

WHO: From 3 by 5 to 3 billion UHC, Emergency, Security, and AMR?

The Executive Board just met Nov 22-23 at WHO headquarters. We saw there WHO director general Dr Tedros riding on a high horse with a 3 billion people objective: at the core of the new program, one billion people covered by UHC (Universal Health Coverage).

One is strongly reminded of Dr Jim Kim initiating the 3 by 5 program at the WHO: the idea of placing 3 million People Living with HIV (PLWH) under antiretroviral treatment by 2005 appeared over-lye ambitious then (in 2003), and it met with cynicism on the part of the leadership at the Global Fund, the later questioning whether Dr J. W. Lee (WHO director general) was in his right mind and 'hadn't had a drink too much' to launch such 3X5 initiative! It did not have the support of the World Bank then either.

In fact the 3x5 'worked', even if it took more time to get off the ground, because many NGOs jumped in the fray (some of us at the NGO Forum for Health with the World Council of Churches), organized support meetings, helped with advocacy, in popularizing the objectives, supported by WHO staff (often deployed into the field), and the outcome was way beyond expectations. Years have passed and many more PLWH are today under treatment while Dr Jim Kim is no longer a 'mere' head of HIV at the WHO, but the DG of the World Bank (named by Obama in 2012). Today the '3 billion' target of the new WHO GPW (Global Program of Work) is similarly met with a lot of shoulder shrugs. Did it get Kim's support in backrooms is a reasonable hunch and Peter Sands' nomination at the Global Fund could, ironically, mean support (while both institutions were hostile to the WHO plan in 2003).

Focusing on achieving notably a one billion people covered by UHC, the program as described by Dr Bernhard Schwartländer (head of Tedros' cabinet, and a UN career man with experience in UNAIDS) means, first of all, recognizing that "**health objectives are central to the SDGs**" (the Sustainable Development Goals adopted at the UN), as Schwartländer said, it demands a number of shifts to succeed, he basically said: better and tighter coordination in the organization of the WHO (which has already started with regular meetings with WHO Region Directors all attending this special session and clearly very much in support of Tedros), more technically competent WHO staff in countries (eg less political), and above all a bigger place and a **bigger role for health ministries**, more often than not neglected and deprived of power (says Schwartländer) in national governmental settings.

For the 3 billion program to work, it will need the mobilized power of civil society.

Schwartländer's insistence that without a central role for health, SDGs would be meaningless, is better understood by reading a remarkable analysis of a long time expert researcher in public health policies, Pr Meri Koivusalo, when she explained recently, that the way the SDG were structured with 'health in all', could entail a dangerous 'second fiddle' discarding of health proper. (see excerpts below). Hence the WHO new team appears intent with reclaiming a global positioning in strategy.

Dr Tedros demonstrated hubris at the finale of the WHO Executive Board meetings this past week, telling the audience that he was consulting EB members but was not obliged to, that he was letting non-EB member states talk, but did not have to take their opinion into consideration. His angry stance came in the same session where the USA representative (not an EB member this year) had delivered a sharp-tongued statement that "the field of global health was a **crowded** one" and that WHO had to develop its 'competitive advantage', that it had no business discussing Intellectual Property Rights (IPR), that WHO had to find its place in a world where 'ROI' (Return on investment) was the rule and PPP (public-private-partnerships) a must. Other 'rich' club countries had previously hit some of the same notes, Germany, the Netherlands, and Malta (delivering the EU

statement this year) as regards the idea of the 'crowded field' and even Horton in the Lancet. Tedros ended by a plea for non-assessed contribution, emphasizing that it was much more efficient, he gave the example of a 100 thousand dollars earmarked grant which would 'costs' more to the organization than it contributed, considering that it required a full staff to manage. Thus, said Tedros, the WHO has to manage and report yearly on 3000 grants!

The African group as a whole and its Member States (such as Nigeria) insisted on 'Access' to medicines, and in general the 'developing' countries groups were very supportive of Tedros, the regional directors appeared mobilized as well.

Some of the NGO members, on the other hand, expressed concern at the neglect of the 'social determinants' of health, basically echoing the opponents of the new Tedros approach, while others complained about the emphasis on 'new means of funding' the organization, fearing more opening to the private sector.

Tedros insisted on two other ambitious targets, one was emergencies implementation, from the concrete implementation of IHR (International Health Regulation plans) to an emphasis on 'prevention' and action in the wake of an emergency, with Ebola as an example.

He mooted that WHO could help deploy 10 000 persons to deal with implementation of containment in an emergency, hence WHO would play a leading role in "Global Health Security", a term which countries like India would prefer be replaced by safety. (The university of Sydney Australia is preparing the first world conference on Global Health Security).

This month also saw the nomination of the financial wizard Peter Sands as the new director of the GFATM, thus it becomes fitting to re-read the recommendations made by the Commission on Ebola as he chaired it. As he presented it at a Geneva Graduate Institute event, the Commission called for strengthening health systems, better attention to IHR implementation, with the overall understanding that 'infectious diseases' must reclaim attention as the number one priority in global health policy. Sands called for, on the one hand, civil society mobilization and enlisting to achieve better health systems and for involvement of the IMF and of the World Bank to make that happen. So the question becomes: would the new leadership at the GFATM come as a backup to the WHO or as a competitor? Sands had been a guest of Pr Illona Kickbush, director of the Global Health Center at the General Graduate Institute, had been a Berlin adviser and one of the architect of the new G20 engagement in global health and AMR, and is now the consultant brought in to assist in elaborating the GPW for Tedros, sitting just behind him at this special EB session.

Pr Kickbush is known for her strong views on both the need for the WHO to adapt to the 'new architecture' of many global initiatives as well as an advocate for WHO to maintain its leadership role and get more funding from member states.

At the same time, the WHO new leadership plowed in to elaborate a strange and massive set of implementation impact targets, in line with the new 'public management' orientation imposed on the WHO in the reform process. To do the data base, the group of Daly (Disability Adjusted Life-Years) 'fathers' around Pr Chris Murray was brought in. Considering that even in the 'relatively' much easier data collection on health research previously conducted by the Global Forum on Health Research, the data crunching was at best guess work (no country has to this day precise data on financing of health research on a national basis! So the estimates are all based on data derived from OECD general information on financing of research and other estimates in an acrobatic exercise.). Hence one wonders how reliable this 'new data' will be, except that it might gut the already very limited capacities of health ministries. Perhaps, perhaps, civil society could be enlisted to 'measure' something: trade unions could report if there was an increase (or a decrease?) in employment within health systems, NGO watchdogs could begin to report if medicines become more accessible or not, or if the poor had better coverage. The upcoming Brazil world social security forum could undertake to report what countries have improved financial-social protection for their populations and how?

Basically, for the 3 billion target to succeed, in our humble opinion, three things will be needed:
1- A grass root mobilization of civil society for proper implementation. NGOs which can make the difference, such as Public Services International and its 10 million members and 120 countries presence putting pressure nationally for governments to strengthen health ministry and fulfill the Abuja promise. Of course the People's Health Movement and its influence, the network of FBOs (Faith based Organizations, those which deliver most of the healthcare services to the poor in the African continent), and the large national or regional coalitions oftentimes bringing together hundreds of NGOs in just one country.

But the NGOs will insist on a full fledged comprehensive approach to achieving UHC and will not easily jump in the fray if UHC is merely a sort of financial insurance with the public sector bringing the money and private healthcare providers cashing in.

2- For UHC targets to succeed, it will have to be getting back to the movement initiated in Alma Ata for real comprehensive primary health care for all. And we will be celebrating its 40 years anniversary this year with a G2H2 event in Geneva prior to the UN World Health Assembly in May, and in Kazakhstan in the fall.

3- If we take the tasks seriously, then new technologies ought to be brought in for a new form of healthcare delivery: use of the internet, ambulatory healthcare, newer methods for diagnostics at a distance, a patient-centered system, as exemplified by the new technologies allowing at-a-distance in-utero surveillance of foetus for proper mother-child health, or solar based electricity at the point of care, potable and portable water systems also at the point of care. Dr Tim Evans, for one, is convinced that the input of these newer technologies is needed for UHC to succeed. As a former WHO director Najeeb Al Shorbaji, an ardent advocate of eHealth and of PHC, there should be no need for poor countries to reinvent the wheel or seek rich countries 'white elephant' hospitals.

While not stated in the EB, and often ignored by health NGOs, the issue of public investments in public health services is central.

Recently the AMR Secretariat came up with a document on national AMR plan implementation which had a large section on Infection prevention and control (IPC), safer health care so the patient coming in with pneumonia doesn't come out with Hepatitis, or the PLWA with tuberculosis, but it was all monitoring... So it's like going around measuring what... does not exist! There is a crucial need for an engineering approach to implementation. In a side talk with AFRO WHO DG Moeti Matshidiso on IPC in the Africa region, she did not need convincing: IPC systems are non-existent in most countries of Africa, yet it would do so much to cut down infectious disease transmission or improve mother-child health dramatically!

Herein lies the problem, governments needs the capacity to allocate credit, resources to back up implementation program, it's relatively easy to do, but the economic policies are not there. Most of the OECD world is operating on the myth that the market is efficient, that financial resources are in a fixed amount in the woolen stockings of the private financial sector and people needs to be "accountable" to have access.

The problem as the AFD (the French ODA) chief economist Gaël Giraud explained very well to everyone, even high school students (L'illusion Financière), is that financial creation, out of nothing, is done every day by the private banks while the public regulations either prevent central banks from issuing credit or else flood the private banks with free money which gets immediately recycled into yet more financial speculation instead of nourishing the SMEs or the infrastructure

needed for public health, education, energy or transport..

Along with a clear cut definition of UHC implementation based on the rights of people for real good efficient healthcare delivery, well, yes, many of us in civil society could follow, support and assist in achieving, Tedros' call for the three billions!

Excerpts of documents below

In April 2017, renown researcher Pr Meri Koivusalo Global health policy in Sustainable Development goals, she writes that:

“Sustainable Development Goals (SDGs) represent global policy goals in contrast to Millennium Development Goals (MDGs), which had developmental focus. This is the global potential of SDGs for global health policy. However, the large number of goals bear the risk of prioritization between different goals and broad global frameworks and specific targets may not be useful in shaping policy guidance and global approaches in policy areas, where we already have a global institutional and normative presence. In contrast to some other global social policy areas, global health policy has also something to lose. SDGs are thus likely to be better for global health in other policies, than for global health policy priorities, institutions and practice. This is a particular concern for the global health policy role of the World Health Organization, global health policies seeking normative action as well as for such health policy priorities, which contrast or conflict with other policy areas or strong corporate interests. This has particular relevance to multi stakeholder partnerships and the role of private sector in implementation of SDGs.”¹

Peter Sands:

“National public health systems are essential components of resilient health systems and the first line of defense against the threat of pandemic disease. “

Peter Sands, now chair of the GFATM, had chaired the Commission on a Global Health Risk Framework for the Future, which published "The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises".

Excerpts:

Recommendation B.9: The World Bank should convene other multilateral donors (including the African Development Bank, Asian Development Bank, New Development Bank, United Nations Development Program, and Asian Infrastructure Investment Bank) and development partners by mid-2017 to secure financial support for lower-middle- and low-income countries in delivering the plans outlined in Recommendation B.6.

Fragile states, failed states, and war zones pose a particular problem for the maintenance of basic public health infrastructure and capabilities. For these situations, we recommend that the UN Secretary General takes the lead, working with WHO and other parts of the UN system to sustain at least minimal public health capacities within the context of the broader UN strategy for each particular circumstance. (...)

BUILDING A GLOBAL FRAMEWORK TO COUNTER INFECTIOUS DISEASE CRISES

For far too long, infectious disease has been the neglected dimension of global security. Few threats pose such risks to human life and well-being. Yet we have invested relatively little to counter such risks, and neither national nor global systems performed well when tested.

The Commission believes the time has come to reverse this neglect. The framework we propose has three key elements:

1 <http://journals.sagepub.com/doi/pdf/10.1177/1468018117703442>

1. Stronger national public health capabilities, infrastructure, and processes built to a common standard and regularly assessed through an objective, transparent process fully consistent with international legal obligations under the IHR. (...)

Tedros interview in AMR-Times, April 2017, during electioneering:

Quote: Is there a relationship between UHC, Global Health Security and AMR?

Clearly yes. In an interview with the three DG candidates in the April edition of AMR Times, Dr Tedros said:

AMR-Times: *How do you envision working with not for profit civil society and will it be a priority for you,*

1- to implement Universal Health Coverage, so as to strengthen means to face AMR?

2- to achieve TB & HIV control as ARV and TB drugs resistance is on the increase?

3- to manage NCDs, considering that cancer treatment is threatened by antibiotic resistance?

Dr Tedros A. Ghebreyesus: Civil society is a critical stakeholder and partner in global health – it helps to hold us all accountable, brings new ideas, gives voice to the voiceless and marginalized, and acts as our greatest advocates when we do good work. If you look at many other, newer global health entities such as the Global Fund, GAVI and UNITAID, they include civil society as full partners. That is the new order for which WHO should also be aligned. WHO is somewhat different, as a member-state organization. But I believe that partnerships and collaboration, including those with civil society, will be critical for the WHO to achieve its mandate. The recently agreed Framework for Engagement of Non-State Actors should provide a systematic way to enhance and facilitate the civil society in the work of WHO without compromise to its role in standard and norm setting as well as protection from conflict of interest.

On the specific issues, in my view, all roads should lead to universal health coverage.

Accordingly, I have made universal health coverage my highest priority. It is an ambitious goal, but it is one that can and must be achieved to create a healthier and more equitable world. Greater commitment to universal health care will help to develop and deliver affordable, effective, safe and quality drugs for diseases that disproportionately affect developing countries and vulnerable populations and remain poorly addressed owing to market failures.

Continuing to scale up treatment for HIV and TB – and addressing the growing rates of resistance – should be high on the agenda of our efforts in combating AMR. We have made tremendous gains on these diseases in the past few decades, and I'm gravely concerned that resistance will start to unwind that progress.

AMR-Times April 2017,

<https://us12.campaign-archive.com/?u=e0843acd65f1015abe3d62b&id=a1cae8fe68>

Dr Matshidiso Moeti, <http://www.afro.who.int/notfound?search-title=cooperation-oms-bad-dr-moeti-et-dr-adesina-saccordent-sur-quelques-priorites-de-financement-pour-la-sante-en-afrique>

<http://g2h2.org/posts/who-consultation-on-the-thirteenth-general-programme-of-work-gpw13-deadline-13-october-2017/>

G. Upham, SOI