**Compilation of comments received from non-state actors on the Zero draft proposal for a resolution at WH74 on Strengthening WHO`s global health emergency and response.**

**Preamble**:

As part of the consultation process leading to the finalisation of a resolution on Strengthening WHO`s global health emergency and response for WHA74, the EU Delegation in Geneva organised an informal consultation with non-state actors (NSAs) on Friday 19 February from 14.30 to 17.00 (CET). The invitees were those whose names were on a list of NSAs that the WHO Secretariat had provided to the EU Delegation for the purpose of organising the meeting. A copy of the zero-draft proposal had been distributed to the invitees alongside the invitation. The EU Delegation was contacted before the meeting by some NSAs that were not on the list with requests that they be allowed to join the meeting. All such requests were granted. WHO Member States had also been invited as observers to the meeting but were requested not to take the floor during it.

At the meeting, the EU Delegation made a presentation of the draft text and invited comments and questions from those present. In closing the meeting, the EU Delegation invited all participants to submit written comments by midday 24 February. It was explained that all comments received would be compiled into a single document which would be shared with WHO Member States and NSAs. This was followed up by an email reminder to the original mailing list.

Comments were received from 26 sources. Some of these were collaborative efforts from two or more NSAs. This document is the compilation of comments received. Comments were submitted in a wide range of styles, formats etc. Some comments were submitted in `track changes` mode. Since these do not lend themselves to copy-and-pasting during compilation, the compiler has, in such cases, indicated insertions in bold text and deletions in strikethrough text. Overall, the compiler has tried to harmonise styles but with limited success.

The intention was and still is, to allow WHO Member States to be aware of the views of NSAs`when forming their national positions for the ongoing Member States informal consultations.

The EU expresses its appreciation to all of those that submitted comments.

This revised compilation contains comments received from three additional NSAs after Wednesday 24 February (WFNMB, ICOH & IEA, and ICN). Preliminary comments received from one NSA (WMA Inc) have been deleted as they were superseded by an additional set of comments prepared after the meeting of 19 February and which were already included in the compilation. One NSA (GHC) presented revised comments after the deadline and these replace the original.

No further revisions of this compilation are foreseen.

Table of Contents

[Grand Challenges Canada 3](#_Toc65318135)

[Cochrane 3](#_Toc65318136)

[Geneva Global Health Hub Member 4](#_Toc65318137)

[Medicus Mundi 5](#_Toc65318138)

[World Federation of Societies of Anaesthesiologists 8](#_Toc65318139)

[The Global Medical Technology Alliance 9](#_Toc65318140)

[The Task Force for Global Health 10](#_Toc65318141)

[The International Federation of Biomedical Laboratory Science 12](#_Toc65318142)

[Global Health Council 13](#_Toc65318143)

[International Planned Parenthood Federation 18](#_Toc65318144)

[United States Pharmacopeia 20](#_Toc65318145)

[Union for International Cancer Control & the NCD Alliance 21](#_Toc65318146)

[Public Services International 27](#_Toc65318147)

[Handicap International / Humanity & Inclusion 29](#_Toc65318148)

[WEMOS 36](#_Toc65318149)

[World Medical Association Inc 38](#_Toc65318150)

[International Baby Food Action Network 45](#_Toc65318151)

[Worldwide Hospice Palliative Care Alliance & International Association for Hospice and Palliative Care Inc 47](#_Toc65318152)

[Royal Commonwealth Society for the Blind (also known as Sightsavers) 49](#_Toc65318153)

[European Society for Medical Oncology 52](#_Toc65318154)

[Médecins sans Frontières International 53](#_Toc65318155)

[Third World Network 55](#_Toc65318156)

[International Federation of Pharmaceutical Manufacturers and Associations & International Council of Biotechnology Associations 57](#_Toc65318157)

[Humatem 58](#_Toc65318158)

[Sabin Vaccine Institute 59](#_Toc65318159)

[World Federation of Nuclear Medicine and Biology 62](#_Toc65318160)

[International Commission on Occupational Health and IEA 63](#_Toc65318161)

[International Council of Nurses 64](#_Toc65318162)

# Grand Challenges Canada

1. Acknowledge that Covid19 has highlighted the inherent gaps in general health systems, that has contributed to poorer outcomes during this health emergency, as demands on these fragile systems increase.
2. Recognize the power of digital technologies in tackling misinformation that endangers public health
3. Acknowledging unforeseen impact of Covid19 and associated measures on decreased access to contraception, increased gender violence and effects on early childhood development
4. Recognize efforts of the WHO to assess and coordinate the scale up of proven innovative solutions to accelerate progress to the SDGs (GCC for example has been working with the WHO SDG GAP)

# Cochrane

Thank you for giving Cochrane the opportunity to input on this proposed zero draft resolution for the 74th World Health Assembly.

Cochrane supports your initiative to strengthen WHO’s preparedness to respond to future health emergencies. However, we were concerned to note that, aside from references to pathogen sharing, research and research synthesis were completely absent from the draft.

As COVID-19 has clearly shown, research plays a crucial role in helping to navigate crises, with the evidence generated forming a key input to decision making by governments and healthcare professionals. We also saw that, in response to the pandemic, there was a major proliferation of studies of variable quality being published in quick succession – contributing to what WHO has described as an ‘infodemic’. Research synthesis is an important tool to make sense of the large volume of studies and get a full view of the current evidence, which can change rapidly as a crisis evolves.

Cochrane therefore suggests that more consideration is given in the resolution to the vital role played by research – and research synthesis – in preparing for future health emergencies. This could both be in the form of an acknowledgement of the significant role of research and synthesis in the preambular paragraphs; and, in the operative paragraphs, a commitment from Member States and WHO to support the research and evidence synthesis community (and vice versa).

We would be delighted to discuss this with you in more detail, should you require any further information. Thank you for involving us in this process at an early stage.

# Geneva Global Health Hub Member

1.   PP14, it would be very useful for all parties concerned to make a distinction between the two main NSAs namely business and civil society. It would be useful to bring more transparency to this difference of NSA since such clarity will help all actors to better see the gaps between the two NSA and governments included. I can understand the eventual thinking to avoid such clarity out of the fear that this would lead to confrontation. In fact, we know form research on negotiations, parties need clarity where they stand so that they can look for negotiated solutions (I am speaking from a position of 30 years of research, teaching and publishing on negotiations- bilateral, plurilateral, multilateral, multi-institutional)

2.   OP1,  investment in health infrastructure are crucial at all times, especially for DCs and LDCs, and even more so during emergencies. PPPs are one way to finance health infrastructure. UNECE PPP unit in Geneva should be included here. Their knowledge would be useful (speaking from experience, I am member of their Bureau on PPPs)

3.   OP4.1,  evaluations are post factum activities. Emergency situations need monitoring much more than evaluations. This is true for the whole 2030 Agenda, not only health emergencies and for monitoring in the field, participation-inclusion of local partners (not officials of the respective MoH!) is crucial and digital literacy is equally crucial. We published on this topic for DPR: <http://www.csend.org/publications/agenda-2030/497-monitoring-the-sdgs-digital-and-social-technologies-to-ensure-citizen-participation-inclusiveness-and-transparency>

4.   OP4.4, NFP need capacity building to enable them to manage  – interministerial policy coordination and government to private sector + CSO consultation. MoH need to be able to talk to all other ministries which contribute to problems and could contribute to solutions

5.   OP4.8, sustainable financing, knowing about the conflict between philanthropic donors and their preferred countries/diseases etc versus the multilateral realities of a pandemic is very crucial. Ear-marked funding should be suspended during times of emergencies. We did a related SNIS research, I am talking from experience see final report: <http://www.csend.org/academic-activities/basic-research/397-trends-and-influence-of-private-finance-on-global-health-initiatives-and-development-goals-in-resource-constrained-countries?highlight=WyJzbmlzIl0>=

6.   OP6.7, see comments above under OP4.1

7.   OP6.12, WTO GATS health sector agreement, countries can suspend their obligations (commitments in WTO language) in times of crisis and emergencies

8.   OP6.13, digital literacy is absent for most older persons especially in DCs and LDCs, older persons are not only a problem during times of emergencies, they could also contribute to counter the threats of a pandemic but should be given technical support and most importantly be treated as a partner, not a dependent victim to be managed by a MoH who most of the time is not able to be inclusive and pro-active, see our WSIS panel- <http://www.csend.org/conferences-and-forum/aging-futures/498-older-persons-and-new-technologies-a-smart-mix>

9.   OP6.24, WHO’s counterpart in the field are the respective MoH who are often incapable to be effective operationally. WHO needs to go beyond policy advise and research and improve on cooperation with NGOs directly active on the ground, not to fall into trap of going only through the local-national MoH

Kind regards and wishing you successful conclusion of the resolution negotiations

[raymond.saner@unibas.ch](mailto:raymond.saner@unibas.ch%0b)

# Medicus Mundi

**Comments on: EU-led Draft Resolution on “Strengthening WHO Preparedness for and Response to Health Emergencies”**

Reiterating our thanks for having involved civil society at this early stage of drafting an “Emergency Preparedness and Response” resolution for the upcoming 74th World Health Assembly, and taking up our oral statements at the consultation meeting on 19 February to which you kindly invited us, we herewith send you our initial comments on the [draft document](http://g2h2.org/wp-content/uploads/2021/02/zero-draft-WHA74-resolution-on-strengthening-WHO.pdf). Thanks in advance for sharing our feedback with Members States and considering our recommendations in the further drafting.

**1. Be clearer on the scope of the document: It should be about WHO strengthening  
AND global pandemic preparedness and response**

According to the draft document’s title “Strengthening WHO Preparedness for and Response to Health Emergencies” and the report by Dr Nolan on how the raw material for the zero draft was compiled from various proposals for WHO reform, the focus of the draft resolution is on the ***World Health Organization*** and on strengthening ***WHO’s*** preparedness for and response to health emergencies.

However, OP1 calls for an open-ended Working Group on WHO strengthening ***AND*** ***global preparedness***, and OP2 refers to the various panels that are mandated with assessing the shortcomings and failures of the Covid-19 response and with making recommendations for strengthening pandemic preparedness and response as a challenge for ***all countries and governments*** and for the ***international system*** as a whole.

***We strongly recommend*** to keep the broader approach (WHO strengthening and global pandemic preparedness and response) and to amend the title of the draft resolution.

**2. Go for a World Health Assembly decision and/or resolution?**

We refer to the hybrid character of the draft document that includes both a proposed ***decision*** (OP1-3: to establish an open-ended working group) and a “proper” ***resolution*** (OP4-6: set of specific calls and recommendations to WHO Member States, the Secretariat and other actors).

***We strongly recommend*** to clearly separate both matters and instruments and to draft, if needed, two separate documents:

(a) a decision to establish a working group (see below, comment 3)  
(b) a resolution with specific immediate calls to Member States and the Secretariat (see below, comment 4)

**3. Sharpen the scope and terms of the proposed Member States Working Group (OP1-OP3)**

We have criticised the lengthy process that has led from the May 2020 World Health Assembly resolution on the Covid-19 response to a special session of the Executive Board in October, and via the resumed World Health Assembly in November to the 148th Session of the WHO Executive Board in January ...and has resulted so far only in ***another EB decision*** that calls for ***another WHA resolution***.

This is clearly [***not the leadership*** we have expected from the Executive Board and the Member States](http://g2h2.org/posts/january2021/), and we still do not fully understand why. Are the political matters that need to be dealt with too controversial respectively too sensitive so that Member States play on time? Is WHO not sufficiently supported by Member States in its constitutional mandate to which you refer in PP3 and PP5 of the preamble?

***If Member States do not just play on time, we strongly recommend*** setting up the working group as “time-bound” and “results-oriented” in the same way as it was discussed and agreed by the Executive Board for a working group on sustainable WHO financing ([document EB148/CONF./12Rev.1](https://apps.who.int/gb/ebwha/pdf_files/EB148/B148_CONF12Rev1-en.pdf)).

***If Members States support WHO’s constitutional role, we strongly recommend*** to explicitly mandate the working group to prepare the ground for the negotiations of a Framework Convention on Health Security or Pandemic Preparedness and Response (or another solid political framework with built-in review processes like Rio or Sendai), as part of its tasks. This process could already be initiated in the negotiations of the draft decision, by sharpening the decision point (see our “[alternative draft](https://www.medicusmundi.org/wp-content/uploads/2021/02/alternative-draft-resolution-on-pandemic-preparedeness-and-response.pdf)” published in early February), and by making this ambition perfectly clear at the highest political level of Member States where explorations on a “Pandemic Treaty” have already started, as confirmed by Dr Nolan.



**4. Drop or redraft the “resolution” part of the document**

Dr Nolan introduced the long document as being the result of a compilation from different WHO reform papers, with the intention to “capture everything” brought up by the various countries and teams.

Unfortunately, this drafting strategy might have helped to identify some “safe ground”, but it has mainly led to a vague and uninspired set up calls/recommendations. This rather contradicts than supports the proposed decision to mandate a working group with undertaking a sound assessment and come up with a set of solid recommendations, and we wonder if such a long list of “preliminary” calls to Member States and the WHO Secretariat will make any difference and lead to any substantial change/progress in national and international health emergency preparedness and response, if it is only covers fields that are not contested.

***We therefore recommend*** either to drop the “resolution” part of the draft document, because the calls it includes are most probably not as straightforward and bold as the recommendations to be expected from the three review panels that will report back to the WHA. If you decide to keep the “resolution”, ***we recommend*** reducing the long list of calls to those that are really challenging– and might make a difference, and use the drafting process for further advancing negotiations on these matters.

# World Federation of Societies of Anaesthesiologists

**PP1** Recalling that the objective of the World Health Organization is the attainment by all peoples of the highest possible **standard** of health;

**PP8bis Recalling WHA68.15 on Strengthening Emergency and Essential Surgical Care and Anesthesia as a Component of Universal Health Coverage in which governments acknowledged and recognized surgery and anaesthesia as key components of health systems strengthening;**

**PP8ter Recognizing that WHA 70.22 called for accurate and thorough data collection and progress reporting of emergency and essential surgery and anesthesia to allow for a more detailed understanding of the status of surgical care around the world, which, in turn, will allow more targeted goal setting and strengthen preparedness and response to health emergencies;**

**PP9bis Acknowledging that an increase in health care workers, including anaesthesiologists, that are on the front line of the COVID pandemic, is essential for addressing health emergency prevention, preparedness and response efficiently ;**

**PP11** Recognizing the potential of digital technologies to strengthen global health security, implement public health measures, bolster national response efforts resulting from COVID-19, to protect [INS: educate,] and empower individuals and communities, including by building on decision WHA73(28) (2020) on Digital Health;

**PP12** Acknowledging the many unforeseen public health impact [INS: s], social and economic consequences, challenges such as postponed treatments and mental health issues, resources and healthcare force needs generated by the COVID-19 pandemic and the potential re-emergences thereof, as well as the multitude and complexity of necessary immediate and long-term actions;

PP17 Bis Recognising also the need to address the unequal distribution and supply of oxygen to respond to, inter alia the COVID pandemic, to those most in need;

**PP18** Highlighting the role of WHO in facilitating universal access to health services in all countries, particularly [DEL] [INS low and middle income] ones, which is also important for preparedness and resilience during a health emergency.

**PP19** Acknowledging the importance of strong health systems, universal, timely and equitable access to, and fair distribution of, all quality, safe, efficacious and affordable essential health services [INS medicines, ] technologies and products, and the need to remove obstacles thereto;

PP19 Bis Encouraging member states to adopt and implement internationally agreed health care standards to help realize the highest attainable standard of physical and mental health, including the WHO-WFSA International Standards For a Safe Practice of Anesthesia;

**PP27bis** Welcoming the International Year of Health and Care Worker and recognising that without significant investment into the training and education of new and existing health care workers, countries will remain insufficiently prepared to address future health emergencies;

**OP5 CALLS ON international actors, partners, civil society** [INS; professional associations] **and the private sector to:**

OP5.2 address the unequal distribution and supply of oxygen to respond to, inter alia the COVID pandemic;

**OP6.13** Make proposals on the use of digital technologies, by WHO and IHR State Parties and, as appropriate, other stakeholders [including civil society], to upgrade and modernize communication on health emergency preparedness and response, including for the improved implementation for IHR during health emergencies, through the development of an interoperability framework for secure global digital health information exchange.;

**P6.22** Strengthen effective, representative and transparent governance, communication and oversight mechanisms that enable Member States **and NSAs?** to provide informed guidance to WHO’s work, especially during health emergencies;

# The Global Medical Technology Alliance

The Global Medical Technology Alliance‘s (GMTA) member associations represent companies that produce the medical devices, diagnostics and health information systems that are transforming health care through earlier disease detection, less invasive procedures and more effective treatments. Our members manufacture the products essential to fighting COVID-19 (like PPE, ventilators, diagnostic tests, etc.) The companies our associations represent produce about 90 percent of the healthcare technology purchased and utilized annually around the world.

The GMTA appreciates the thoughtful preparation of the EU’s “Draft Resolution on Strengthening WHO Preparedness for and Response to Health Emergencies.” There is much to commend about this draft resolution. However, we are concerned that among the acknowledgements of

the tremendous effort by many parties to attack COVID-19, there is no mention of private industry.

The private sector very quickly ramped up development, manufacturing and distribution of the full range of medical devices, diagnostics, and vaccines essential to fight this terrible pandemic. We responded to a surge in demand never seen before and have engaged in unprecedented levels of

collaboration in an effort to further increase manufacturing of life-saving medical technologies. We were able to accomplish these remarkable results despite facing government trade restrictions and internal lockdowns, as well as severe transportation bottlenecks that disrupted global supply chains. We hope future drafts of this resolution will recognize our critical role ***–*** by either expanding OP5, or by inserting appropriate language in the preambular paragraphs – and

will encourage governments to avoid measures that constrain and disrupt supply chains.

# The Task Force for Global Health

The Task Force for Global Health, founded in 1984 and located in Decatur, Georgia, USA, works with WHO, national governments, and partners in more than 150 countries to eliminate diseases, ensure access to vaccines and essential medicines, and strengthen health systems to protect populations.

We have joined with many others on COVID-19 activities including providing vaccine safety guidelines; digital contact tracing; training epidemiologists on disease surveillance and response; distributing essential protection and treatment to hard-hit communities; using existing health programs to ensure protection for vulnerable groups; and providing technical assistance to low- and middle-income countries on vaccine distribution.

Most recently, in partnership with the U.S. Centers for Disease Control and Prevention (CDC), we are working with up to 50 low- and middle-income countries with COVID-19 immunization programs with expertise from three Task Force programs: the Partnership for Influenza Vaccine Introduction (PIVI), which supports expanded access to influenza vaccines in low- and middle-income countries; the Brighton Collaboration, which evaluates vaccine safety; and the Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET), which trains field epidemiologists in more than 100 countries. Through this effort, The Task Force and CDC will help countries develop plans and capacity to receive and rapidly administer COVID-19 vaccines. Additionally, the initiative will assist countries to conduct monitoring and evaluation of vaccine delivery, use, timeliness, safety, and effectiveness. This new initiative will focus on refining and strengthening established vaccination programs to support the current COVID-19 response, improving readiness and response capacity, while strengthening health systems for future pandemic and epidemic threats.

We appreciate this opportunity to comment on the EU-led Draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies, and congratulate the drafting team on its comprehensive and timely approach. We strongly support the call for adequate and sustainable financing for public health preparedness activities, and ask for careful consideration of how outbreaks can be quickly and appropriately investigated, including the potential for an independent body of experts that could be convened regionally on an emergency basis.

Comments:

COVID-19, by highlighting massive racial and social inequities in disease, infection, and mortality, has brought unprecedented public attention to the issue of health equity. The global availability of COVID-19 vaccines is currently limited to a privileged few. Equitable distribution of COVID-19 vaccines represents one of the most complex, urgent, and publically scrutinized challenges for health equity ever faced by our global community. Widespread vaccine hesitancy and distrust of government institutions threaten to *increase,* rather than reduce, the health inequities laid bare by the pandemic. How we as a global health community address this challenge will reveal whether our rhetoric about health equity is matched by our commitment to actions that deliver equitable outcomes.

While we all agree that health equity is a primary core value, and goal, of global health, there is no consensus that global health programs actually improve health equity, and little is known about how to design and implement initiatives to achieve it. Typically, global health programs focus on achieving population-level objectives, such as national vaccine coverage. Health equity is assumed – and often neglected – rather than built into the design of programs and measured explicitly.

Furthermore, existing approaches to vaccine equity have not adequately accounted for critical factors, such as preferential access through advance purchase agreements, vaccine availability, manufacturing costs, variability in cold chain requirements, and limited public health workforce and systems capacity. Nor have existing approaches defined operational procedures for fair vaccine allocation, or addressed contextual factors, such as structural contributors to health inequity in different settings, or considered equity in the context of other public health and economic recovery goals —particularly among low- and middle-income countries and LMICs. Adding a statement on the importance of health equity to the Resolution, and asking Member States and partners to plan for and measure the impact of the COVID-19 vaccine on health equity, will be strong steps in the right direction.

Recommendations

Therefore, we respectfully recommend that:

1. In the PP section, it would be pertinent to note that COVID-19 has revealed and exacerbated existing global health inequities.

2. In the OP section, it might be recommended that WHO, member states, and partners establish plans for equitable vaccine distribution and develop monitoring systems to document the extent to which equity is achieved. Member States could be asked to report back to the WHO Executive Board in 2 years.

Thank you for the opportunity to comment. We thank and congratulate this group for its excellent work to move the discussion forward.

# The International Federation of Biomedical Laboratory Science

The International Federation of Biomedical Laboratory Science (IFBLS) represents a global workforce that contributes enormously to the drive for preparedness and response to biological health emergencies.

IFBLS welcomes the EU led Draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies.

IFBLS notes and supports the statements in PP5, 6, 8, 9, 10, 14, 18, 19, 25 and 27. We support OP4.2 and 4.3.

IFBLS believes that a competent and resourced clinical diagnostic laboratory capacity is critical to the detection, monitoring and defeat COVID-19 and to assist in building back a more prepared, equitable healthcare environment.

Lessons learned through the sharing of sequencing data of the original virus and its subsequent mutations in this pandemic should become the norm in any future such emergencies. Furthermore, the emergence of variants highlights the need for sequencing capacity at a global and regional level. The long term sequelae of this disease highlights the importance of quality diagnostics for monitoring and disease prognosis if this disease burden on individuals and society is to be diminished.

**IFBLS wish to make the following proposal for inclusion in the draft resolution.**

That WHO proposes recommendations on how the uneven preparedness of countries for the molecular testing of Covid 19, or other biological challenges, can be addressed by global investment in the education, training and equipping of Biomedical Laboratory Scientists to ensure there is equality of access to diagnosis and treatment.

# Global Health Council

Thank you for providing the opportunity for civil society organizations including the Global Health Council (GHC) to provide input and feedback on the EU-led Draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies. The EU has an opportunity to elevate the level of ambition for a WHO reform process that will galvanize political support and catalyze action. We hope that this process will not only include Ministries of Health from WHO members states but also engage heads of state and whole of governments participation to drive meaningful progress towards supporting a stronger WHO and enhanced global ecosystem for health preparedness.

Our community already provided an initial response to the consultation, but given significant additional input from partners before tomorrow’s deadline,  are pleased to share an expanded list of comments and revised language suggestions for your consideration. This particularly reflects contributions by the GHC Multilateral Roundtable, GHC Global Health Security Roundtable, Global Health Technologies Coalition, United Nations Foundation, Pandemic Action Network and Women in Global Health.  We are pleased to provide additional background on any of these comments or would be pleased to convene a dialogue on specific areas of input if helpful.  Thank you in advance for our consideration and best of luck with the ongoing WHO reform consultation efforts.

**PP10** Acknowledging further that the Covid-19 pandemic has highlighted the critical role of timely and transparent sharing of epidemiological and clinical data, samples, knowledge and information, including sex-disaggregated data timely identification and notification and acknowledging the primary role and responsibility of Member States in preventing, preparing for and responding to health emergencies;

**GHC Comment on PP10:** Please consider adding expanded language in red above.

**PP12** Acknowledging the many unforeseen and intersectional public health impacts, social and economic consequences, challenges such as postponed treatments and mental health issues, resources and healthcare force needs generated by the COVID-19 pandemic and the potential re-emergences thereof, as well as the multitude and complexity of necessary immediate and long-term actions;

**GHC comment on PP12**: please consider adding the language noted above in red.

**PP15** Noting also the need for continued Member State coordination and inclusive collaboration at all levels of governance across organizations, regions and sectors, including with non-state actors and the whole of society;

**GHC Comment  on PP15**: This could be strengthened by fully defining non-state actors and the important role civil society, the private sector and others play in the WHO universe

**PP16** Recognizing that the COVID-19 pandemic, and its health, social and economic consequences, have further underlined the need, inter alia, for strong global multilateral cooperation, including in global public health, across all sectors using a holistic One Health approach and alignment with commitments to achieve Universal Health Coverage in SDG 3 (3.8);

**GHC Comment on PP16**: please consider language expansion noted above in red.

**PP24** Taking note of the report of WHO Director General, the report of the Independent Panel for Pandemic Preparedness and Response (IPPR), the report of the Review Committee on the Functioning of the International Health Regulations (2005), the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC), as well as the report of the Global Preparedness Monitoring Board;

**GHC Comment on PP24:** We encourage the delegation to strengthen the language here.  Rather than “taking note” of these reports, we would suggest “leveraging” these recommendations as a means to facilitate Member State uptake and action.

**PP25** Recalling the reviews and evaluations following the Severe Acute Respiratory Syndrome (SARS-CoV) epidemic, the H1N1 influenza pandemics and the Ebola outbreaks, which have highlighted shortcomings and inequities in the global capacity to prepare for and respond to outbreaks, and have made numerous and specific recommendations to address these shortcomings;

**GHC Comment on PP25:** Please consider including language noted above in red.

**OP4.1** step up efforts to prioritize and invest in global health security and pandemic preparedness and to build, strengthen and maintain the capacities required under the International Health Regulations (2005), including through timely Joint External Evaluations of their IHR capacities in light of the COVID-19 pandemic; the development, funding and implementation of National Action Plans for Health Security; establishment of an enduring, sustainable financing mechanism to bolster country preparedness; review of gaps in capacity measurements for pandemic preparedness such as R&D for medical countermeasures;  and  support to global evaluation mechanisms and multisectoral follow-up actions on their recommendations;

**GHC Comment on OP4.1:** Please consider suggested language expansion above in red. This OP could also be divided into two or more action items as leaders should place strong emphasis on these actions.

**OP4.2** strengthen integrated surveillance and continuous information-sharing with WHO as required under the IHR as well as simplification and unification of reporting, in particular the timely notification to WHO of all events which may constitute a public health emergency of international concern in accordance with article 6 of the IHR. These efforts should leverage existing bodies such as GOARN, better integrate data from PHC records, consensus data and regional surveillance networks such as IDSR;

**GHC Comment on OP4.2:** Please consider language expansion above in red.

**OP4.4** strengthen National IHR Focal Points (NFP) and foster a One Health approach to strengthen health security at national level, taking into consideration recommendations provided by the WHO secretariat, including by reviewing the position of NFPs within national institutional structures, and to consider an increased level of autonomy to improve the effectiveness and efficiency of NFPs in the implementation of health measures under the IHR;

**GHC Comment on OP4.4:** GHC suggests linking this more explicitly to the need for national health emergency coordinators who have sufficient reach and authority, such as someone with a cabinet level position. GPMB has called for every country to appoint someone to this role.

**OP4.6** protect against the spread of disease and, giving due consideration to global health, avoid unnecessary interference with international traffic and facilitate cross-border movement for essential humanitarian purposes, especially during public health emergencies of international concern;

**GHC Comment on OP4.6:** GHC sees these as two important topics which should be split into two distinct operative paragraphs.

**OP4.7** consider how best to de-link travel from trade restrictions under emergency conditions, with the goal of maximizing the effectiveness of public health measures while minimizing economic impacts and adhering to the principle of human rights enshrined in IHR;

**GHC Comment on OP4.7:** Please consider the expanded language proposed above in red.

**OP4.9** commit to continuous follow-up to the recommendations of the IHR Review Committee and the Independent Panel on Pandemic Preparedness (IPPR);

**GHC Comment on OP4.9:** Per comments reflected previously, GHC suggests a more ambitious approach of recommending a specific process convened by the UNSG to take forward the IPPR recommendations and table them for member state action and commitments at a forthcoming Special UN Summit on Preparedness and a mandated year on year intergovernmental process akin to the COP that will drive policy commitments, financing and accountability.

**OP5.1 commit to step up efforts to prioritize and invest in global health security and pandemic preparedness, to** strengthen partnerships, global coordination and cooperation to detect, prevent and respond to infectious disease outbreaks based on lessons learned from COVID-19 and fostering an equitable, gender-transformative, and  one health approach, including between WHO and relevant organizations and UN agencies, including through the Global Action Plan for healthy Lives and well-being for all and commitments to achieve Universal Health Coverage;

**GHC Comment on OP5.1:** Please consider language expansion proposed above in red.

**GHC Comment proposing addition of OP5.2:** GHC suggests adding an OP 5.2 focused on evaluating the effectiveness of Access to COVID Tools Accelerator to determine how elements of that COVID-19 response coordination effort may pivot to longer-term multi-partner health preparedness and response efforts in the future, and what WHO’s and the Global Action Plan's role should be in that.

**OP6 REQUESTS the Director General to:**

**OP6.1** Strengthen the WHO’s normative role, including by empowering as appropriate the Chief Scientist’s Office to advance the development of target product profiles for therapeutics, vaccines diagnostics and other medical technologies to address health threats, and support the development of the WHO Academy to enable WHO to rapidly disseminate high-quality guidance for scientists, health workers and the general public and make global expertise available at all levels of WHO and Member States. WHO should continue to serve as a key focal point for regulatory bodies to ensure consistent safety, efficacy and programmatic suitability reviews of all new health products and to facilitate efficient national and regional uptake, including through Emergency Use Listing and Prequalification;

**GHC Comment on OP6.1:** Please consider the proposed language expansion above in red. The last sentence could also be inserted as an additional OP.

**OP6.9** Develop a detailed concept note and report, inclusive of conducting an open and public consultation process, on the proposed voluntary pilot phase of the Universal Health and Preparedness Review (UHPR) mechanism with the aim to assess and improve overall preparedness, for the consideration of Member States;

**GHC Comment on OP6.9:** Please consider language expansion proposed above in red.

**OP6.10** Propose options for approaches to increase the diversity of and transparency on the appointment, the membership and the deliberations of the IHR Emergency Committee, in particular in relation to a declaration of and suggested response measures to a PHEIC, including options for the engagement of Member States with it;

**GHC Comment on OP6.10:** Please consider language expansion proposed above in red.

**OP6.13** Make proposals on the use of digital technologies, by WHO and IHR State Parties and, as appropriate, other stakeholders, to upgrade and modernize communication on health emergency preparedness and response, including for the improved implementation for IHR during health emergencies, through the development of an interoperability framework for secure global digital health information exchange.;

**Comment on adding a new OP after OP6.13:** GHC suggests adding a new OP focused on R&D for medical countermeasures as this is a significantly overlooked aspect of health preparedness “"Make proposals on including research and development of medical countermeasures as an additional component of IHR implementation to ensure all member states have the capacity or a pathway to gain access to the tools it needs when it needs them during a health emergency.”

**OP6.16** Propose strategies to coalesce the normative role WHO plays coordinating with researchers, product development partners, and the private sector to ensure the rapid development, production, and global equitable deployment of medical and other countermeasures and commodities to respond to future health emergencies, based on lessons learnt from the COVID-19 response, including through strengthened product development partnerships;

**GHC comment on OP6.16:** Please consider language expansion proposed above in red. GHC recommends that WHO not be positioned as directly advancing product development but rather informing and serving as a key focal point for product developers.

should not all be under the purview of the WHO DG - they should not solely own the future as the global R&D coordinating and implementation hub for the reasons we have discussed - they can't be judge, jury and implementor  - their role is normative, the arbiter of the science and standard setting

**OP6.22** Strengthen effective, representative, diverse, equitable and transparent governance, communication and oversight mechanisms that enable Member States to provide informed guidance to WHO’s work, especially during health emergencies;

**GHC Comment on OP6.22:** Please see suggested language expansion in red above.

**OP6.25** Mandate an existing committee or an ad-hoc time-limited panel or expert group to follow up on the implementation of this resolution and, in consultation with this panel, present a report on the implementation of this resolution through the Executive Board to the 75th World Health Assembly.

**GHC Comment on OP6.25:** GHC believes the GPMB already serves this purpose so it would be duplicative to create a new WHO-convened expert group or panel. An alternate proposal is member states should ask the UN Secretary General to form a special task force that will turn these recommendations into actionable commitments by UN member states at the head of state leve, rather than at a Ministry of Health level. The DG should ensure WHO's technical support for that process.

**OP6.26** (a) support the convening of the Working Group on WHO Strengthening and Global Preparedness, as frequently as necessary, (b) provide complete, relevant and timely information to the Working Group for its discussions; and (c) allocate the necessary resources for the Working Group to carry out its mandate.

**GHC Comment on OP6.26:** GHC suggests cutting or reframing this OP in light of comment reflected on OP6.25

**OP6.27** Based on the recent explicit recognition of the gendered effects of COVID-19 response policies by the IHR Emergency Committee and in alignment with the IHR Article 3 commitment to human rights, the United Nations Security Council Resolution 1325 for Women, Peace and Security, the UN Political Declaration for Universal Health Coverage , and the UN Sustainable Development Goals, explicit efforts to strengthen gender equity in pandemic preparedness and response, including:

**OP6.27.a -** Ensuring core capacities within the IHR explicitly recognize the wider gendered effects of health emergencies, including on health, economic stability, and wellbeing;

**OP6.27.b -** Mandating National Health Security Action Plans, the Joint External Evaluations (JEE), WHO’s monitoring and evaluation processes, IHR Risk assessments, and After Action Reviews to reference and be inclusive of gender inequities;

**OP6.27.c -** Commiting to equal gender-representation on the IHR Emergency Committee and participation of gender advisors as non-participant observers of EC meetings;

**OP6.27.d -** Ensuringall data collected by WHO (including reported under the IHR & by the Health Emergency Programme) is published and disaggregated by sex;

**OP6.27.e -** Ensuring lessons learned exercises mainstream gender to support diverse, equitable, resilient, and sustainable emergency response and recovery.

**GHC Comment on adding section OP6.27:** GHC recommends adding a new OP based on joint Women in Global Health and Gender & COVID-19 recommendations, which were actually shared publicly by DG Tedros in October. A specific section is necessary given the widespread issues and signalled support by WHO to translate some of these into actual commitments.

- <https://twitter.com/DrTedros/status/1321882198635589634>

-<https://www.genderandcovid-19.org/wp-content/uploads/2020/10/Strengthen-gender-mainstreaming-in-WHOs-pandemic-preparedness-and-response.pdf>

-<https://blogs.bmj.com/bmj/2020/11/20/strengthening-pandemic-preparedness-and-response-begins-with-answering-the-question-where-are-the-women/>

These are based on joint Women in Global Health and Gender & COVID-19 recommendations, which were actually shared publicly by DG Tedros in October -- I've tried to mainstream elsewhere, but feel a specific section is necessary given the widespread issues and signalled support by WHO to translate some of these into actual commitments.

- [https://twitter.co/DrTedros/status/1321882198635589634](https://twitter.com/DrTedros/status/1321882198635589634) -<https://www.genderandcovid-19.org/wp-content/uploads/2020/10/Strengthen-gender-mainstreaming-in-WHOs-pandemic-preparedness-and-response.pdf>

-<https://blogs.bmj.com/bmj/2020/11/20/strengthening-pandemic-preparedness-and-response-begins-with-answering-the-question-where-are-the-women/>

# International Planned Parenthood Federation

Thank you so much for convening this meeting amongst CSO representatives and EU Member States.  As promised, I am attaching written comments to strengthen the draft resolution on Strengthening WHO Preparedness and Response to Health Emergencies.

We believe that while it is a good basis for our work, it currently leaves out the critical role that CSO and community participation play in addressing health emergencies, a role numerous states highlighted during the most recent Executive Board as more critical and evident than ever. It also lacks a mention of those most left behind and disproportionately affected health services.  We have therefore suggested some additions to strengthen the draft in these areas.

**PP3** Recalling the constitutional mandate of WHO to act, inter alia, as the directing and coordinating authority on international health work, and recognizing the Organization’s key leadership role within the broader United Nations response and the importance of strengthened multilateral cooperation in responding to health emergencies and the**ir** extensive negative impacts ~~thereof;~~

**PP11** Recognizing the potential of digital technologies to strengthen global health security, implement public health measures, bolster national **ADD:** **preparedness and** response efforts **ADD:** **to health emergencies, including [DELETE:** ~~resulting from ]~~COVID-19, to protect and empower individuals and communities, including by building on decision WHA73(28) (2020) on Digital Health;

**PP14** Noting the need for a coordinated UN system wide approach, including the involvement of non-state actors and communities, **ADD:** **including women, youth and community based organizations** to prevent emergencies and address them as soon as they appear;

**PP17** Recalling the United Nations General Assembly resolutions 74/270 (2020) on global solidarity to fight the coronavirus disease 2019 (COVID-19) and 74/274 on international cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19; **ADD:** **and resolutions A/RES/75/157 Women and Girls and the Response to the coronavirus disease (COVID-19), and A/RES/75/156 Strengthening National and International Rapid Response to the Impact of the coronavirus disease (COVID-19) on Women and Girls**

**PP19** Acknowledging the importance of strong health systems, universal, timely and equitable access to, and fair distribution of, all quality, safe, efficacious and affordable essential health services, technologies and products, **ADD:** **including on sexual and reproductive health** and the need to remove obstacles thereto **ADD:, including in humanitarian settings**;

**OP1 DECIDES** to establish an open-ended Member State Working Group on WHO Strengthening and Global Preparedness, open to all Member States **ADD:, and to non-state actors as observers** [footnote: and, where applicable, regional economic integration organizations.];

**OP5.1** strengthen partnerships, global coordination and cooperation [**DELETE:** ~~in response to infectious diseases ]~~based on lessons learned from COVID-19 and fostering a one health approach, including between WHO and relevant organizations and UN agencies, including through the Global Action Plan for healthy Lives and well-being for all;

***Note****: We suggest not limiting the lessons learned from COVID to those related to infectious disease, but to include lessons learned from COVID in any area related to health to increase coordination and cooperation. This also brings it into alignment with OP 6.16*

**OP6.1** Strengthen the WHO’s normative role, including by empowering as appropriate the Chief Scientist’s Office, and support the development of the WHO Academy to enable WHO to rapidly disseminate high-quality guidance and make global expertise available at all levels of WHO **ADD:, in partnership with CSOs, including women, youth and community based organizations**

**OP6.8** Support countries in strengthening capacities to report on the information required under the IHR **ADD:, including national statistics institutions to provide quality data disaggregated by income, sex, age, race, ethnicity, migratory status, disability and geographic location, and other nationally relevant status,** and encourage early reporting and sharing of information in line with IHR Article 44 requiring Member States to collaborate for IHR implementation;

***Note****: Strengthening the capacities of national statistics institutions are key to their abilities to report information required under the IHR, and this list of disaggregation brings it in line with the 2030 Agenda on Sustainable Development.*

**OP6.12** Lead an evidence-based process, in consultation with the Member States (REIO footnote) and relevant UN **ADD:, civil society organizations, including women, youth and community-led organizations,** and other international organisations, as appropriate, to:

**OP6.16** Propose strategies to ensure the rapid development, production, and global equitable deployment of **ADD:** **age and gender-responsive** medical and other countermeasures and commodities to respond to future health emergencies, **ADD:** **especially for communities which are disproportionately impacted,** based on lessons learnt from the COVID-19 response;

**OP6.17** Develop strategies and tools for managing the collateral health risks associated with health emergencies, including by comprehensively increasing the resilience and, capacity of health systems, in particular the health workforce, in the provision of essential public health functions and essential health services**,** **ADD:** **including sexual and reproductive health,** during health emergencies;

# United States Pharmacopeia

USP is a 200-year-old nonprofit organization that sets standards for the identity, strength, quality, and purity of medicines, food ingredients, and dietary supplements worldwide. Through our standards, advocacy, and education, we help increase the availability of quality medicines, supplements, and food for billions of people worldwide. We support WHO’s efforts in strengthening the preparedness and response to health emergency strategies, and in particular for the COVID-19 pandemic (<https://www.usp.org/covid-19>)

The following is USP’s comment for consideration in the EU resolution:

During global health emergencies like the COVID-19 and other recent pandemics, governmental institutions, as well as other national or international organizations develop response tools (e.g., guidelines, toolkits, position papers, webinars) to address individual country, regional or global needs. Wide dissemination and rapid access to these tools, and subsequent use, could be critical for countries facing similar health emergencies but lacking the resources to develop them. We recommend creating a space on the WHO web site, where Member States and Non-State Actors who are in an official relationship with WHO could upload those newly developed tools, so countries could have free access to them and adapt them to their own needs. That space could be located-in or linked-to IRIS. Given that time is of the essence for a response that can save lives, access and availability of this unique repository will represent an important resource for many Member States. Should that space be created on WHO’s website, a disclaimer could be included to state that the tools at the site have not been vetted by WHO and their inclusion does not constitute an endorsement or recommendation by WHO.

Union for International Cancer Control & the NCD Alliance  
UICC and the NCD Alliance congratulates the EU delegation on the development of the draft resolution text and thank them also for their proactive engagement of civil society organisations through an online consultation.

The COVID-19 pandemic has simultaneously demonstrated the importance of health as a foundation for global development and prosperity and the vulnerability of health systems and populations around the world. It has exacerbated the economic and social inequalities within and among countries and has reversed some of the hard-won development gains and hampering progress towards achieving the SDGs.[[1]](#footnote-1)

In its omnibus resolution on the COVID-19 response, the UN General Assembly calls on Member States to further strengthen efforts to address non-communicable diseases (NCD), recognising that people living with are amongst the most impacted by the pandemic.1 These individuals have been directly and indirectly affected both from their heightened risk of severe COVID-19 infection, but also as a result of disruptions, delays and cancellations of treatment and palliative care services delayed. The WHO PULSE survey found that 69% of countries reported disruption to NCD diagnosis and treatment and 55% of countries reported some disruption of cancer services.[[2]](#footnote-2) The impact of these disruptions could be severe with a recent review in Lancet Oncology found that every four weeks of delay cancer surgery increased the risk of death from the leading causes of cancer by 6-8%.[[3]](#footnote-3)

Indirectly, the unintended consequences of lockdown and other control measures have increased exposure to key risk factors like physical inactivity and the use of alcohol and tobacco as coping mechanisms. Finally, the disruption of screening services and concerns over on the part of the general public to seek help in response to concerning symptoms has resulted in concerning declines in cancer diagnoses over the past year in many countries. In Europe alone, rates of cancer diagnosis have dropped around the region from 90% in Kazakhstan to 30-40% in the Netherlands and Belgium.[[4]](#footnote-4) Cancer rates are unlikely to have declined, meaning that many patients will simply be diagnosed later, reducing their chances of successful treatment and survival and increasing the need for resource-intensive treatment in weakened health systems.

Looking ahead, the growing global burden of NCDs and persistent inequities in exposure to risk factors and access to affordable and quality diagnosis, treatment and palliative care will be that certain populations will remain acutely vulnerable to the direct and indirect impacts of future pandemics. Efforts to improve public health and address inequities will therefore be critical to effective preparedness and response. We identify several opportunities to better integrate health promotion, disease prevention to further strengthen the document, and in this spirit we offer the following comments:

|  |  |
| --- | --- |
| **Paragraph** | **Rationale** |
| **PP12** Acknowledging the many unforeseen public health impact, social and economic consequences, challenges such as postponed treatments, missed or delayed diagnoses, and mental health issues, resources and healthcare force needs generated by the COVID-19 pandemic and the potential re-emergences thereof, as well as the multitude and complexity of necessary immediate and long-term actions; | One of consequences of the COVID-19 pandemic is likely to be a rise in preventable mortality and morbidity as a result of missed or delayed diagnosis. Early diagnosis is critical for cancer and other NCDs to improve the chances of successful treatment, with fewer side effects and at lower costs to individuals and health systems. As countries emerge from the pandemic, they are likely to be faced with a subsequent wave of undiagnosed and late-stage conditions which will put additional toll on patients, already weakened health systems and healthcare workers. |
| **PP14** Noting the need for a coordinated UN system wide approach, including the involvement of non-state actors and communities, to improve population health and resilience, strengthen health systems, prevent emergencies and address them as soon as they appear; | COVID-19 has demonstrated how underlying conditions, like NCDs, significantly increases both the risks of infection and potential severity of disease. As such, improving population health should be a key component of future pandemic preparedness plans to increase the resilience of individuals, community, and the potential burden of health systems. |
| **PP16** Recognizing that the COVID-19 pandemic, and its health, social and economic consequences, have further underlined the need, inter alia, for strong global multilateral cooperation, including in global public health and health systems strengthening, across all sectors using a holistic One Health approach; | COVID-19 was a severe stress test for health systems around the world and as part of a comprehensive response, and to ensure populations are better protected against future pandemics, further investment, technical support and political prioritisation is needed in health system strengthening as part of a OneHealth approach. |
| **PP18** Highlighting the role of WHO in facilitating universal access to health services across promotion, prevention, treatment, rehabilitation and palliative care in all countries, particularly the most vulnerable ones, which is also important for preparedness and resilience during a health emergency. | The pandemic has highlighted and exacerbated inequities in access to health services and health outcomes. We would urge Member States to explicitly recognise this and centre future work to address these inequities and ensure the safety and health of all populations. |
| **PP22** Acknowledging that the Covid-19 pandemic, together with the latest health emergencies, have shown that the international community’s expectations, while varying according to national contexts, generally outweigh the current WHO resources, capacities and its ability to support Member States in developing strong and resilient health systems for emergency outbreak prevention and response and that deliver high-quality services to all those in need, leaving no one behind; | As recognised later in the document, WHO’s resources to respond to Member State requests are currently not sufficient, and an increase in resources will be required to fulfil the roles set out in the draft resolution (text included for the sake of coherency). |
| **OP2 REQUESTS** the Working Group to review interim and final recommendations from the IHR Review Committee, the Independent Oversight and Advisory Committee for WHE, the Independent Panel for Pandemic Preparedness and Response (IPPR), and to take into account relevant work of WHO and other relevant bodies and organizations including non-state actors, with a view to ensuring that WHO and the international system are effectively empowered to defeat COVID-19 and build back better for a more prepared, equitable, and healthy world; | Non state actors, particularly civil society organizations have played multiple active roles throughout the pandemic response (including conducting research into the impact of COVID-19 on different patient populations, providing support to continue services etc.) as such these organizations provide a further body of knowledge and good practices which could be drawn on. We strongly encourage Member States of the Working Group to explore the development of a civil society consultation group or other such mechanism to coordinate input drawing on experience Including clinical and public health experts, health professionals’ associations, and patient groups across all WHO regions. |
| **OP4.6** protect against the spread of disease and, giving due consideration to global health, avoid unnecessary interference with international traffic and facilitate cross-border movement of healthcare workers, medicines, vaccines, technologies, PPE and other health products for essential humanitarian purposes, especially during public health emergencies of international concern; | ACT-A and COVAX have provided useful platforms to address some of the issues faced throughout the pandemic, particularly with regards to access to essential medical products in LMICs. But, ensuring the free flow of PPE, vaccines, diagnostics etc. for future pandemics will be critical to effective pandemic responses, including ensuring sufficient protection of healthcare workers and patients accessing essential and time-critical health care unrelated to the pandemic. |
| **OP5.1** strengthen partnerships, global coordination and cooperation in response to infectious diseases and other health threats including AMR and climate change based on lessons learned from COVID-19 and fostering a one health approach, including between WHO and relevant organizations and UN agencies, including through the Global Action Plan for healthy Lives and well-being for all; | In light of projected health impacts of antimicrobial resistance and climate change far outstripping those experienced during the COVID-19 pandemic to date, it is vital to ensure that lessons learned, partnerships and collaborations established are transferable to other anticipated and unanticipated global health threats, and not only (respiratory / viral) epidemics. |
| **OP6.1** Strengthen the WHO’s normative role, including by empowering as appropriate the Chief Scientist’s Office, and support the development of the WHO Academy to enable WHO to rapidly disseminate high-quality guidance, including on the maintenance of essential health services, and make global expertise available at all levels of WHO | Due to concerns regarding infection, many some health systems were forced to cancel or shut down essential health services during the pandemic while others were able to continue provision with new safety measures in place. We see a critical role for WHO to provide guidance around how Member States can preserve/ continue essential health services in the midst of a pandemic in order to minimise the subsequent preventable mortality, ill health and suffering from delayed or missed diagnoses, treatment and palliative care. |
| **OP6.7** Make recommendations to build a more consistent overall evaluative system enabling accurate and independent assessment and reporting on national capacities in IHR implementation and underlying population health indicators, including through reviewing and strengthening existing mechanisms such as the IHR evaluation and Joint External Evaluations (JEE) mechanisms, with a view to strengthening the preparedness and response capacity of the States Parties; | COVID-19 has demonstrated how underlying health conditions, like NCDs, significantly increases both the risks of infection and potential severity of disease. As such, monitoring and improving population health should be a key component of future pandemic preparedness plans to increase the resilience of individuals, community, and the potential burden of health systems. We also strongly encourage Member States to consider and use existing data sets which, while sometimes drawing on modelled data an estimates where national-level data is missing, can provide some reference points for decision making (including national cancer registries and GLOBOCAN, IHME Global Burden of Disease, and WHO progress monitors and country capacity surveys). |
| **OP6.8** Support countries in strengthening capacities to report on the information required under the IHR as part of strengthening national health information systems, including vital registration, and encourage early reporting and sharing of information in line with IHR Article 44 requiring Member States to collaborate for IHR implementation; | A strong health information system is one of the essential building blocks of a robust and resilient health system, providing Member States with the data required for evidence-based decision making. Investments in IHR information and reporting systems should reinforce and further strengthen national health information systems, the absence of which has significantly hindered national COVID-19 responses and recovery, and ultimately global security. |
| **OP6.9** Develop a detailed concept note and report on the proposed voluntary pilot phase of the Universal Health and Preparedness Review (UHPR) mechanism with the aim to assess and improve overall preparedness, encompassing health system resilience and the status of public health, for the consideration of Member States; | COVID-19 has demonstrated how underlying health conditions, like NCDs, significantly increases both the risks of infection and potential severity of disease. As such, monitoring and improving population health should be a key component of future pandemic preparedness plans to increase the resilience of individuals, community, and the potential burden of health systems. |
| **OP6.12** Lead an evidence-based process, in consultation with the Member States (REIO footnote) and relevant UN and other international organisations, including non-state actors, as appropriate, to: | Non-state actors have been actively supporting Member States and WHO throughout the COVID-19 pandemic and could provide a valuable source of additional experiences, expertise, and practical support for the implementation of the IHR. |
| **OP6.12bis** Lead an evidence-based process, in consultation with the Member States and relevant UN and other international organisations, including non-state actors, as appropriate, to develop recommendations on improving public health and health systems resilience to mitigate impacts of future health emergencies; |
| **OP6.17** Develop strategies, tools and resource commitments for managing the collateral health risks associated with health emergencies, including by comprehensively increasing the resilience and, capacity of health systems, in particular the health workforce, in the provision of essential public health functions and essential health services, across promotion, prevention, treatment, rehabilitation and palliative care during health emergencies | Member States are call for futher resources for WHO, recognising (including at WHA73 and EB148) that WHO does not currently have the resources required to meet the demands of Member States, as such it may be valuable for the WHO to facilitate the development of resources commitments by Member States (as achieved through COVID and ACT-A) to provide an initial pool of funding and other resources to support rapid response to future emergencies. |
| **OP6.19** Increase efforts to broaden the donor base, including through the WHO Solidarity Fund and the WHO Foundation, while ensuring full Member State oversight, transparency and accountability, while identifying and preventing conflicts of interest; | Given WHO’s reputation and the high-profile nature of pandemic preparedness and response work it will be critical to protect WHO from perceived or actual conflicts of interest, and prevent different private sector actors from using engagement with WHO as a mechanism to whitewash their reputations etc. |

# Public Services International

Public Services International is a Global Union Federation of more than 700 trade unions representing 30 million workers in 154 countries. We bring their voices to the UN, ILO, WHO and other regional and global organisations. We defend trade union and workers' rights and fight for universal access to quality public services

We appreciate the opportunity for civil society organisations, as non-state actors in official relations with the World Health Organization, to participate in the formulation of a World Health Assembly resolution on “Emergency Preparedness and Response”. We welcome the fact that the zero-draft includes recommendations of steps for both the WHO secretariat and Member States, towards strengthening global crisis preparedness and response, in the light of lessons learnt from the COVID-19 pandemic.

There are two issues, which we would urge you to include/emphasize in the draft resolution. These are the pressing need for:

**1. Adequate investment in public health for universal access.**

PP18 highlights the importance of “universal access to health services in all countries” for “preparedness and resilience during a health emergency.” PP19 further acknowledges “the importance of strong health systems”, which can ensure “universal, timely and equitable access”, and the need to remove obstacles to this critical necessity.

Only strong, well-funded public healthcare systems can ensure universal, timely and equitable access. And one of the key lessons from the COVID-19 pandemic is that years of cuts in the funding of public health, including for disease control and prevention, undermined crisis preparedness.

We thus propose the reformulation of **OP4.1** thus:

*Step up efforts to build, strengthen and maintain the capacities required under the International Health Regulations (2005), including through adequate funding of the public health system and support to evaluation mechanisms and multisectoral follow-up actions on their recommendations;*

**2. Health employment and public health emergencies**

PP27 expressed “the highest appreciation of, and support for, the dedication, efforts and sacrifices” of health professionals. This is quite welcome. But health and care workers need much more than applause. Governments have to address the root cause of why there was so much burden on health workers. This is because we do not have adequate numbers of health workers and a large number of the available health workforce work under increasingly precarious circumstances.

The 70th World Health Assembly adopted the “Working for Health: Five-Year Action Plan for Health Employment and Inclusive Growth (2017-2021)”. The Plan speaks to the need for transforming the health workforce and enabling change in general, as well as with regard to

public health emergencies. Unfortunately, the Plan’s uptake by Member States has not been inspiring.

This draft resolution presents an opportunity to reiterate the need to invest in the health workforce, laying the basis for safe and effective healthcare delivery and enhanced crisis preparedness. We thus urge you to emphasize the need for Member States to integrate the insights and recommendations of the “Working for Health” plan and the recommendations of the UN High-Level Commission on Health Employment and Economic Growth’s “Working for Health and Growth; Investing in the health workforce” which informed it, as key elements for strengthening global pandemic preparedness and response.

**3. Clearly putting health before wealth in pandemics**

The pandemic showed quite clearly that no-one is safe when we are not all safe. The need for international solidarity was appreciated, but only to an extent. “Vaccine nationalism” has undermined the necessary universal access envisioned in the COVID-19 Resolution of the 73rd World Health Assembly.

While the Access to COVID-19 Technologies (ACT-Accelerator) and COVID-19 Technology Access Pool (C-TAP) have helped to ameliorate this situation, it is important moving forward to take steps which make sure that access to vaccines, medicines and technologies relevant for pandemic response, is not based on how wealthy countries and individuals are. These should include a stand for the suspension of intellectual property rights to such vaccines, therapeutics and technologies, as well as solidarity support for the poorer countries that might still be unable to procure these on their own.

# Handicap International / Humanity & Inclusion

**Comment on PP1-PP8**

**Humanity & Inclusion / Handicap International recommends adding explicit reference to the United Nations Convention on the Rights of Persons with Disabilities (CRPD).**

The focus is on the Article 11 -Situations of risk and humanitarian emergencies-, which refers to persons with disabilities as including those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including Health Emergencies.

**References:**

United Nations (2007). Convention on the Rights of Persons with Disabilities. *United Nations General Assembly resolution 61/106*. Available at: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

**Comment on PP9**

**We suggest expanding this point acknowledging the necessity to promote inclusive debate on ethical considerations related to measures of Health Emergency response.**

Many critical ethical questions arise in pandemic planning, preparedness and response. Health equity is a concrete crucial issue during Health Emergencies: priority access to medications, vaccines and intensive care; obligations of healthcare workers; surveillance, isolation, quarantine and social-distancing measures. A publicly discussed ethical framework is essential to maintain public trust, promote compliance, and minimize social disruption and economic loss. To address those particularly complex questions effectively, open public discussion and careful deliberations must be part of preparedness strategies and plans.

**References:**

World Health Organization (2007). *Ethical considerations in developing a public health response to pandemic influenza*. Geneva: World Health Organization. Available at: <https://www.who.int/ethics/publications/who-cds-epr-gip-2007-2/en/>

**Comment on PP10 and OP4.2**

**We strongly propose to adopt systematically disaggregated data system per gender, age, and disability in data collection before and during Health Emergencies.**

The SARS-CoV2 pandemic has provided additional and strong evidence of the need for data disaggregation to determine whether the rights of persons with disability are being protected during the response. The increased vulnerability of this population to COVID-19 makes imperative to public health officials, governments and researchers to track the pattern of COVID-19 appearance among persons with disability. Disaggregated data facilitate assessing risks, anticipating and planning for appropriate clinical and public health interventions, and maximizing the overall safety and dignity of vulnerable populations.

**References:**

Washington Group on Disability Statistics (2020). Using the Washington Group Tools to Assess the Impact of COVID-19 on Persons with Disability. Paper). Hyattsville: Washington Group on Disability Statistics. Available at: <https://www.washingtongroup-disability.com/>

**Comment on PP12**

**According to Humanity & Inclusion expertise and experience in humanitarian settings, taking into account the long-term impact of Health Emergencies and, therefore, we consider crucial to incorporate rehabilitation in Health Emergency planning and in actions aiming to strengthening the health system.**

Decisions related to epidemic preparedness, response, and management need to be informed not only by short-term priorities, but also by awareness of how those decisions are likely to affect the ultimate destination. In a long-term perspective, COVID-19 survivors may report persistent consequences of their illness. Rehabilitation is crucial to address the needs of people with severe COVID19 during the acute phase (on ventilatory support), the sub-acute phase (during hospitalization) and over the long-term (to optimise physical, mental, cognitive and social functioning). Rehabilitation shortens the duration of hospitalization, relieves pressure on acute care and facilitates long-term recovery.

**References:**

Ceravolo MG, Arienti C, de Sire A, Andrenelli E, Negrini F, Lazzarini SG, Patrini M, Negrini S; International Multiprofessional Steering Committee of Cochrane Rehabilitation REH-COVER action, (2020). Rehabilitation and COVID-19: the Cochrane Rehabilitation 2020 rapid living systematic review. *European Journal of Physical Rehabilitation Medicine*, 56(5):642-651. Available at: <https://doi.org/10.23736/s1973-9087.20.06501-6>

Skegg, D, Gluckman, P, Boulton, G, Hackmann, H, Abdool Karim, S, Piot, P, and Woopen, C (2021). Future scenarios for the COVID-19 pandemic. *The Lancet*. Availabe at: <https://doi.org/10.1016/S0140-6736(21)00424-4>

World Health Organization (2020). *COVID-19: Operational guidance for maintaining essential health services during an outbreak*. Geneva: World Health Organization; 2020. Available at: <https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1>

World Health Organization (2020). *The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment*. Geneva: World Health Organization; 2020. Available at: <https://www.who.int/teams/noncommunicable-diseases/covid-19>

**Comment on the PP15**

**We suggest clarifying the ‘non-state actors’ category mentioning the representative organizations of the most marginalized groups (including the organizations of persons with disabilities).**

For instance, Risk Communication and Community Engagement (RCCE) should promote community participation in order to resulting in increased trust and social cohesion, and ultimately a reduction in the negative impacts of epidemics. It is crucial to ensure meaningful consultation with and active participation of persons with disabilities and their representative organizations in all stages of the emergency preparedness and response. Perspectives and lived experiences of disability contribute to creativity, new approaches and innovative solutions to challenges.

**References:**

United Nations Secretary-General (May 2020). *A Disability-Inclusive Response to COVID-19*. (Policy Brief). New York: Unites Nations. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>

World Health Organization (2020). *COVID19 Global Risk Communication and Community Engagement Strategy*. Geneva: World Health Organization. Available at: <https://www.who.int/publications/i/item/covid-19-global-risk-communication-and-community-engagement-strategy>

**Comment on the PP17**

**We suggest specifying ‘global solidarity’ adding the concept of ‘equitable access’ to medicines, vaccines and medical equipment.**

In a pandemic no one is safe, unless everyone is safe. Having licensed vaccines is not enough to achieve global control of COVID-19: they also need to be produced at scale, priced affordably, allocated globally so that they are available where needed, and widely deployed in local communities. Mechanisms to ensure proportional allocation of vaccines and to ensure fair and equitable access to medical supplies and health technologies are crucial. The Intellectual Property regime should not exclude or limit equitable access to the Right to Health of the most marginalized groups and their access to global public common goods during Health Emergencies.

**References:**

GAVI The Vaccine Alliance (n.d.). *COVAX*. (Website). Available at: <https://www.gavi.org/covax-facility>

Herzog, LM, Norheim, OF, Emanuel, EJ, McCoy, MS (2021). Covax must go beyond proportional allocation of covid vaccines to ensure fair and equitable access. *BMJ*, 372. Available at: <https://doi.org/10.1136/bmj.m4853>

Mofokeng, T, De Schutter, O, Ramasastry, A, Pesce, D, Deva, S, Karska, E, Muigai, G, Okafor, OC, Alfarargi, S (2020). *Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world*. United Nations Human Rights Office of the High Commissioner (website). Available at: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26484&LangID=E#_ftn6>

Wouters, OJ, Shadlen, KC, Salcher-Konrad, M, Pollard, AJ, Larson, HJ, Teerawattananon, Y, Jit, M 2021). Challenges in ensuring global access to COVID-19 vaccines: production, affordability, allocation, and deployment. *The Lancet*. Available at: <https://doi.org/10.1016/S0140-6736(21)00306-8>

**Comment to PP19 & OP5**

**We strongly recommend adopting the concept of ‘inclusive health systems’ recognizing that persons with disabilities are disproportionately affected by public health emergencies.**

According to the UN Secretary General, “persons with disabilities generally have more health-care needs than others – both standard needs and needs linked to impairments – and are therefore more vulnerable to the impact of low quality or inaccessible healthcare services than others”.

Preventive measures often do not take into account particular needs of persons with disabilities and negatively impact their safety, physical and psychological wellbeing. According to Humanity & Inclusion/Handicap International report during the COVID19 crisis in humanitarian settings, persons with disabilities face inaccessible environments and barriers to information hindering their ability to protect themselves and stay healthy. Persons with disabilities are challenged to access therapeutic and prophylactic measures, in particular to maintain long term medical treatment, and access rehabilitation care or social support services.

Inclusive preparedness should ensure:

* Inclusive response considering the needs of persons with disability;
* Promoting universal design of the response tools and services making health care Accessible, Affordable and Inclusive;
* Reinforcing disability service providers in the community and ensuring meaningful participation of persons with disabilities, their representative organizations (OPDs) and other local organizations.

**References:**

Humanity & Inclusion (2020). *COVID-19 in humanitarian contexts: no excuses to leave persons with disabilities behind! Evidence from HI's operations in humanitarian settings*. (Report). Lyon: Humanity & Inclusion. Available at: <https://reliefweb.int/report/world/covid-19-humanitarian-contexts-no-excuses-leave-persons-disabilities-behind-evidence>

World Health Organizations (2020). *Disability considerations during the COVID-19 outbreak*. (Paper). Geneva: World Health Organizations. Available at: <https://www.who.int/publications/i/item/WHO-2019-nCoV-Disability-2020-1>

World Health Organization (‎2020)‎. *Whose Life Matters? Challenges, barriers and impact of COVID-19 pandemic on persons with disability and their care givers*. (Report summary). New Delhi: World Health Organization,Regional Office for South-East Asia. Available at: <https://apps.who.int/iris/handle/10665/336569>

United Nations (May 2020). *Global Humanitarian Response Plan COVID-19*. (Report). United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Available: <https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf>

United Nations Secretary General (May 6 2020). *COVID-19 Outbreak and Persons with Disabilities*. United Nations, Department of Economic and Social Affairs, Disability (Website). Available at: <https://www.un.org/development/desa/disabilities/covid-19.html>

**Comment on PP22**

**We highlight how ‘resilient health systems’ has to include and specify the environmental sustainability.**

To strengthen the building blocks of health systems means to take into considerations the conditions in which a health system operates, thus, its ecosystems. On one hand, non-resilient health system not adapted to their environment could be not able to respond to future health demand and crisis. On the other hand, health care sector accounted for the 4.6% of global greenhouse gas emissions in 2017 contributing to climate change and therefore to exposing health systems to climate related hazards. The COVID-19 pandemic and climate change represent converging crises: aligning the global COVID-19 recovery with the response to climate change offers the chance to protect health, promote a sustainable economy, and preserve the planet.

**References:**

Pichler, P, Jaccard, IS, Weisz, U and Weisz, H (2019). International comparison of health care carbon footprints’, *Environmental Research Letters*, 14(6). Available at: <https://doi.org/10.1088/1748-9326/ab19e1>

Watts, N, Amann, M, Arnell, N, Ayeb-Karlsson, S, Beagley, J, Belesova, K, Boykoff, M, Byass, P, Cai, W, Campbell-Lendrum, D, Capstick, S, Chambers, J, Coleman, S, Dalin, C,Daly, M,Dasandi, N, Dasgupta, S, Davies, M, Di Napoli, C, Dominguez-Salas, P, Drummond, P, Dubrow, R, Ebi, KL, Eckelman, M, Ekins, P, Escobar, LE, Georgeson, L, Golder, S, Grace, D, Graham, H, Haggar, P, Hamilton, I, Hartinger, S, Hess, J, Hsu, S, Hughes, N, Mikhaylov, SJ, Jimenez, MP, Kelman, I, Kennard, H, Kiesewetter, G, Kinney, PL, Kjellstrom, T, Kniveton, D, Lampard, P, Lemke, B, Liu, Y, Liu, Z, Lott, M, Lowe, R, Martinez-Urtaza, J, Maslin, M, McAllister, L, McGushin, A, McMichael, C, Milner, J, Moradi-Lakeh, M, Morrissey, K, Munzert, S, Murray, KA, Neville, T, Nilsson, M, Sewe, MO, Oreszczyn, T, Otto, M, Owfi, F, Pearman, O, Pencheon, D, Quinn, R, Rabbaniha, M, Robinson, E, Rocklöv, J, Romanello, M, Semenza, JC, Sherman, J, Shi, L, Springmann, M, Tabatabaei, M, Taylor, J, Triñanes, J, Shumake-Guillemot, J, Vu, B, Wilkinson, P, Winning, M, Gong, P, Montgomery, H and Costello, A (2020). The 2020 report of The Lancet Countdown on health and climate change: responding to converging crises, *The Lancet.* Available at: <https://doi.org/10.1016/S0140-6736(20)32290-X>

**Comment on OP6.13**

**We advise to specify ‘inclusive digital technologies’ in order to ensure access to information by everyone concerned by Health Emergencies. We also point out the need of protection by the risk of stigmatization for certain groups during infodemics.**

If public health information, the built environment, communications and technologies, and goods and services are not accessible, persons with disabilities cannot take necessary decisions, live independently and isolate or quarantine safely, or access health and public services on an equal basis with others.

As the COVID-19 crisis demonstrated, we are living an ‘infodemic’, an overabundance of information. This is of great concern as it often leads to reduced trust in health institutions and services and impedes the evidence-informed approach in managing the pandemic. The infodemic may also promote hate speech and associated stigmatization which may contribute to exclusions of vulnerable sections of society. Particular attention in terms of prevention, monitoring, and action should be dedicated to fight stigma against persons with disability and psychosocial disabilities before and during a Health Emergency.

**References:**

Dash, S, Parray, AA, De Freitas, L, Mithu, IH, Rahman, M, Ramasamy, A, and Pandya, AK (2021). Combating the COVID-19 infodemic: a three-level approach for low and middle-income countries. *BMJ Global Health*, 6:e004671. Available at: <http://dx.doi.org/10.1136/bmjgh-2020-004671>

United Nations Secretary-General (May 2020). *A Disability-Inclusive Response to COVID-19*. (Policy Brief). New York: Unites Nations. Available at: <https://www.un.org/en/coronavirus/disability-inclusion>

World Health Organization (‎2020)‎. *An ad hoc WHO technical consultation managing the COVID-19 infodemic: call for action*. Geneva: World Health Organization. Available at: <https://apps.who.int/iris/handle/10665/334287>

**Comment on OP6.17**

**We advocate to add ‘mental health and psychosocial support to health workforce’ as part of comprehensive actions to increase the resilience of health systems.**

Healthcare workers suffer increased exposure to health emergencies: during the COVID19 crisis they accounted for as many as 8.3% of cases in Italy during the first wave; in past epidemic certain healthcare workers were up to 32 times more likely to become infected with Ebola than the general population. Considering the workload as well as the ethical dilemmas and moral injuries the may suffer, it is not surprising that academic literature found that, among 1.257 healthcare workers working with COVID-19 patients in China, 50.4% reported symptoms of depression, 44.6% symptoms of anxiety, 34% insomnia, and 71.5% reported distress. Therefore, preventive communication campaigns in order to reduce the risk of stigmatization and policies to support health workforce and mainly frontline workers including not-specialized staff are part of the Health Emergency preparedness and response.

**References:**

BMA - British Medical Association, (2020). The mental health and wellbeing of the medical workforce – now and beyond COVID-19 report. Available at: <https://www.bma.org.uk/media/2475/bma-covid-19-and-nhs-staff-mental-health-wellbeing-report-may-2020.pdf>

Greenberg, N, and Wessely, S (2015). Potential mental health consequences for workers in the Ebola regions of West Africa - A lesson for all challenging environments. *Journal of Mental Health*, 24(1). Available at: <https://doi.org/10.3109/09638237.2014.1000676>

International Labour Organization (2020). Managing work-related psychosocial risks during the COVID-19 pandemic. (Report). Geneva: ILO. Available at: <https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_748638.pdf>

Lai, J, Ma, S, Wang, Y, et al. ( 2019). Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease. *JAMA Netw Open*, 3(3). Available at: <https://doi.org/10.1001/jamanetworkopen.2020.3976>

# WEMOS

Highly appreciating the opportunity to provide input into this consultation, we would hereby like to share a number of suggestions on the zero draft resolution on Strengthening WHO Preparedness and Response to Health Emergencies. As a member of MMI, we support the input provided by the network, and would like to make some additional suggestions with a view to emphasizing the important role of strong and resilient, equitably accessible health systems in the pandemic response, integrating health security measures with health systems strengthening, as well as the need to secure sufficient public funding for these.

In line with this consideration, we would like to suggest the following:

* To add under PP19 an additional paragraph:   
  “PPXX Recognizing the role of the whole government to mobilize sufficient resources and the crucial role of public funding for equitable and resilient health systems, the importance to explore all possible avenues for increasing domestic public resources for health, including through debt cancellation and progressive taxation;”
* To add the green coloured text to OP4.1, OP4.9, OP5.1, OP6.17 as follows:
  + OP4.1 step up efforts to build, strengthen and maintain the capacities required under the International Health Regulations (2005), including through support to evaluation mechanisms and multisectoral follow-up actions on their recommendations, simultaneously stepping up efforts to strengthen publicly funded Universal Health Coverage and ensuring that IHR capacities are integrated into the health system;
  + OP4.9 commit to continuous follow-up to the recommendations of the IHR Review Committee and the Independent Panel on Pandemic Preparedness (IPPR), which need to be integrated with health systems strengthening measures supported by adequate public funding;
  + OP5.1 strengthen partnerships, public stewardship, global coordination and cooperation in response to infectious diseases based on lessons learned from COVID-19 and fostering a one health approach, including coordinated support for publicly funded unified health systems, including between WHO and relevant organizations and UN agencies, including through the Global Action Plan for healthy Lives and well-being for all;
  + OP6.17 Develop strategies and tools for managing the collateral health risks associated with health emergencies, including by comprehensively increasing the resilience and, capacity of health systems, in particular the health workforce, in the provision of essential public health functions and essential health services during health emergencies and work with Member States to identify – involving Ministries of Finance – all possible avenues to expand fiscal space for health;
* To add a call on international actors with an additional paragraph OP5.2:   
  OP5.2 step up efforts to enable Low and Middle Income Countries to increase domestic public resources for urgently needed investments in pandemic response and resilient and equitable health systems, including through debt cancellation and tackling illicit financial flows.

# World Medical Association Inc

The WMA is the global federation of National Medical Associations representing the millions of physicians worldwide. Acting on behalf of patients and physicians, the WMA endeavors to achieve the highest possible standards of medical care, ethics, education and health-related human rights for all people.

We thank the European delegation for inviting the World Medical Association (WMA) to this informal consultation on a zero draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies. We would like to draw the attention of Member States on the [WMA Statement on epidemics and pandemics](https://wmafrance.sharepoint.com/:w:/s/WMASecretaritat/EfeJYZBdJDNHqsUPw2w7gzQBaNlL6B7pedAXnOQtYmR8IA?e=Nl4z8Q) which includes recommendations for a reactive and quick response at international level, with effective communication and collaboration between countries.

**GENERAL COMMENTS**

We welcome the holistic approach taken in the draft proposal, incorporating the many features to be addressed with a view to strengthen WHO preparedness in situation of emergencies. We note in particular with appreciation the emphasis put on the need to provide WHO with the financial means to conduct its leadership role in responding to health emergencies as well as the use of the One Health approach being refined and strengthened, through adequate cooperation and expertise.

We regret however the nearly complete absence of health professionals in the proposed strategy. The appreciation of Members States of the dedicated efforts and sacrifices of health professionals and health workers during the Covid-19 outbreak and the reference to the need of a strong health workforce are not enough. These sole references fall short of our expectations and do not allow a comprehensive response to health emergencies. As a reminder, a frontline physician was the first to sound the alarm on a cluster of viral pneumonia in Wuhan.

Health professionals constitute one of the key backbones of health systems and must be included in any response to health emergencies as primary actors to be consulted and involved in the decision-making process. In addition, urgent strong measures are required to strengthen the workforce and ensure protection of its members, so that they can provide quality and safe care to those in need. The WMA recalls the primary necessity to ensure the personal safety of health professionals and health workers during the event of disasters and emphasizes the need of investment in public health systems to enhance capacity to effectively detect and to contain rare or unusual disease outbreaks.

The resolution would benefit from a stronger focus on contingency management for essential treatment, diagnosis, prevention, rehabilitation and palliative care. The collateral damages derived from e.g. missed treatment opportunities, discontinued immunization campaigns or from mental health problems induced by isolation and separation are yet to be fully understood and quantified.

**SPECIFIC COMMENTS I**

1. **Ensuring an inclusive dialogue and cooperation with Health professionals**

We recommend that health professionals be consulted in the development and implementation of the WHO Preparedness and Response to Health Emergencies, in particular by including health professional organisations in the proposed “*Open-ended Member State Working Group on WHO Strengthening and Global Preparedness*” (OP1) and in the proposed “*One health High-Level Expert Council*” (OP6.3)

1. **Fostering the One Health approach**

We recommend expanding collaboration between human and veterinary medicine, namely through dialogue with relevant stakeholders, such as the World Veterinary Association, to accelerate human public health efficacy as well as advanced health care options for humans (and animals) via comparative biomedical research.

1. **Safeguarding the personal safety of health professionals and health workers during the event of disasters**

***Ensuring safe working conditions of health professionals and health workers***

* With the support of WHO, Member States must develop adequate education for the health workforce to ensure rapid detection and response to health emergencies and prevention of epidemics and pandemics.
* It is essential that the epidemic/pandemic disease be recognized as an occupational illness, providing compensation and other support to health professionals and health workers in case of infection with special consideration for immigrant health workers and their families who may face expulsion and significant financial strain if they fall ill or die from infection as was observed during this pandemic in many countries around the world.
* The security of the supply chain of personal protective equipment as well as safe and effective vaccine for all health personnel on the frontline must be ensured and prioritized
* During this pandemic, health worker shortages became even more apparent. Respecting the International Code on recruitment of health care personnel is essential during global emergencies. In preparation for the next emergency, additional investments in health workers education and jobs are crucial to maintain essential services and provide Universal Health Care but also to ensure a well prepared workforce to detect and provide care during emergencies.

***Violence against health professionals and health workers***

* Given the increased acts of violence against health professionals in emergency contexts, we recommend to recognise the protection of health personnel from violence and discrimination as an international priority requiring urgent actions from Member States, supported by WHO;
* Adequate accountability mechanism by governments against perpetrators of violence against health personnel must be guaranteed;
* WHO should be provided with the necessary support to fulfil its leadership role in documenting attacks on health personnel and facilities, through an accurate and systematic data collection on violence incidents in relation to the pandemic;

***The protection of health professionals exposed to ethical dilemmas***

* The ethical dilemmas that health professionals experience in emergency contexts include, but are not limited to, the respect of medical neutrality. Ethical dilemmas are complex but are essential and must be recognised within an adequate public health emergency policy. To this end, we urgently call for the promotion and implementation of the [Ethical Principles of Health Care in Times of Armed Conflict and other Emergencies](https://www.who.int/gender-equity-rights/news/ethical-principes-in-hc/en/) endorsed by civilian and military healthcare organizations in 2015.
* The proposed preparedness and response to health emergencies must address the possibility of resorting to a system triage to determine treatment priorities. Triage should be foreseen on the basis of clear and defined ethical criteria, as referred in the [WMA Declaration of Geneva](https://www.wma.net/policies-post/wma-declaration-of-geneva/), the [WMA International Code of Medical Ethics](https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/) and the [WMA Statement on Medical Ethics in the Event of Disasters](https://www.wma.net/policies-post/wma-statement-on-medical-ethics-in-the-event-of-disasters/).

1. **Building resilient health care systems including human and material reserves to enable and strengthen surge capacities**

* International health regulations (IHRs) are of limited value, when national health care systems fail. The Covid-19 Pandemic has demonstrated that even the health care systems in some of the most affluent countries were unprepared for the pandemic, most of them for reason of ill-guided economic measures reducing reserves and by that surge capacities. Forced austerity measures have tragically augmented the lack in response capacity. Thus, International Health Regulations require a defined response capacity that health care systems should build up and maintain. The IHRs need a monitoring method to facilitate this process.
* Resilience also requires regional capacities to produce and maintain essential materials and drugs, including PPE and other medical equipment. As demand for certain materials grows exponentially during a pandemic, regular stockpiling has proven to be insufficient. Strategies of “just in time” have to be reviewed and “just in case” aspects have to be incorporated.

1. **Mandatory Reporting and Survey Standards**

* The current pandemic is not only characterized by a lack of information, it is also characterized by a low comparability of information. Tools to measure, monitor and precisely describe the pandemic have either been missing or not being applied. This is true for the development of the pandemic (reliable incidence measurements e.g.by cohort studies), the effect on subpopulations (e.g. school children, pregnant women or senior citizens) and the comparability of death statistics (which death is due to the pandemic and which is not, must be the same in every country). Effective and evidence-based interventions however do require reliable and comparable standards. Therefore, reports and surveys must adhere to internationally agreed standards. Non-compliance with such standards should be classified as a safety hazard.

1. **Transparency and truthfulness as key factors to fight a pandemic**

* The free flow of accurate and reliable information is not only necessary for a scientific and clinical understanding of the pandemic and its health consequences, it is also critical to build trust and to justify counteracting control measures. As pandemics may require restrictions to civil rights, the handling of information should be clearly defined. Retention of information should be considered as a grave violation of public health.

We do hope that the current outbreak will finally persuade Member States to invest in long-term reforms for sustainable health care systems, including by underpinning WHO’s global leadership in pandemic and epidemic preparedness and response. However, leadership demands competence. WHO structures have to reviewed to cut red tape and put health first. The most vulnerable must no longer be those bearing the heaviest burden of health emergencies.

The performance of WHO is directly dependent on the performance of its members. Their willingness to contribute, their truthfulness, timeliness and accuracy in reporting, their engagement for sustainability and capacity of their health care system as well as their compliance with the rules and measures of any International Health Regulation are key for any success in coping with the ongoing or any future pandemic.

**SPECIFIC COMMENTS II**

Please find attached proposed wording for amendments of the draft resolution text. Proposals are highlighted in the track-changes-mode.

**PP27bis Acknowledging that urgent strong measures are required to strengthen the workforce and ensure protection of its members, so that they can provide quality and safe care to those in need;**

**PP27ter Recalling the primary necessity to ensure the personal safety of health professionals and health workers during the event of disasters and emphasizing the need of investment in public health systems to enhance capacity to effectively detect and to contain rare or unusual disease outbreaks;**

**OP1 DECIDES** to establish an open-ended Member State Working Group on WHO Strengthening and Global Preparedness, open to all Member States [footnote: and, where applicable, regional economic integration organizations, **and representatives of relevant health professional organizations.];**

**OP4.2** strengthen surveillance and continuous information-sharing with WHO as required under the IHR as well as simplification and ~~unification~~ **mandatory standardisation** of reporting, in particular the timely notification to WHO of all events which may constitute a public health emergency of international concern in accordance with article 6 of the IHR; ((*The current wording does not really add to the status quo.))*

**OP4.3** collaborate with the WHO Secretariat, the **elected representatives of the** medical and scientific community, and laboratory and surveillance networks to promote safe and rapid sample sharing of pathogens with pandemic potential or high risk, including during the assessment phase of outbreaks; ((*The current mode of non-transparent selection does not lead to a buy-in of elected leaders, it rather confuses participation, acceptance and prevents responsibility sharing. Democracy should be a respected value, even on the international arena.))-*

**OP4.4** strengthen National IHR Focal Points (NFP) **to an extend that they can operate permanently and independently from political interference** ~~and foster an One health approach~~ to strengthen health security at national level, taking into consideration recommendations provided by the WHO secretariat, including by reviewing the position of NFPs within national institutional structures, and ~~to consider an increased level of autonomy to improve~~ the effectiveness and efficiency of NFPs in the implementation of health measures under the IHR; ((*The current text is too weak*.))

**OP4.4bis** **foster a One Health approach by including the representatives of the relevant professions and by prioritising public health over commercial interests including food production, in order to accelerate public health efficiency and to provide advanced health care options for humans and animals by comparative biomedical research.**

**OP4.5** provide WHO officials and WHO-led international expert teams with support and **without delay** ~~rapid~~ access to outbreak areas to facilitate independent investigation and assessment of outbreaks and potential health emergencies; *((One year maybe rapid for some. During a pandemic it is not.))*

**OP4.6** protect **effectively (in accordance with scientific evidence where available) and immediately** against the spread of disease and, giving due consideration to global health, avoid unnecessary interference with international traffic and facilitate cross-border movement for essential humanitarian purposes, especially during public health emergencies of international concern;

**OP4.7** ~~consider how best~~ **develop and internationally consent** **strategies** to de-link travel from trade restrictions under emergency conditions, with the goal of maximizing the effectiveness of public health measures while minimizing economic impacts;

**OP4.7bis develop certifiable pandemic-safe-protocols to ensure continued secured operations of industry, commerce and service sectors during pandemic situation to avoid shut downs.**

**OP4.8** building on the outcomes of the working group on sustainable financing (EB148(12) (2021)), **rapidly** ensure the adequate, flexible, sustainable and predictable financing of the WHO’s Programme Budget, the Contingency Fund for Emergencies and the WHO Health Emergency Programme (WHE) therein;

**OP4.9** commit to continuous follow-up to the recommendations of the IHR Review Committee and the Independent Panel on Pandemic Preparedness (IPPR) **and to report back about implementation or necessary deviation;**

**OP4.9bis strengthen the health workforce to combat the pandemic by ensuring safe and sustainable working conditions of health professionals and health workers, in particular:**

* **Foster education for pandemic preparedness;**
* **Protect frontline health personnel with sufficient PPE and vaccination when available;**
* **Provide sufficient material for treatment, diagnosis, and personal protection for health personnel;**
* **Recognize infections of health personnel as occupational disease and compensate accordingly;**
* **Secure health personnel effectively against stigma related violence;**
* **Protect and care for migrant health personnel and their families exactly in the same way as domestic health personnel;**
* **On a midterm range, invest in self-sufficiency in the education of health professionals to avoid recruiting personnel from resource poor countries, and support the efforts to strengthen the health work force globally;**

**OP4.9ter Combat Violence against health professionals and health workers by**

* **recognizing the protection of health personnel from violence and discrimination as an international priority requiring urgent actions from Member States, supported by WHO;**
* **guaranteeing adequate accountability mechanism by governments against perpetrators of violence against health personnel;**
* **providing WHO with the necessary support to fulfil its leadership role in documenting attacks on health personnel and facilities, through an accurate and systematic data collection on violence incidents in relation to the pandemic;**

**OP4.quat Ensure the protection of health professionals exposed to ethical dilemmas bypromoting and enabling the implementation of the** [**Ethical Principles of Health Care in Times of Armed Conflict and other Emergencies**](https://www.who.int/gender-equity-rights/news/ethical-principes-in-hc/en/) **endorsed by civilian and military healthcare organizations in 2015 and by developping clear and defined ethical criteria to address the possibility of resorting to a system triage to determine treatment priorities.**

**OP4.9quin strengthen equitable access to efficient and quality health care by Universal Health Coverage;**

**OP4.ses build resilient health care systems by providing the necessary means to build up necessary surge capacities to be able to appropriately deal with pandemic health needs;**

**OP4.9sep Ensure regionally diversified supply chains to ensure the continuity of supplies during disruptions for whatever reason;**

**OP4.oct contribute to funds to allow equitable access to health care for countries in need;**

**OP5.2 Request the elected representatives of the health professions to participate in the international coordination of pandemic efforts on the basis of the WHO set recommendations;**

**OP5.3 Request the NSAs to engage in monitoring and report on the equity situation concerning the effects of the pandemic, the countermeasures including economic and social effects;**

**OP6.3** Report on efforts to accumulate expertise on and raise visibility of “One Health” issues with a specific view to zoonosis, including through the establishment of a “One Health High-Level Expert Council” **Such council should include representatives of the major professional bodies;**

**OP6.4** Review, ~~and~~ strengthen **and introduce mandatory standards for the** existing tripartite reporting mechanisms, such as the Global Early Warning System for Major Animal Diseases (GLEWS);

**OP6.6** Based on the recommendations of the IHR Review Committee in this area, make concrete suggestions for intermediate and regional levels of alert, complementary to a Public Health Emergency of International Concern (PHEIC), with clear criteria and practical implications for countrieswith the objective of improving **mandatory** transparency **and reporting to the WHO**, communication, and the quality of reporting, enhancing earlier preparation and preventive action, and better resource allocation in the early stages of outbreaks and emergencies as requested in resolution WHA73.8 on “Strengthening preparedness for health emergencies: implementation of the IHR (2005)”;

**OP6.7** Make recommendations to build a more consistent overall evaluative system enabling accurate and independent assessment ~~and~~ **as well as transparent and mandatory** reporting on national capacities in IHR implementation, including through reviewing and strengthening existing mechanisms such as the IHR evaluation and Joint External Evaluations (JEE) mechanisms, with a view to strengthening the preparedness and response capacity of the States Parties;

**OP6.8** Support countries in strengthening capacities to report on the information required under the IHR and ~~encourage~~ **mandate** early reporting and sharing of information in line with IHR Article 44 requiring Member States to collaborate for IHR implementation;

**OP6.9** Develop a detailed concept note and report on the proposed voluntary pilot phase of the Universal Health and Preparedness Review (UHPR) mechanism with the aim to ~~assess and improve overall preparedness~~ **develop a general pandemic preparedness standard describing and measuring the very actual ability to cope with a pandemic**, for the consideration of Member States;

**OP6.10** Propose options ~~for approaches to increase~~ **to guarantee** the transparency on the appointment, the membership and the deliberations of the IHR Emergency Committee, in particular in relation to a declaration of and suggested response measures to a PHEIC, including options for the engagement of Member States with it;

**OP6.11** Provide recommendations on how to empower IHR National Focal Points within their national institutional structures **to ensure their autonomy**, and on how to improve the communication between WHO and National Focal Points to secure timely **and transparent** sharing of information and alerts **by mandatory standards**;

**OP6.17** Develop strategies and tools for **standardised measuring, reporting** and managing the collateral health risks associated with health emergencies, including by comprehensively increasing the resilience and, capacity of health systems, in particular the health workforce, in the provision of essential public health functions and ~~essential~~  **appropriate quality** health services during health emergencies;

**OP6.19** Increase efforts to broaden the donor base, including through the WHO Solidarity Fund and the WHO Foundation, while ensuring full Member State oversight, transparency and accountability; ((*Should be addressed to the Member States*.))

**OP6.20** Implement a sustainable funding and replenishment mechanism for the Contingency Fund for Emergencies (CFE); ((*Should be addressed to the Member States*.))

**OP6.21** Clarify and strengthen the roles, **transparent** nomination procedures and mandates of the Independent Oversight and Advisory Committee and the Global Pandemic Monitoring Board;

# International Baby Food Action Network

**ADD: PP13bis**

*Recognising that Breastfeeding is lifesaving in emergencies and that babies are at greatest risk of water-related diseases – with diarrhoeal disease the second biggest killer of under-fives.  That breastfeeding is resilient and provides food, care and immune support, and protection from the worst of emergency conditions.*

*Recognizing that epidemics and pandemics, such as HIV, ZIKA, Ebola and COVID-19 have had a profound impact on infant and young children’s feeding practices with interpretation of the same scientific data leading to differing guidance  and both negative and positive impact on child survival.*

*Regretting the continuing commercial exploitation of emergencies with misleading claims that commercial ultra processed products for babies build immunity and are provided purely for humanitarian purposes.*

*Recognising that the climate crisis is fundamentally linked with health outcomes and that  interventions during emergencies must not undermine sustainable food production, food security and biodiversity.*

**INSERT:OP4.10** : Urges Member States to support and protect breastfeeding and appropriate infant and young child feeding from misleading marketing and inappropriate donations through the adoption, implementation and monitoring of regulations that fully implement the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions, and Infant and Young Child Feeding in Emergencies – Operational Guidance for Emergency Relief Staff and Programme Managers.

**OP5.1** Strengthen [**INSERT: appropriate**] partnerships, global coordination and cooperation in response to infectious diseases based on lessons learned from COVID-19 and fostering a one health approach, including between WHO and relevant organizations and UN agencies, including through the Global Action Plan for healthy Lives and well-being for all **INSERT: while safeguarding against Conflicts of Interest and ensuring that when needed, locally sourced and sustainably produced food assistance is prioritised.**

**OP6.19 ADD: Whilst ensuring adequate increases in the Assessed Contributions from Member States,** increase efforts to  broaden the donor base, **[DELETE:** **~~including through increased the WHO Solidarity Fund and the WHO Foundation~~]** ensuring full Member State oversight, transparency and accountability, and safeguards against conflicts of interest;

**INSERT: OP6.20** **Requests the Director General to prepare a framework to enable rapid understanding and response to emergent or epidemic infections and their implications for breastfeeding and infant feeding practices, survival and health, that will guide responses to future outbreaks for this particularly vulnerable group.**

**Rationale for above OP6.20 Framework:**

In the past policies to move away from supporting breastfeeding in the HIV pandemic had a devastating impact on infant mortality in many middle- and low-income countries. More infants lost their lives through diarrhoea and pneumonia related to infant formula feeding compared to those who lost their lives through HIV infection. The aftermath of these recommendations had serious repercussions that lasted for more than a decade as the fear of HIV transmission and the normalisation of bottle feeding changed infant feeding practices. Though caused by a different virus, recommendations during the COVID-19 pandemic caused a similar risk as various countries initially steered away from breastfeeding of children by mothers with suspected or confirmed SARS-CoV-2 infection.

WHO is the best organization to formalize an objective (‘universal’) framework indicating the process on identifying when breastfeeding or human milk is no longer safe in an outbreak of a (novel) infectious disease. It should provide an outline of steps when is it justified to divert from the global WHO recommendations concerning breastfeeding and human milk taking into account transmission, detection of infective agent and/or disease, mortality and morbidity both on the short and long term.

The framework should identify steps to guide the process shaping the following policies (examples):  
On consideration of a balance of risk, public health policy would be in favour of separation and avoiding breastfeeding among mothers with confirmed Viral Disease X there is evidence of: 1) Significant, immediate (infection fatality rate) and/or potential for long-term adverse health impacts of Viral Disease X in infants/young children, and; 2) Substantive Virus X transmission through breastfeeding and/or mother-infant contact; 3) being able to identify mothers with Virus X while infectious with or without symptoms.

Conversely, it would be expected that public health policy for mothers with confirmed Virus X infection would favour continued breastfeeding and mother-infant contact if there is evidence for: 1) Significant immediate infant or child mortality and/or long-term adverse effects associated with separation and non-breastfeeding for the infant/child or mother; 2) Low health impact of COVID-19 (infection fatality rate) among infants/young children; 3) Low Virus X transmission risk through breastfeeding and mother-infant contact.

# Worldwide Hospice Palliative Care Alliance & International Association for Hospice and Palliative Care Inc

We congratulate the EU delegation on the development of the draft resolution.

The majority of people who need palliative care during health emergencies do not receive it as palliative care services are rarely available. Where palliative care services do exist, COVID-19 has shown how severely they can be disrupted during health emergencies.[1] The WHO includes palliative care as an essential service within the Universal Health Coverage spectrum[2] and includes palliative care medications in its list of essential medicines.[3] Yet we know that approximately 84% of people who need palliative care do not get it.[4] Palliative care is included in key guidance relating to health emergencies[5] yet, the reality is that palliative care is rarely integrated into health emergency responses in practice.

As an example, in the Rohingya camps in Bangladesh, research found that over 60% of those with serious illness were suffering from pain but that effective pain treatments were largely unavailable.[6] We cannot leave behind people who need palliative care during health emergencies. While WHO is committed to the integration of palliative care as an essential health service, financing for palliative care is limited and there is little member state leadership on this issue. It is crucial that WHO is strengthened and supported to ensure its preparedness and response to health emergencies includes palliative care. The inclusion of the spectrum of essential health services e.g. from promotion to palliative care is crucial in the resolution in order to prevent neglected aspects of the spectrum, such as palliative care, being forgotten in health emergency responses. The result of this neglect is avoidable suffering.

Therefore, we request the following amendments to the draft resolution.

**PP18** Highlighting the role of WHO in facilitating universal access to health services across promotion, prevention, treatment, rehabilitation and palliative care in all countries, particularly the most vulnerable ones, which is also important for preparedness and resilience during a health emergency.

**PP19** Acknowledging the importance of strong health systems, universal, timely and equitable access to, and fair distribution of, all quality, safe, efficacious and affordable essential health services, across promotion, prevention, treatment, rehabilitation and palliative care, technologies and products, and the need to remove obstacles thereto;

**OP6.17** Develop strategies and tools for managing the collateral health risks associated with health emergencies, including by comprehensively increasing the resilience and, capacity of health systems, in particular the health workforce, in the provision of essential public health functions and essential health services, across promotion, prevention, treatment, rehabilitation and palliative care, during health emergencies;

[1] WHO (2020) The impact of the COVID-19 pandemic on non-communicable diseases resources and services. Results of rapid assessment.

[2] WHO definition of UHC<https://www.who.int/health-topics/universal-health-coverage#tab=tab_1> (Accessed Feb 23 2021)

[3] WHO Model Lists of Essential Medicines (2019)<https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists> (accessed February 23 2021)

[4] WHPCA/WHO (2019) Global Atlas on Palliative Care at the End of Life

**[5]** WHO (2018) Integrating palliative care and symptom relief into responses to humanitarian emergencies and crises: a WHO guide

[6] Doherty, M et al (2020) **I**llness-related suffering and need for palliative care in Rohingya refugees and caregivers in Bangladesh: A cross-sectional study

# Royal Commonwealth Society for the Blind (also known as Sightsavers)

1. Sightsavers, also known as the Royal Commonwealth Society for the Blind, is an international development organisation which works with partners to eliminate avoidable blindness and promote equality of opportunity for people with disabilities in over thirty developing countries. Our programmes also include working to ensure strengthening of health systems, elimination of neglected tropical diseases (NTDs) and quality inclusive education.

2. We strongly welcome the opportunity to input into the draft resolution on strengthening WHO preparedness and response.

3. Our submission emphasises that people with disabilities have been disproportionately impacted by the COVID-19 pandemic and there is therefore the need for the Resolution to clearly recognise the need for disability inclusion in pandemic preparedness and response mechanisms.

**General comments**

4. Sightsavers congratulates the EEAS Delegation and commends their efforts in facilitating the development of this draft Resolution. It is a step in the right direction to ensure lessons learned from the COVID-19 pandemic are taken forward in strengthening WHO preparedness for, and response to, health emergencies. This comes at a critical time.

5. Prior to the pandemic, assessments of national health security preparedness and response mechanisms revealed that no country was fully prepared to effectively deal with health emergencies 1,2,3. The COVID-19 pandemic has clearly revealed fault lines in existing global architecture for pandemic preparedness and response and the vulnerability of states and communities to the impact of health emergencies.

6. One of the fault lines is the weakness in mainstreaming disability inclusion into the frameworks and mechanisms for preparedness and response to health emergencies. The aftermath of this has been evident during the COVID-19 pandemic.

7. The WHO and other UN agencies have reported that ***people with disabilities are being disproportionately affected by COVID-19***4. This disproportionate impact is being shaped by various factors, including the existing barriers that prevent many people with disabilities accessing adequate health care5

8. Quite often in epidemic response, ***people with disabilities do not have their specific needs considered in the design and implementation of interventions***6, thereby negatively impacting their psychological wellbeing and health outcomes7.

9. The issue of discrimination is particularly pressing. Due to discrimination during health emergencies and in contexts with limited resources ***people with disabilities are less likely to be prioritised and allocated resources and treatments***8.

10. Dangerous narratives have emerged **that the lives of people with disabilities are not worth saving compared to *others*** – in direct contradiction of the UN Convention on the Rights of Persons with Disabilities (CRPD)9 and all other human rights instruments.

11. Another systemic challenge is the ***limited availability of data on disability before and during health emergencies***. The current global surveillance and data systems for managing epidemics are not designed to generate information on disability. The lack of evidence on the inclusion of people with disabilities in preparedness and response activities means that the evidence base to build effective responses from is very limited10. This impacts on the ability of the WHO and Member States to determine the impact, and identify appropriate responses, for people with disabilities11.

12. Sightsavers therefore notes with concern the lack of specific acknowledgement of these issues in the draft Resolution. There needs to be specific reference to **the disproportionate impact of health emergencies on people with disabilities** in the Resolution. Also, the need for ***mainstreaming disability inclusion in the strengthening of WHO preparedness and response*** to health emergencies should also be mentioned.

13. Recognising the pivotal role the WHO plays in leading and coordinating global response to health emergencies, ***it is imperative that the WHO is strengthened and sufficiently resourced to lead efforts in mainstreaming disability inclusion into emergency preparedness and response,*** and support Member States to do likewise.

14. The Resolution may also be strengthened by recognising the need to ensure the ***needs of people with disabilities are considered in the financing of WHO pandemic preparedness and response* mechanisms**12. This will ensure efforts to achieve disability inclusion in emergency preparedness and response are properly funded.

15. Furthermore, for greater impact, the WHO could be strengthened by strongly featuring disability inclusion as a core element for reporting and measuring impact of investments in global health security13

**Specific recommendations**

16. PP9 to PP22 would be strengthened by specifically referencing the disproportionate impact of the pandemic on people with disabilities.

17. PP19 could be strengthened by including specific reference to people with disabilities as part of the acknowledgement that certain population groups face specific barriers.

18. OP1 could reinforce the need for involvement of people with disabilities and their representative organisations in the open-ended Member State Working Group on WHO Strengthening and Global Preparedness.

19. Paragraphs OP4.1, OP4.2, OP6.5, OP6.6 and OP6.8 which refer to strengthening of WHO in the areas of surveillance, data and reporting systems are strongly appreciated. Strengthening implementation of IHR (2005) including surveillance and data systems is one of the areas where disability inclusion will make a huge difference. A specific mention of disability-inclusive surveillance and data systems in these paragraphs will be a welcome addition.

20. Paragraphs OP6.18, OP6.19 and OP6.20 could be strengthened by recognising the need to make financing mechanisms more disability-inclusive by ensuring funding mechanisms directly target people with disabilities and other marginalised groups.

21. The mention of strengthening of WHE’s capacity through reinvigoration of WHO’s leadership of the IASC Health Cluster at the global and field levels in OP6.24 is a step in the right direction. This can be further strengthened by mentioning the need to incorporate IASC guidance on disability in the COVID-19 response14 in WHO strengthening efforts.

**Conclusion**

22. We thank you for the opportunity to participate in this consultation. We stand ready to participate in further consultations as may be necessary, as well as in the finalisation process of the draft of the Resolution.

**References:**

1 Pg. 6, Annual report on global preparedness for health emergencies, GPMB, 2019

2 Pg. 9, Global Health Security Index, 2019

3 WHO (2020), Review of Health Security Capacities in Light of 2019-nCoV Outbreak – Opportunities for Strengthening IHR (2005) Implementation

4 WHO (2020) Disability considerations during the COVID-19 outbreak page 2 and Several speakers during WHO webinar: Covid-19 and Disability April 15th 2020

5 UNDESA (2020) COVID-19 Outbreak and Persons with Disabilities – Web page

6 WHO (2020) Disability considerations during the COVID-19 outbreak page 5

7 IAWG (2020) COVID-19 Response in Humanitarian Settings: Examples of Good Practices for Including Persons with

Disabilities

8 UNICEF (2020) COVID-19 response: Considerations for Children and Adults with Disabilities page 1 and 2

9 UN (2006) Convention on the Rights of Persons with Disabilities 10 Rohwerder, B. (2020). Secondary impacts of major disease outbreaks in low- and middle-income countries, https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/15129

11 UNICEF (2020) COVID-19 response: Considerations for Children and Adults with Disabilities page 1

12 IAWG (2020) Disability Inclusion in COVID-19 Funding Checklist  
13 IAWG (2020) Checklist for Planning a Disability Inclusive COVID-19 Socio-Economic Response and Recovery  
14 IASC Key Messages on Applying IASC Guidelines on Disability in the COVID-19 Response

# European Society for Medical Oncology

The European Society for Medical Oncology (ESMO) is the leading professional organization for medical oncology. Comprising more than 25,000 oncology professionals from over 160 countries, ESMO is the society of reference for oncology education and information at European and global levels.

ESMO thanks the EU Delegation for leading the Draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies for the 74th session of the World Health Assembly. We welcome the opportunity to participate in this important consultation.

ESMO’s proposed comments to the draft resolution are reflected within the attached ESMO statement supporting the 73rd WHA Resolution 73.1 on COVID-19 Response. The ESMO statement emphasises the need for WHO and Member States to protect healthcare workers and vulnerable populations, to ensure continued access to healthcare services, and to provide institutes and health workers with ethical and methodological decision-making guidelines, where financial and physical cancer resources must be re-allocated or are in shortage.

Regarding how Non-State Actors can support WHO and Member State efforts, ESMO recommends they reach out to scientific societies like ESMO, and patient groups, as early as possible for guidance to address the challenges affecting the specific disease group, e.g., cancer, healthcare workers, patients, and their caregivers.

For example, ESMO launched a COVID-19 and Cancer Portal with useful information and resources to help medical oncologists to deliver optimal care to cancer patients. The portal contains adapted clinical practice guidelines per tumour type, patient guides per tumour type, palliative care recommendations, and a repository of important resources for all healthcare professionals in oncology.

Please find a list of ESMO resources below:

• COVID-19 and Cancer Portal: https://www.esmo.org/covid-19-and-cancer

• Adapted ESMO Clinical Practice Guidelines: https://www.esmo.org/guidelines/cancer-patient-management-during-the-covid-19-pandemic

• Patient Guides: https://www.esmo.org/for-patients/patient-guides/cancer-care-during-the-covid-19-pandemic

• All ESMO registries, studies and surveys on COVID-19: https://www.esmo.org/covid-19-and-cancer/registries-studies-and-surveys

• An ESMO Call to Action on COVID-19 Vaccinations and Patients with Cancer: Vaccinate. Monitor. Educate., supported by over 40 healthcare professional and patient organisations: https://www.esmo.org/policy/esmo-call-to-action-on-covid-19-vaccinations-and-patients-with-cancer-vaccinate-monitor-educate, accompanied by an editorial in ESMO’s scientific journal Annals of Oncology https://www.annalsofoncology.org/article/S0923-7534(21)00096-X/fulltext, and ESMO Statements for Vaccination Against COVID-19 in Patients with Cancer https://www.esmo.org/covid-19-and-cancer/covid-19-vaccination

• COVID-19 full coverage: https://www.esmo.org/covid-19-and-cancer/covid-19-full-coverage, including all relevant scientific articles published in ESMO journals: https://www.esmo.org/covid-19-and-cancer/covid-19-resource-centre/covid-19-and-cancer-care-in-the-esmo-journals

We thank you in advance for your kind consideration of our comments and will be pleased to answer any questions or provide further information as necessary.





# Médecins sans Frontières International

The Delegation of the European Union organized an informal consultation with non-state actors (NSA) who are in relation with WHO in order to get some feedbacks on this resolution. MSF welcomes this initiative and is happy to contribute providing below some comments.

Considering that at this stage, the objectives and content of this resolution are still not completely defined and that several consultations with Member States (MS) are planned in the coming weeks, MSF would like, however, to highlight some general comments which are also valid beyond this specific resolution.

**1. The status and role of NSA vis-à-vis WHO’s role**

As already mentioned in a statement for the WHA 72 in February 2020, MSF is registered as a NSA with WHO. The NSA constitute a very diverse group, which represents a real asset for WHO and MS in finding solutions to current health challenges. Yet interests pursued by different CSOs, foundations and the private sector are of different nature and this should be acknowledged. While MSF understands the need for rationalisation, MSF is convinced that **mixing independent humanitarian actors and private actors like manufacturers in the same group is creating a confusion**. To this end, the wording of the current resolution acknowledges that MS and WHO-Secretariat do not recognize enough the **specific role of the NGOs who play a major role (strategic and operational) in response to health emergencies** and more broadly in the health care given to in-need populations in support to the National Authorities in humanitarian settings, protracted crisis or fragile contexts (alert, preparedness, response, follow up, monitoring, etc.). On this note, MSF reminds the important role of WHO as not only coordinator but also facilitator, assisting and ensuring that unnecessary bureaucratic barriers and blockages are placed that would impede swift operational response.

In some words, **If MS and WHO Secretariat want to improve the preparedness and response in health emergencies, the role of humanitarian independent actors should be clearly integrated in their analysis and plans.** It should be consequently mentioned in this resolution in order to show the spectrum of actors and mechanisms that can be used in in order to respond to health crisis. It means also a coordinated approach **with respect to the specificities of each group. For humanitarian actors, the humanitarian principles, flexibility, evidence-based approach, proportionality, duty of care, do not harm are the most important issues to consider.**

Finally, there should be more implicit mention of what would be the accountability mechanisms put in place to ensure standards are met in as much as feasible in the most equitable, responsible and, ideally, impartial way.

**2. The response to health emergencies and especially outbreaks**

**WHO already developed some mechanisms or is part of some mechanisms in order to prepare and respond to crisis**, which are of course not perfect but are part of an effort to gather different actors like the GOARN, EMT or even the Health clusters. This list is not exhaustive. MSF is part of these different mechanisms as a humanitarian and independent observer/operational actor. As a major health humanitarian actor working in health emergencies since more than 50 years, in response to outbreaks all around the world and in very difficult humanitarian settings, MSF have made the choice to coordinate with other actors including WHO even when we are not always in agreement with some orientations and decisions taken.

An **evaluation of these different mechanisms in order to improve the different tools** we have today would be relevant. It is **important especially today with the COVID 19 and the creation of new platforms** which will manage the COVAX facility allocation and notably the Humanitarian buffer. These platforms are following the example of the International Coordinating Group (ICG) on Vaccine Provision (cholera, meningitis, yellow fever and more recently Ebola). However, **a clear understanding of the different platforms and role of the different Global health actors involved would help in making decisions and proposing a more strategic resolution.**

Lastly, as it has been stated several times, **MSF requested to MS and WHO an adequate emergency response,** notably during the first vague of Ebola in 2015 in West Africa. MSF shared also concerns on the management of Ebola response in DRC with a very centralized decision which didn’t give the opportunity to actors like MSF to propose alternative to the official Riposte response.

**MSF recognizes that there is a need for and value in WHO in its normative role**. WHO is responsible for convening MS and health experts, establishing evidence base recommendations / norms for population-level health decisions, and reinforcing health as a human right.

**MS must be clear on what are their expectations with WHO**. As a medical humanitarian organization specialized in emergency response, MSF is frequently frustrated by the slow and inadequate response to health emergencies around the world. However, according to the MSF understanding, **WHO is not structured to enforce the application and implementation of its guidance especially in conflictual contexts.**

However, based again on the COVID 19 example, WHO plays a major role on the writing of guidance and negotiations for a humanitarian buffer considering populations regularly excluded from the health policies like migrants, refugees or populations not under the control of the official authorities. MSF acknowledges this role and the support given to MS in the design of their strategies and policies.

**MS should give a clearer role to WHO on proposing and establishing a real plan in managing future pandemics and health crisis based on multilateral platforms where the diversity of health actors is represented**, and **with the aim to provide an equitable access to health care**. It doesn’t exclude national decisions but today a global and coordinated approach must be developed, again in the respect of each actor and first in the interest of people we want all to treat.

# Third World Network

1. The proposed resolution raises several important issues that require more discussions and

deliberation among member States especially following the final recommendations of the IHR Review Committee, the IAOC, the IPPR and the challenges faced by WHO member states in preparedness and response activities.

On receiving the final recommendations of the various expert committees, WHO Member

states should go through the recommendations made, consider what is being implemented,

its shortcomings and what further needs to be implemented following the review of the

recommendations, and other gaps that should be addressed based on the experience of WHO Members.

The draft resolution proposes a member state working group, and at the same time prejudges the outcome of the working group by including extensive recommendations, most of which require much more in-depth discussion among WHO Member States.

Hence it would be more appropriate that the focus of the resolution be on the process of

setting up the working group rather than on substantive recommendations. Further there

should be opportunity for civil society to interact with the working group and to provide

relevant inputs for the consideration of the working group.

2. One of the most crucial aspects of dealing with public health emergency is timely and

affordable access to diagnostics, therapeutics, vaccines and other equitable products. Since

the beginning of the pandemic, there have been staggering disparities in access between

developed countries and developing countries. We need to recognize this and there must be

concrete and legally binding action taken to ensure fair and equitable allocation of medical

products, their availability and affordability. We must ensure that such disparities are

addressed immediately and do not recur in future pandemic. This aspect is barely addressed

in the draft resolution. It is one of the most important areas where reform is needed. WHO’s

current allocation framework has failed to deliver due to vaccine nationalism. There have also been severe supply shortages due to flawed “business as usual voluntary licensing

approaches”, the lack of sharing of proprietary technology and know-how by manufacturers

to scale up production leading to inequitable access and a prolonged pandemic.

OP6.16 requires the DG to propose strategies. But this is inadequate. Following the various

recommendations of the expert committees, WHO member states should really take the lead unpacking the reasons for inequitable access and the steps that should be taken to address this matter.

3. PP10, P4.3, OP6.14 mention the sharing of samples of pandemic potential. However, any

such sharing has to be undertaken consistently with national laws and international

instruments. At the international level, the rights of countries under the the Convention on

Biological Diversity and the Nagoya Protocol on Access and Benefit Sharing have to be

recognized. The principles of these instruments have been the basis of WHO’s Pandemic

Influenza Preparedness Framework, an innovative instrument that has through its benefit

sharing mechanism greatly contributed to strengthening surveillance capacity and COVID-19

response. Under the Framework, to access samples, manufacturers have to make concrete

legally binding commitments in terms of providing access to diagnostics, anti-virals and

vaccines. A similar approach should be taken with respect to sharing of any samples of

pathogens with pandemic potential.

It is important to recall that the majority of WHO Members are also parties to the CBD and

the Nagoya Protocol and should uphold the principles and rights granted by those

instruments. Hence any sharing of biological material and related sequence information has

to be subject to rules governing access as well as fair and equitable benefit sharing and has

to be done consistently with the requirements of the CBD and the Nagoya Protocol.

# International Federation of Pharmaceutical Manufacturers and Associations & International Council of Biotechnology Associations

Thank you very much for the opportunity given to Non-State Actors to share their views on the Zero-Draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies; ICBA and IFPMA welcome this initiative and the EU Delegation’s leadership in this engagement.

We fully support the EU-led Draft Resolution, and hence OP1 through OP3 of the Draft Resolution. The need for a coordinated and streamlined Member State review of the various interim and final reports of the IHR Review Committee, IPPR, IOAC and others is clear. By forming a Member State working group, to systematically review the findings of these various bodies, an inclusive process can be launched while avoiding a duplication of work. It is critical that the world learns from the current pandemic and is prepared for the next. We would also encourage the facilitators of the process to continue considering industry views throughout the process.

In particular, we appreciate that the Draft Resolution remains sensitive to the very real issue facing pathogen sharing due to unclear and burdensome regulatory systems. PP10 clearly states the issue and OP4.3 and OP6.14 both call on Member States and the WHO DG to work towards ensuring that pathogens can be shared in a timely manner with the scientific community. The current review processes open a unique opportunity to ensure a legally binding obligation for member states to share pathogens in a timely manner. Without timely access to pathogens, treatments, diagnostics and vaccines cannot be developed and the world would remain at the mercy of the pathogen.

With regards to the interventions made during the call of the 19th of February, we would like to address the reference made to the PIP Framework and how this mechanism includes rules governing the sharing of pandemic influenza viruses, under the aegis of equitable benefiting sharing principles. It is often forgotten that the sharing of pandemic influenza viruses under the PIP Framework is not legally binding, and that each Member State is free to decide whether to share those viruses or not; the only legally binding component of the PIP Framework are the SMTA-2 contracts signed with industry. As such, the access (to samples) component of the PIP Framework is based on goodwill only, and can easily be overcome by national ABS legislation, whereas the benefit sharing component is the only component which is enforceable. Without enforcing the sharing of viruses and their information, the ability to share benefits with Member States will be very limited.

We greatly appreciate the EU’s efforts to undertake consultations with NSAs. Following facilitators’ instructions, we refrained from inviting our members (ICBA, etc) to join; even though we believe that a wider representation of voices would have been beneficial for the consultation. The presence of numerous non-NSA limited the possibility for an open and frank discussion. We would like to kindly ask the EU Delegation that, should attendance be extended to non-NSAs, all NSAs are made aware of it so we also have a chance to invite other interested parties to the process.

Again, we are extremely thankful to the EU Delegation for their leadership and look forward to continuing engaging as the draft resolution process continues.

# Humatem

**OP4.2** strengthen surveillance and continuous information-sharing with WHO as required under the IHR as well as simplification and unification of reporting, in particular the timely **and transparent** notification to WHO of all events which may constitute a public health emergency of international concern in accordance with article 6 of the IHR;

**OP6.1** Strengthen the WHO’s normative role, including by empowering as appropriate the Chief Scientist’s Office, and support the development of the WHO Academy to enable WHO to rapidly **and efficiently** disseminate **multilingual** high-quality guidance**, technical resources and training tools to Member States and especially vulnerable countries** and make global expertise available at all levels of WHO

**P6.15bis : Increase WHO Biomedical Engineering HR to better assess and support Member States and particularly vulnerable countries in the area of medical equipment management (from needs assessment to medical equipment waste treatment), as this area is severely understaffed.**

**OP6.15ter : Set up a working group to assess, validate and capitalize on innovative medical devices and innovative processes related to their use or re-use which have been developed or experimented during the Covid-19 crisis and which could be of major interest in other high constraints contexts and especially in vulnerable countries**

**OP6.15quat : Strengthen the WHO's readiness to answer rapidly the need of medical devices and, particularly of medical equipment by vulnerable countries during an emergency by adopting a normalized naming, classification and codification of medical devices, freely accessible to all and easy to use.**

**OP6.16** Propose strategies to ensure the rapid development, production, and global equitable deployment of ~~medical~~ **health products including medical devices** and other countermeasures and commodities to respond to future health emergencies, based on lessons learnt from the COVID-19 response;

# Sabin Vaccine Institute

The Sabin Vaccine Institute (Sabin) thanks the European Union for providing Civil Society Organizations (CSOs) with the opportunity to provide input on this draft resolution on “Strengthening WHO Preparedness for and Response to Health Emergencies” (Resolution) prior to its presentation at the 74th World Health Assembly. Below are Sabin’s comments and recommendations, first on the overall document, followed by comments on specific Operative Paragraphs. Language suggested by Sabin is written in blue to differentiate from the draft Resolution language.

• **The Resolution must strengthen its language calling on WHO to reaffirm its commitment**

**to equitable access to COVID-19 diagnostics, therapeutics and vaccines**. While the

preambular section of the Resolution recalls the importance of equitable access to and

distribution of COVID-19 countermeasures and the WHO’s role in ensuring that (PP17-20), the operative paragraphs do not provide specific actions or recommendations on how to achieve that.

Sabin suggests amending the Resolution to include:

o **[Under OP4 URGES Member States to:]** commit to equitable allocation of the global

supply of diagnostics, vaccines, and therapeutics based on public health need

.

o **[Under OP5 CALLS ON international actors, partners, civil society, and the private**

**sector to:]** commit to facilitating access to new diagnostics, vaccines, and therapeutics,

including through the development and delivery of health products which are available,

accessible, acceptable, affordable, and of assured quality

.

• **The Resolution must expand its call to “ensure the rapid development, production, and**

**global equitable deployment of medical and other countermeasures and commodities to**

**respond to future health emergencies,” (OP6.16).** This should include calling on the WHO

Director to include regulatory strengthening and local manufacturing among the “strategies” they consider (OP6.16). Increasing regulatory system and local manufacturing capacities have the potential to significantly accelerate production and distribution of quality-assured

countermeasures both for COVID-19 and for future health emergencies. Member States and

international actors, etc. should be included in the call to support regulatory strengthening and harmonization efforts, such as those already underway by the African Medicines Regulatory Harmonization (AMRH) Initiative.

Furthermore, in addition to the “development, production and deployment,” of countermeasures, systems to evaluate their impact (effectiveness, safety, compliance, appropriate use) must also be strengthened and established where currently absent. The idea of “science preparedness”

should be integrated into efforts to strengthen health systems in order to facilitate the conduction of science during a pandemic emergency. The capacity to perform scientific studies with real-time data on medical and other countermeasures would allow health systems to adjust and improve ongoing strategies. Many countries currently report deficiencies in data collection systems, which hinders their ability to measure the true impact of COVID-19 countermeasures. Building “science preparedness” into health systems now will ensure that future countermeasures are used in the most efficient and effective manner possible.

o **[Under OP4 URGES Member States to:]** participate in regulatory harmonization and

strengthening efforts to increase capacity to evaluate countermeasures and ensure that

quality assured diagnostics, vaccines, and therapeutics reach populations in need.

o **[Under OP5 CALLS ON international actors, partners, civil society, and the private**

**sector to:]** participate in regulatory harmonization and strengthening efforts to increase

capacity to evaluate countermeasures and ensure that quality assured diagnostics,

vaccines, and therapeutics reach populations in need.

o **[Under OP6 REQUESTS the Director General to:]** Propose strategies aimed at

regulatory harmonization and strengthening to ensure that the impact (effectiveness,

safety, compliance, appropriate use, etc.) of medical and other countermeasures and

commodities is measured in real time so that response efforts can be quickly and

appropriately adjusted.

• **The Resolution must call on WHO to be more inclusive of additional expertise as it**

**considers future pandemic responses**. The COVID-19 pandemic has reminded us of not only

the gross inequities within societies that exacerbate poor health outcomes for marginalized

populations, but also of the inextricable link between health and the well-being of individual

economies. There is currently a paucity of representation of experts who can speak to non-health societal factors which affect and/or are affected by pandemics (including such contributing factors as gender, poverty, race; or impacts such as security, migration, economic success) which must be considered by WHO as well as by member states during the development of pandemic response and management strategies. The lack of consideration of how to manage and address these issues during the early stages of the COVID-19 pandemic has worsened health outcomes for vulnerable members of society (e.g., higher illness and death rates among Black Americans).

Sabin suggests amending the Resolution to include:

o **[Under OP6 REQUESTS the Director General to:]** include additional stakeholders who

represent sectors that are impacted by global pandemics, including representatives from

civil society, health professional associations, and others, as advisors to relevant

advisory boards, working groups and committees within WHO (i.e., WHE, IOAC, and the

proposed Working Group).

o **[UNDER OP6 REQUESTS the Director General to:]** propose strategies to increase

coordination and collaboration with other United Nations bodies, in recognition of how

their focus areas affect and/or are affected by health emergencies (i.e., FAO, HCR,

OHCHR, IOM, UNSC, ECOSOC, UNDP, WFP, UNIFEM, IOM, etc.).

• **OP4.3 [URGES Member States to:]** collaborate with the WHO Secretariat, the medical and

scientific community, and laboratory and surveillance networks to promote safe and rapid sample sharing of pathogens with pandemic potential or high risk, including during the assessment phase of outbreaks;

o It should be explicitly stated that “safe” includes only sharing pathogens with entities who

have the knowledge and resources required to handle them responsibly.

o “Sample” should also refer to genomic sequencing, in addition to actual pathogens.

• **OP4.4 [URGES Member States to:]** strengthen National IHR Focal Points (NFP) and foster a

One Health approach to strengthen health security at national level, taking into consideration recommendations provided by the WHO secretariat, including by reviewing the position of NFPs within national institutional structures, and to consider an increased level of autonomy to improve the effectiveness and efficiency of NFPs in the implementation of health measures under the IHR;

o It is unclear to which issue/entity “autonomy” refers to in this statement.

• **OP4.5 [URGES Member States to:]** provide WHO officials and WHO-led international expert teams with support and rapid access to outbreak areas to facilitate independent investigation and assessment of outbreaks and potential health emergencies;

o This statement should be strengthened by urging Member States to grant WHO rapid

access to relevant data sources, in addition to outbreak areas, in order to facilitate

independent investigations and assessments.

• **OP4.6 [URGES Member States to:]** protect against the spread of disease and, giving due

consideration to global health, avoid unnecessary interference with international traffic and

facilitate cross-border movement for essential humanitarian purposes, especially during public health emergencies of international concern;

o Further detail needs to be provided to explain as to what would and would not quality as

“unnecessary interference”. As it stands, this standard is unclear and unhelpful for

making decisions in emergency contexts.

• **OP6.14 [REQUESTS the Director General to:]** Work together with Member States, the medical and scientific community, and laboratory and surveillance networks, to promote early, safe and rapid sample sharing of pathogens of pandemic potential or high risk;

o Same comment as made on OP4.3. “Sample” sharing should include sharing variant

genomic sequences.

Once again, Sabin thanks the European Union for this opportunity to comment on the resolution on “Strengthening WHO Preparedness and Response to Health Emergencies.” As a CSO in official relations with WHO, Sabin takes this issue very seriously and hopes that the comments provided above will strengthen the Resolution and will ultimately provide WHO with sound recommendations for how to better respond to future health emergencies.

# World Federation of Nuclear Medicine and Biology

The "World Federation of Nuclear Medicine and Biology" abbreviated to WFNMB extends it s activities throughout the world. It is a voluntary non-profit making organisation of societies/associations or groups associated for the following purposes (frm its statutes <https://www.wfnmb.org/statutes>):

* To organise congresses, workshops and other educational activities covering all aspects of Nuclear Medicine and Biology
* To develop co-operation between societies/associations or groups active in Nuclear Medicine and Biology
* To promote the development of Nuclear Medicine and Biology
* To facilitate the exchange of scientists between the member societies/associations or groups, and to set up a body which will centralize and help such exchange
* To prepare and recommend the organization of a unified programme of teaching and training in the field of Nuclear Medicine and Biology
* To establish technical standards, to aid in the diffusion of knowledge and exchange of scientific and technical information by means of conferences, colloquia, symposia and courses on regional, national and international levels
* To publish, alone or in collaboration, monographs, studies, teaching, courses, reports from conferences, colloquia, symposia and congresses concerning Nuclear Medicine and Biology
* To represent with one voice all Nuclear Medicine activities to **the World Health Organization,** the International Atomic Energy Agency and other appropriate organizations
* To organize whatever commissions and meetings are necessary to attain such objectives
* To work with and support WFNMB subsidiary organizations and related organisations to promote worldwide expansion of Nuclear Medicine and Biology

Like many organizations of health care professionals, WFNMB closely monitors the current situation due to the global COVID-19 outbreak.  We at WFNMB are of course particularly concerned about the health and well-being of our member states, participants, volunteers, staff, and last but not least all of our patients that we serve. WFNMB strongly promotes specific guidance tailored to the needs of the individual countries, given the very different situation amongst WFNMB’s member countries.

Thus, to share knowledge and information on how to keep nuclear medicine practice running for the benefit of our patients, WFNMB worked with the International Atomic Energy Agency (IAEA) in 2020 and enrorsed the publication “COVID-19 Pandemic: Technical Guidance for Nuclear Medicine Departments” that is freely accessible under <https://www.iaea.org/publications/14733/covid-19-pandemic-technical-guidance-for-nuclear-medicine-departments>.

# International Commission on Occupational Health and IEA

The International Commission on Occupational Health, ICOH, is the largest global NGO in the field of occupational health. The main mission of the ICOH is the protection and promotion of health and work ability of the 3.4 billion working people throughout the world.

COVID-19 pandemic seriously affects workers' health and leads to serious economic downturn in all countries. According to Italian workmen compensation statistics 19.4% of all SARS CoV-2 infection cases occurred at the workplace; which is 30% of the study population at working age (15-65 years).

Globally all 1.7 billion workers in various service occupations are considered as risk populations. If infected, workers in some occupations may play an important role as vectors of infection, such as health workers, other service occupations, food industries and many others. Several occupational activities have exposed workers to the SARS CoV-2 virus particularly in sectors with high rates of human-to-human contacts or with animal contacts.

Workplaces in different sectors of economies, such as animal husbandry, food processing and food markets, health services, various social services, such as elderly care, community services, such as waste handling and many others are potential sources and origins of potential epidemics. Therefore, workplaces should be considered as important arenas for early detection of epidemic risk and for early actions for primary prevention and management. This requires effective regulation for inspection and advice for good preventive practices.

Besides prevention and management of COVID-19 pandemic at community level and in private, family and social life, prevention and management of epidemics and pandemics need effective actions at workplace. Such measures need competence in occupational health and good knowledge on work, working environment and conditions of work. Occupational health services should be made available for all workers in all sectors of economies and for all types of workers, private and public for formal and informal workers as requested by the WHA and the UN General Assembly resolutions (WHA Resolutions 49.12; 30.43 and 60.26 and the UNGA Resolution 74.2).

While supporting the presented EU-led Draft Resolution on Strengthening WHO Preparedness and Response to Health Emergencies, the ICOH wants, most respectfully, to call attention to following points concerning prevention and management of epidemics and pandemics at work. To ensure successful prevention and management policy for health emergencies, such as the COVID-19 pandemic and of potential new epidemics and pandemics at work the ICOH proposes the following:

1) Recognition working environment and workplaces as potential sources of epidemic (and pandemic) risk including the risk of SARS CoV-2. Recognition of the need to internationally regulate the risk of epidemics and pandemics at work and ensure competent inspectors a right to enter the workplaces for risk identification at earliest possible stages.

2) Paying special attention to protection of high-risk workers, such as health workers, social workers, food sector workers, police, emergency respondents, cleaners, and workers in small-scale enterprises and numerous other service occupations.

3) To provide guidelines for protection of workers against infectious hazards at work, introducing safe working practices, at the workplace and work environment, and undertake all the necessary actions for protection of workers health and thus also contribute to prevention of epidemics or pandemics.

4) Consider the special protection needs of numerous vulnerable groups of workers, such as informal workers, domestic workers, ageing workers, workers with chronic diseases and migrant workers,

5) To ensure competent and universally covering occupational health services for all workers in all sectors of economies and in all types of workplaces, public and private, workplaces in all sectors of economies and for all sizes of enterprises and covering all modes of employment, formal and informal, employed and self-employed.

6) To work for universal recognition of work-related infections, including the COVID-19 cases as occupational diseases.

# International Council of Nurses

The International Council of Nurses (ICN) is a federation of over 134 National Nurses Associations representing the more than 27 million nurses worldwide.

ICN wishes to thank the EU delegation for engaging civil society organisations in the early stages of developing the draft resolution on “Emergency Preparedness and Response”.

As the largest group of health care professionals, nurses played a critical role in the response to the COVID-19 pandemic providing strong leadership roles and finding innovative solutions in the attempt to reduce harm and save lives. In the International Year of the Nurse and the Midwife, the COVID-19 pandemic put nurses in the spotlight as the backbone of health systems.

Over the last 12 months, ICN has seen how countries’ ill-preparedness has taken a toll on the physical and mental health of health care workers. ICN has also seen how health workers have been at the centre of the COVID-19 response. Recognising this, the Draft Resolution must have a stronger focus the health workforce.

Recommendations:

* As 2021 was designated the International Year of the Health and Care Worker, this should be acknowledged in the Resolution.
* Health care workers, including a nurse, should be involved in the continued dialogue related to this Resolution and consulted in the work of the proposed Working Group.
* Reliable and timely information is essential for the public and for the health care workforce. Information must be clear, accessible and accurate. Information is essential for effective response but also to build and maintain the trust of the public.
* The COVID-19 pandemic has exposed and widened the pervasive inequities that have long existed in society and, importantly, in health systems. The PP section would benefit from acknowledging inequities.
* Recommend that the IPPR includes a monitoring framework for country reporting on progress.
* **Protecting the health and wellbeing of the health workforce:**

This pandemic has seen a catastrophic number of infections and deaths among health care workers. These numbers continue to increase which poses an immediate and serious threat to the safety of the public and to the essential resource that is health care workers.

- Countries should recognise COVID-19 as an occupational illness and compensate frontline workers.

- Governments must ensure and prioritise a secure supply chain of high-quality and appropriate personal protective equipment (PPE) for health care workers.

- Prioritise the vaccination health care workers so that their health and wellbeing and that of their patients and the health care systems they work in are protected.

- Ensure vaccine equity by mobilising resources so that access to immunisation will be determined by need, rather than wealth or geographic location

- There has been at least 400 reports of threats and attacks against health care workers directly related to the COVID-19 pandemic. Governments must act immediately to prevent this violence. Effective responses must address the root causes, which include fear and misinformation, and through strong but responsible enforcement actions.

-Adequate reporting mechanisms to ensure data availability for health workforce monitoring in the pandemic are not in place in many countries, or countries are failing to make the information available publicly. Comparable country data on health worker infections and deaths is essential to keeping track of the impacts of the pandemic on the health workforce, monitoring for the COVID-19 response, improving infection control measures and saving lives.

-Support and protect the mental health of the health workforce

ICN’s latest report contains evidence from around the world showing that nurses are experiencing psychological distress, abuse and mass traumatisation as a result of the COVID-19 pandemic. Data shows that in every region nurses are experiencing high rates of burnout, stress and anxiety. Governments must place mental health at the centre of national emergency preparedness and response and COVID-19 response plans. Governments must urgently scale up investment for sustainable community-based mental health services and support services.

-Invest in the health workforce

Particularly the nursing workforce which has seen chronic underfunding and will face a shortage of at least 10 million by 2030, a number that could potentially rise to half the size of the current nursing workforce. Nursing shortages will severely impact health systems and their ability to both deliver healthcare to the world’s population and to respond to future emergencies. Health workforce shortages are not only impacting the health workforce, they impact the safety and quality of care delivered to individuals and communities.

1. UN General Assembly (2020) Comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic (document A/74/L.92\*) <https://undocs.org/A/74/L.92> [↑](#footnote-ref-1)
2. WHO (2020) Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 27 August 2020 <https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1> [↑](#footnote-ref-2)
3. Hanna et al. (2020) Mortality due to cancer treatment delay: systemic review and meta-analysis. BMJ; 371:m4087 [↑](#footnote-ref-3)
4. Statement by Dr Hans Henri P. Kluge, WHO Regional Director for Europe. 4 February 2021, Copenhagen, Denmark <https://www.euro.who.int/en/media-centre/sections/statements/2021/statement-catastrophic-impact-of-covid-19-on-cancer-care> [↑](#footnote-ref-4)