Health for All Now!
People's Health Movement

Daily Brief - Day 3 of WHA76
Tuesday 23 May 2023

The third day of WHA76 was organised around the discussion of agenda items:

14. Public health emergencies: preparedness and response

14.1 The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (Document A76/8)

14.2 Implementation of the International Health Regulations (2005) (Document A76/9 Rev.1)

15. Review of and update on matters considered by the Executive Board

15.1 Strengthening WHO preparedness for and response to health emergencies
• Strengthening the global architecture for health emergency preparedness, response and resilience (Document A76/10)
• Strengthening clinical trials to provide high-quality evidence on health interventions and to improve research quality and coordination (Document A76/7 Rev.1)

15.2 WHO's work in health emergencies (Document A76/11)
• Implementation of resolution WHA75.11 (2022)

15.3 Global Health for Peace Initiative (Documents A76/7 Rev.1, A76/7 Rev.1 Add.2 and A76/7 Rev.1 Add.3)

Morning Session

The President of IOAC opened the session with a reflection that it is imperative that WHO be empowered with the authority and capacitated with all financial and human resources required to make it fit for purpose. They noted that WHO's leadership role in emergencies has been achieved at considerable cost to the staff. This was followed by interventions by member states. In its intervention Finland and Canada called attention to the late publication of documents and the fact that it made it difficult to prepare for the meeting. Many countries that had supported Ukraine during the EB again reiterated their commitment to Ukraine and used Item 14 to condemn Russia's invasion of Ukraine and the destruction of healthcare infrastructure and harm to healthcare workers that has resulted. Canada lauded WHO for its investments in addressing sexual abuse and sexual misconduct in emergency contexts where WHO intervenes. Thailand also commended the DG and regional directors on progress made in the past 12 months in addressing sexual exploitation, abuse and harassment.

NSA Barriers to Participating

Many NSAs had difficulty making their interventions on the important items under this grouping. On the 20th of May, one day before the opening of WHA76, NSAs were informed that all sub-items under items 14 and 15 would be discussed as one grouping, and that a single statement would have to cover all these topics. During its intervention Australia noted that having so many items in the same agenda point makes it hard even for member states to give real guidance to WHO.

Though NSAs were given two minutes to speak on all this content, this time was inadequate given the importance of the proposals and reports being discussed. Furthermore, NSAs had to wait until after 10pm on the 23rd of May to deliver their statements. At this point in the evening many NSAs had left

the Palais, though many other NSAs working for equity and justice in Global Health Governance stayed on to read their statements. Despite being forced to wait until so late in the evening to share their contributions, the chair summarily cut off NSA statements at the 2 minute mark. NSAs were further constrained in participating as there were accounts that when some of them tried to enter the Palais des Nations after 6.30pm on the 23rd of May they were told access to the venue was no longer possible and refused entry.

Item 14

Tanzania on behalf of **AFRO** called for greater equity in access to health products in response to health emergencies. It noted that IHR capacity for the Afro region has increased, but many countries are below the average score and called for greater global solidarity and sustained long-term strategies. It was concerned that systems to ensure equitable access to health products and medical countermeasures do not feature in the current document. It pointed out that partnerships and collaboration for R&D, technology transfer and trade barriers all affect access to countermeasures and should be addressed. It also called for agencies like GAVI, the Global Fund, UNICEF, and others should look at the possibility of apportioning at least 30% of their funds to procuring the regional domestic manufacturers to enhance sustainability and growth of the regional pharma industries and improve equity.

Thailand called for regional and country office and headquarters that host emergency programs to be adequately resourced with sufficient staffing, budget and procurement of public health emergency supplies.**Barbados** called for ensuring resilience in health care systems to withstand all forms of disasters including biological, hydrological, and meteorological events that result in health emergencies. It indicated its commitment to the full implementation of the International Health Regulations, including to expanding capacities in the areas identified in the One Health joint action plan. **China** indicated its willingnes to provide human, technical and financial support for WHO operations in Health Emergencies Response. It encouraged the IOC to strengthen oversight and guidance to identify problems in a timely manner, for regional emergency response and upscale.

Item 15.1(a) Health Emergency Response

Equity

Tanzania on behalf of **AFRO** noted that the changes to the 10 proposals seems to have lost some of the key aspects that the DG outlined in the White Paper, one of which is the critical importance of systems to ensure equitable access to health products and medical countermeasures. It reiterated the importance of aligning the DG document with the ongoing Member State-led processes (INB and IHR) currently underway to avoid confusion, as the issues outlined in the DG's document are also issues to be addressed in the two Member State-led processes. As some of the proposals are also key for both instruments, including for example financing and implementation mechanisms. It called for the governance mechanism to ensure equitable representation of voices from the North and South and for financing that ensures sustainability not just for the public health response, but for the critical multisectoral approaches required for pandemic preparedness and response.

Core Capacities under IHR

The **EU** framed the issue of health emergency response in terms of the common good and called on core capacities to be strengthened and implemented. Germany stated that COVID-19 had shown that aid in core capacities are crucial, and that it would provide support to assist LMICs to reach core capacities by 2026.

National Sovereignty; Appreciation of Local Conditions

France noted that it would continue to discuss WHO's 10 proposals for health emergency preparedness, while noting that member states ultimately decide on pursuing specific topics. **Barbados** indicated its support for regulations that facilitate early alerting of significant public health events without unduly burdening either member states or the World Health Organization due to prescriptive mandatory reporting periods, the removal of country autonomy in requesting investigative assistance or the application of sanctions for states achieving less than full compliance. **Lebanon** called for country specific conditions to be considered in the context of the INB and IHR amendments. It noted that the proposed amendment to Article 19 (General Obligations) needs more reflection, as it becomes difficult to develop bilateral policies when neighbouring countries are in conflict. The **Philippines** called for guarding against the implementation of IHR activities being subject to penalisation.

People over Profit

SEARO noted that access to pandemic response products was the major problem during the height of the COVID-19 due to IP legislation. It called for WHO to act as the directing and coordinating authority during health emergencies and stated that during pandemics the health of the people should prevail and be prioritised over commercial interests.

Item 15.1(b) Clinical Trials Resolution

The **EU** noted that clinical trials are important for patient safety and called for more countries to have access to trials so they can participate in testing solutions. They called for contributions made to clinical trials to be made payable to WHO.

France mentioned that trials are essential in ensuring access to effective new technologies for neglected neglected tropical diseases and potentially vaccines against malaria, HIV or tuberculosis. It went on to promise to intensify its collaboration with African and other partners, including through the future pandemic instrument, to increase R&D capacities and reiterated its proposal that contributions made by WHO to clinical studies should be made payable to WHO in case of commercialization of the tested products.

Thailand raised concern about fair sharing of benefits generated from a clinical trial between the owners of products and clinical trial participants particularly in developing countries, and requested that WHO to review and develop guidance in this area.

Item 15.3: GHPI

The **EU** indicated it looked forward to the adoption of a roadmap for GHPI, and reminded the meeting that conflicts are gender and context specific. **EMRO** noted that it supports the GHPI and will continue to discuss WHO's 10 proposals for health emergency preparedness, while noting that member states ultimately decide on pursuing specific topics.

Afternoon Session: continuation of the same agenda items

Some of the contributions made during the afternoon included **Denmark's** call for strengthening core capacities in countries that need it the most, effective communication and multi-sectoral approaches. It urges WHO to use assessment as a tool to identify gaps. **Jamaica** noted the importance of addressing antimicrobial resistance and indicated its commitment to participating in the working group on the IHR amendments. **Brunei** called on the secretariat to recognise the difference between countries intentionally failing to comply with the IHR and those incapable of complying. It also raised the question of how the new Hub for pandemic and epidemic intelligence in Berlin would benefit member states. **Colombia** noted the clinical trials should consider the needs of participants. **Mexico**

demanded that the new global health emergency architecture be reviewed by member states before it gets adopted and that PAHO participates in the development of the proposal, which should reflect the needs of the region.

Namibia commended the DG and secretariat on ongoing work on emergency preparedness reiterating their belief in the WHO vital role in global health protection. They support IOAC's independent oversight role and advice to the WHO in ensuring the success of this emergency program. They however urge that this should be done fully adhering to the principles of transparency and accountability. For IHR implementation, Namibia recognizes the IHR role in protecting, preventing, and responding to PHEIC, where implementation is critical for health, wellbeing and livelihoods all over the globe. They emphasize the importance of building core capacities inscribed in IHR necessary for effective domestication, enforcement of laws and preservation of public health in countries. They also urge member states to report outbreaks in a transparent manner in line with the IHR. For HEPR, Namibia noted the report to strengthen it, appreciated categorization into the three pillars guided by the core principles of equity, inclusiveness, and coherence which allows MS meaningful engagement in discussions. They highlighted the pivotal importance to prioritize operational readiness in the five interconnected, multisectoral systems. This includes collaboration surveillance, community protection, and safe and scalable care.

Evening Session: continuation of the same agenda items

Notable interventions during the evening session included **Brazil** resisting the suggestion that "health is part of the security agenda". It argued that "health is not a matter to be dealt with by armies or coercive measures,but it is an essential part of the broader sustainable development agenda." It also expressed concern that the current text still contains a number of undefined expressions and loose terms with no clear legal definition.

The **Russian Federation** delegate interrupted a floor speech by Poland condemning its aggression in Ukraine and the resultant health crisis, claiming such matters "don't have any relationship to the mandate of the WHO" and "should be discussed in New York at the Security Council." **Namibia** noted that the HEPR regime has been skewed for decades, resulting in devastating inequity and that the pressures exerted on developing countries carrying out surveillance and reporting without taking into account their capacities to take on such obligations is an injustice.

Mexico argued that the COVID-19 pandemic showed the challenges of multilateralism in the current political context and the limitations of its institutions, including the WHO. It added that the lack of global coordination and the lack of equity and solidarity prevented a better response.**Switzerland** again reiterated its position that rapid information sharing including sharing of pathogenic sequences is vital, and an essential and non-negotiable element in PPR. It stated that it opposes any nationalizing of epidemiological data, but admitted that the COVID 19 pandemic has demonstrated that there is much left to be done to have better access for response measures.

Burkina Faso called attention to the promotion of local procurement of countermeasures, and the need for strengthening financing for clinical trials that address the needs of local populations. **Maldives** noted that WHO's report on emergencies does not acknowledge that WHO country officers often have inadequate resources to assist member countries, particularly in small island states, where the necessary human and financial resources to effectively build and sustain operational capacity during emergencies are still lacking. **Botswana** mentioned the need for equitable procurement mechanisms. **Argentina** expressed concern about the establishment of initiatives or groups outside the WHO that could undermine the functions of the emergency response programme.