add.1](#))**. *Colombia* supported **administration of supplements and vaccination to mothers** to prevent micronutrient deficiencies and spina bifida. Canada asked to intensify identifying interventions to **address nutrition needs against the backdrop of climate change** and requested WHO help MS to put in place functional systems such as early warning signs for malnutrition. They implored MS to integrate gender equality in the nutrition framework which was later echoed by France. *Malaysia* asked for more support on the strategies to **synergise with multilateral partners**. They proposed a strengthening of the second proposal, that is, to **not only governmental approach, but also civil society**. *Timor Leste* emphasized **increased taxation on alcohol and sugar beverages on the national level** with a focus on the first 1000 days as a window of opportunity. *Senegal* recommended the Secretariat to support MS: to review and strengthen implementation of their national plans, to boost capacity to analyze food systems, to develop and implement strategies to adapt food systems and make them more resilient in the face of climate change and other crises, and to implement the essential actions. *Syria, on behalf of the EMRO region*, supported prevention programs on infant feeding and baby friendly hospital initiatives. *The UK* reminded us that **child wasting was expected to worsen in 2023**. They asked WHO for **critical and refreshed child wasting guidelines, and operationalized them** (the same sentiment was echoed by the USA). They questioned whether WHO had made any progress in monitoring its work with regard to improving nutrition outcomes across its portfolio since the discussion on nutrition in EB150. *Russia* asked WHO to give technological support based on the latest data. Brazil stated that WHO plays an important role in preventing malnutrition, particularly in encouraging countries to recognize that **food consumption goes beyond individual choices and needs a broad approach, from food production to distribution and consumption**. *Maldives* asked to acknowledge the role of natural disasters, conflict and trade in reaching nutrition targets and pointed out that **5-19 years olds are not included in nutritional targets**. *Ethiopia* wished to see greater emphasis on strengthening national and subnational efforts, as well targeted support in humanitarian emergencies. *Bangladesh* asked **WHO to engage with WTO and Unicef** for a normative framework. *Ecuador* proposed an **exchange of technology** to enhance

sustainable production of healthy food. *Guatemala* asserted that the food industry was responsible in ensuring food is fortified with micronutrients. *Argentina* commented on paragraph 26 in the document about networks. They reminded us that there is a **WHO-PAHO-FAO network** in the region which has worked to bring down salt consumption and consumption of processed foods. Such networks were **useful but needed greater participation**. We should maintain momentum. *Australia* advocated **clear and informative food labeling**. *DG Dr. Tedros* responded to statements and said that **WHO had not been working with the food industry; the opposite was true**, that they had mainly been confrontational. He asked not to use this kind of approach. He affirmed that WHO could enforce regulation when needed but preferred cooperation. He added that there were still **problems with regard to salt and sugar consumption as well as breastfeeding**. WHO would continue to debate and also enforced or used regulatory functions to address it, adding that there had been progress in that regard. WHO had a **civil society commission** which would be established before WHA76. They wanted to work more closely with civil societies to understand their perspectives and to leverage them to make progress. There was no objection or more comment, the report and the draft decision were adopted.

Lastly, on agenda item **19. Behavioural science for better health (Documents [EB152/25](#), [EB152/CONE./6](#) and [EB152/CONE./6 Add.1](#))**. *Malaysia* went first and advocated for **systematically integrating behavioural science (BS) across interventions** to make health policy most effective and also to scale up the integration of BS. They supported the resolution and welcomed cosponsorship. *Russia* asked that **cultural factors (sexual behaviors) be looked at**. They supported the strategic objectives but asked for standards to be aligned with countries. *Botswana, on behalf of the AFRO region*, proposed **WHO to continue fostering an enabling environment for BS** and facilitate the generation and use of BS evidence in context-specific interventions by working closely with academia and other stakeholders to boost use and create databases. They advocated for behavioural data to be a core piece of the national health research agenda. *The USA and the UK* also encouraged WHO to **collaborate with academic institutions and the private sector, as well as UN organizations such as UNICEF, and other organizations with behavioral science expertise**. *Israel* regretted that once again the platform had been used to promote the Palestinians' narrow, cynical agenda. They claimed that Palestinian children had been exposed and indoctrinated to glorify violence. *Russia* rejected the French accusations against them in relation to food insecurity, particularly in connection with the special military operation in Ukraine. They claimed that the normal supply chain would be resumed if only the West removed illegitimate economic operations. *France* confirmed that there were no EU sanctions on food systems and accused Russia of using hunger as a weapon and tried to blame Europeans for it. *Palestine* accused Israel of defamation and said that "the idea that we are educating and raising terrorists is not true and it is not acceptable". They urged MS to look at reports by Unicef, WHO, and UNHCR to get a real picture of the situation of Palestinian children.

The meeting was closed. Tomorrow it will continue at 10:00.