

MMI contribution to WHO GPW13 consultation

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The Medicus Mundi International Network, committed to the Constitution of the WHO, appreciates the forward looking character of the draft GPW13 and stands ready to work with WHO under its new leadership in a renewed effort to achieve Health for All.

The GPW is the highest level planning document of WHO and sets out the policies and priorities which will frame the biennial programme budgets that it encompasses. It is proposed that GPW13 will span the period 2019-23. This document and the related processes therefore require our highest attention.

We particularly appreciate that public consultations on the GPW13 are being undertaken. We hope that input received through this channel will complement the short oral statement at the upcoming EB Special Session (EBSS), and we hope that such public hearings will continue in view of the regular EB session in January.

Please be aware that the short delay to provide comments and the short notice of the EBSS make it difficult for civil society organizations to provide input based on broader consultations. We also hope that the EBSS will be fully webcast so that those who cannot make it to Geneva (status, financial capacities) can follow the conversation.

Having assessed the draft from a global governance perspective, and taking up and at times quoting input provided by Network members, academics engaged in our work such as Remco van de Pas and Julian Eckl, and civil society partners such as the People's Health Movement and IBFAN, we herewith submit the following initial comments for consideration at the upcoming Special Session of the WHO EB and in the further process.

1. The draft GPW is largely silent on WHO's financial crisis or relates to the need of resource mobilization only in general terms

The draft refers to a separate "investment case" document : *"WHO will strengthen its approach to resource mobilization. (...) The focus on impact will strengthen the case for investing in WHO. Value-for-money will be shown by clear measures of cost-effectiveness."*

So GPW13 is expected to boost the confidence of member states and perhaps build support for lifting the freeze on assessed contributions, broadening the donor funding base and untying voluntary contributions. This is not convincing. The Member State chokehold over WHO's finances is the most critical challenge to be addressed as such by the new leadership.

The majority of current funding goes to communicable diseases, polio, health emergencies (health security) and health systems (health security- UHC), much less to the SDH, health promotion, prevention and addressing NCDs.

If the current "funding dialogue" model is maintained, regardless of what will be covered in the 13th GPW 2020-2025, influential MS and other funders (via the dialogue) keep having the right to prioritize certain areas of work (via voluntary contributions) and not fund certain programs (even though covered in the 13th GPW) that hence will not be implemented.

The only practical solution is a substantial increase in the level of assessed contributions.

2. The draft GPW13 takes up the "partnership" language of SDC17 (global partnership for sustainable development) and partnership initiatives from previous DGs, in particular from Brundtland (PPP)

The draft states that *"WHO cannot accomplish the ambitious targets of GPW 13 without partners from all sectors including civil society and the private sector. It can also serve as a catalyst for partnerships between non-State actors and government."*

Together with many civil society colleagues engaged in global health governance and in particular the governance of WHO, we expect WHO, by engaging in any kind of "partnerships" to protect its most valuable asset: its independence, integrity and trustworthiness.

This needs a WHO at arms' length from rich funders and corporations - who have fiduciary duties to maximise profits. Commercial entities, guided by a market (profit-making) logic and through their economic power, undermine regulation by pretending to be part of the team. So-called "multi-stakeholder partnerships" are an ideal entry-point for doing this. In particular in the field of NCDs and their determinants, extreme caution in any WHO engagement with the commercial sector and its lobby organizations and allied MS is a must, and proper WHO policies and instruments on dealing with conflicts of interest need to be established beyond the current FENSA.

In this sense, and in particular at a global level, we also do not expect WHO to be just a "leading advocate" for health, but the main leader for global sectoral and intersectoral health-related normative work and regulation, "acting as the directing and co-ordinating authority on international health work." (WHO Constitution)

3. It is particularly noteworthy that the draft GPW13 acknowledges the relevance of the social determinants of health – including social protection and social justice.

We expect a vocal and engaged WHO in all ‘non-health’ fields respectively SDGs with significant health implications, such as industrial animal husbandry, land grabbing, tax avoidance and tax competition associated with foreign investment, chemicals control and air pollution – just to mention a few.

We expect that WHO shows leadership and takes a normative stand in protecting and improving gender equality, human rights and health equity. This would imply the organisation and its leadership to be firmly engaged in (non-health) multilateral and regional governance mechanisms and platforms. This will be diplomatically difficult, as the question will then be to what extent WHO has the mandate to be engaged in such high-level policy dialogues (e.g. G7/G20, WTO trade rounds, COP FCCC etc).

Health is now considered a high-level political and foreign policy issue. WHO will “strengthen its public voice and advocacy” (see above). In a global risk society with increasing and complex threats WHO must *not only* be an advocate for health (with the risk to become a ‘token’ health voice at the global governance level), it must show persistent, consistent and outspoken leadership by speaking truth to power about factors and actors that worsen health inequities, undermining health for all (let’s call them global ‘public bads’ for health). The planet is, arguably, in a much ‘unhealthier’ state (from a sustainability, social and ecological perspective) than 50 years ago. There is no time for contemplation anymore and we should move beyond ‘soft diplomacy’ to further health objectives.

Bold, urgent, outspoken, pro-public, pro-planet, pro-marginalised political leadership, based on strong democratic legitimacy, is required to defend health in the face of vast powers, interests and forces that are a serious threat to the integrity of our planet and our societies.

Action around trade, NCDs and the social determinants of health has been consistently underfunded in the last three biennia reflecting the donors’ lack of enthusiasm for confronting the global regulatory challenges involved. Meanwhile under the aegis of the Human Rights Council, proposals for a global treaty with a view on regulating transnational corporations and other business enterprises are under development. WHO should be engaging with this process.

4. The draft GPW promises to place countries squarely at the centre of its work.

This is done with a new ‘operating model’ and with enhanced country cooperation strategies. The focus of country engagement will have varying emphases on policy dialogue, strategic support, technical assistance and service delivery depending on the capacity and vulnerabilities of particular countries.

We appreciate in particular the reference to closer engagement with civil society at the country level, as civil society mobilisation is an important driver of health development, locally, nationally and globally. We look forward to seeing progress in this field, as, according to our civil society

colleagues, the caution of country offices in engaging with local civil society has been a significant weakness in WHO's country work.

5. We appreciate the commitment in the draft GPW to more meaningful metrics for assessing the outcomes and impact of WHO's work.

WHO has been pressured to cost and measure outputs and outcomes through a narrative of alleged inefficiencies, opacities and lack of accountability designed to justify the freeze on assessed contributions. WHO should not be driven by such self-serving arguments.

However, a linear scheme of inputs, activities, outputs, outcomes and impacts is overly simplistic ("1 Billion"...) and mainly promotional, notwithstanding the recognition of the 'combined contribution of WHO, member states and partners'. In the rush to (better) measurement, systematic reflection on the quality, efficiency and impact of processes and deliverables risks to be neglected.

We reject the tendency to assess the work of WHO with the same business administrative tools that would be used for any (other) global health partnership. The focus on measurement and indicators can easily lead to phenomena such as "picking only low hanging fruits" / "cherry picking" and "teaching to the test" which can undermine various public health goals that call for action even in the absence of likely success. Instead, it should be WHO's task to point at the challenges that the global health community faces and to identify marginalized problems (rather than to engage in the business of "demonstrating" successes and glossing over problems).

6. Discourses and legitimacy

Overall, the GPW13 emphasises 5 overlapping, heterogeneous, health frames (discourses). The 'investment' frame (health coverage), the 'security' frame (health emergencies) the 'public health' frame (health priorities), the 'rights' frame (under global leadership and somewhat cross-cutting) and Global Public Goods (financing GPG and its impact). Global leadership and governance models that are part of the SDG framework should make all of these elements possible.

Arguably, the health effects of climate change and environment (planetary health/ boundaries, ecological limits) could (should) have featured as a discourse in itself, given their huge impact on wellbeing.

More importantly, WHO and its leadership must ensure that all these frames are ranked, which (see above in relation to speaking out on factors being a 'public bad' for health) also requires bold proposals and/or policy suggestions that might go *against* some of the direct interests of member states and other agencies, in some (many?) instances.

Worryingly, the document *doesn't speak about* the (financial) 'shared responsibilities' of MS and others required to make this happen. It rather follows the multi-stakeholderism model, focusing on 'leveraging' private money and seeking domestic investments, recognising national

sovereignty and hence also emphasizing the national responsibility to advance health (a bit weird, given the many “global” public bads in health LMICs are facing).

If no steps are being taken to advance shared responsibilities governance mechanisms (e.g. for UHC, or addressing NCDs), the human rights and health equity language of the GPW13 might become hollow phrases (i.e. not implemented). This is in line with broader analysis of health in the SDGs and how human rights considerations typically tend to get ‘sidetracked’ or ignored.

Lastly, regarding the final sentence the following must be considered:

It is mentioned that “WHO comprises both the Secretariat and its Member States. It will be important to further develop a culture of common purpose and trust between them for the Organization to reach its full potential.”

That is true but *beyond the accountability and trust between WHO and its MS*, there is first and foremost accountability by *WHO and its MS* to people, citizens and societies. (“*We, the Peoples of the United Nations*”). This follows from the WHO constitution, which is in line with the UN charter.

So, for WHO to maintain its legitimacy, in times of multilateral crisis, withdrawal and growing nationalist trends across the globe, it must keep in mind that according to its mandate, the health and rights of *people* need to be protected, safeguarded, promoted, and fulfilled.

This might even imply the requirement to stand up for health *against the (diplomatic) wishes* of (dominant) member states and other (funding) agencies. Perhaps the WHO’s governance model (diplomatic consensus) needs to be amended (democratic voting, inclusion of public representatives of actors beyond member states) to make this possible.

We live in uncertain times. The health of our planet and its people faces serious and urgent challenges. Our times require unusual, non-conformist steps and new governance mechanisms to address the current ‘wicked’ health threats and global public ‘bads’. We are obliged, also in order to do justice to future generations, to overcome the current multilateral gridlock.