

MEMBER STATES



Republic of the Philippines
Department of Health

HEALTH POLICY DEVELOPMENT AND PLANNING BUREAU

June 28, 2019

1. Comments / Suggestions on the Global Action Plan Draft Outline

- The list of accelerator areas is aligned with the Philippine health sector strategic framework (FOURmula One Plus for Health).
- Either in the *Accelerate* or *Account* step of the operational approach, we recommend the requirement to conduct *regular dialogue* with the government recipients of development assistance. This is for efficient implementation monitoring of commitments and the resolution of identified implementation bottlenecks and issues.
- The proposed *dialogue* is suggested to be scheduled frequently as deemed necessary by the government. A development partner is suggested to be nominated as secretariat to facilitate the documentation of the proceedings.
- Further, it is suggested to have a provision that commits development partners to engage with only a *single cooperation pathway* within the health ministry (e.g. through the international health cooperation bureaus / units of health ministries). This is to avoid fragmented and vertical engagement with different units within the health ministry.

2. Comments / Suggestions on Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access

- The plan implicitly focuses on product innovation, more explicit inclusion of other types of innovation may be pursued. These include process, organizational and even marketing innovation which are just as important as product innovation if improved access is really a goal.
- The plan may also explicitly acknowledge the need for varied types of research and development to support innovation and access. This includes explicitly indicating more novel fields of research such as health policy and systems research (a much broader field than implementation research which is mentioned in the document).
- Acceleration in capacity building may be further elaborated - not just for R&D production but for research uptake and utilization as well.
- While international collaboration is worthwhile, these relationships may be pursued as equitably as possible before, during, and after the research is done (e.g. Research Fairness Initiative of the COHRED).

3. Comments / Suggestions on Accelerator Discussion Paper 6: Data and Digital Health

- Active promotion of the need for data and digital health among Member States that may also be utilized for the improvement of surveillance systems, prices of drugs and medicines monitoring, and public access to information.
- Include a discussion on sustainability of information communication technology and artificial intelligence projects, by ensuring government capacity to accept and sustain projects developed by or through development partners.

Italy is pleased to provide comments on the papers relating to the “Global Action Plan on Healthy Lives and Well-Being for All” published on the WHO website, in the context of the online consultations opened between 17-30 June 2019.

General comments on the Global Action Plan

Italy is generally supportive of the commitment undertaken by the 12 signatory agencies to strengthen cooperation and align their efforts to accelerate progress towards the achievement the health-related targets of the 2030 Agenda for Sustainable Development.

It is undeniable that the international community is currently off track to achieve SDGs by 2030 and we share the idea that fragmentation, duplication and inefficiency are undermining progress and that it is necessary to recalibrate and amplify efforts made by single agencies to get closer to reaching the health-related targets.

However, the draft outline and the Accelerator discussions papers, published on the WHO website, seem to go beyond the objective of promoting better and improved coordination among the signatory organizations. Instead, they elaborate in depth on several health-related issues and provide policy recommendations that are directed at member States.

The only opportunity that member States had to hear from the Secretariat about the plans for the development of the GAP and to express their views about it was an information session for Permanent Missions in Geneva held at WHO headquarters held on 17 April 2019. On such an occasion, many delegations expressed their view that the GAP should not “reinvent the wheel” but rather build on existing tools, strategies and action plans. The Secretariat informed the Permanent Missions in Geneva that – given the nature and the scope of the proposed GAP, that was meant to be an operation tool aimed at facilitating coordination and accelerating progress towards the achievement of SDGs – WHO had not planned any consultation process with member States.

Italy thanks WHO for having instead decided to open a public online consultation on the development of the GAP. However, after examining the documents published, their scope and the magnitude of the topics being dealt with, Italy believes that a much broader consultation, review and approval process with member States should have been promoted. The online consultations were, in fact, announced only on 14 June 2019 and started already on 17 June 2019 for a period of just 10 working days: many member States were not even aware of the process, nor it was publicly announced or mentioned during the World Health Assembly which ended on 28 May 2019.

Moreover, no information has been shared on the way forward nor on the Secretariat’s plan to share a draft version of the GAP for subsequent consultations, review and approval by member States.

On a general note, Italy would like to recall that 3 High Level Meetings were held at the margins of the United Nations General Assembly in 2018 (on antimicrobial resistance, on tuberculosis and on non-communicable diseases). Notwithstanding their relevance, no or little reference is made in the text of the outline of the GAP and, more importantly, in the accelerator discussion papers, to the outcomes of such events. In some cases, it appears that the work of the Secretariat on the GAP has gone beyond the consensus reached in New York with the high-level meetings, if not clearly in an opposite direction, as it’s clearly the case for some aspects of the Political Declaration of the High-Level Meeting on the Prevention and Control of Non-Communicable Diseases.

Comments on Accelerator Discussion Paper 1: Sustainable Financing

Italy generally agrees with the principles set out by the discussion papers and, in particular, with the idea that enhanced support for countries is needed to mobilize adequate and sustainable revenues for achieving the health-related SDGs, to ensure that “no one is left behind” and that it is necessary to work better to align development assistance for health with national priorities.

However, with regard to the main drivers identified by the Secretariat to reach such objectives, Italy expresses concern over the content of the second component of Driver 1: “Support country dialogue on scaling up or introducing of taxes on products and processes harmful to health (especially cigarettes, alcohol, sugar) and on broader domestic revenue mobilisation efforts such as global action against tax avoidance”. The definition of “products and processes harmful to health” looks ambiguous, inaccurate and therefore misleading. The proposed text puts sugar in the same category of “harmful products” as for tobacco. It must be recalled that the 2018 Political Declaration of the High-Level Meeting on Prevention and Control of NCDs makes no use of terms such as “harmful products”, especially when related to food and nutrition: this reflects the general idea that there are no “healthy” or “unhealthy foods” but rather “healthy or unhealthy diets”. As for sugar, it is itself an essential nutrient that cannot be considered harmful or unhealthy “per se”: it is, instead, the excessive consumption of sugar in the context of an overall unbalanced and unhealthy diet that is indeed to be considered potentially harmful.

As for taxes such as those on sugary sweetened beverages, it must be recalled that there’s no evidence on their effectiveness to promote healthier diets and therefore have a positive impact on public health: the only evidence available is relating to the reduced commercialization of targeted products (which is indeed self-explanatory).

Italy therefore asks to eliminate the reference to taxes or to limit it to tobacco products.

In more general terms, more time would be needed to examine and digest the overall content of the Accelerator Discussion Paper 1. Italy asks the language of the draft be made strictly compliant with the latest political consensus and, in particular, with the 2018 Political Declaration of the High-Level Meeting on the Prevention and Control of NCDs.

Comments on Accelerator Discussion Paper 4: Determinants of Health

The commitment signed by the 12 participating organizations affirms: “Healthy lives and well-being for all at all ages cannot be achieved without the full commitment of governments, and participation of all stakeholders, including civil society, the private sector, academia, and other international, national, and local institutions, that influence health and well- being”. In another passage it says “Global health has forged new ways to leverage the power of civil society and the private sector and generated innovative modalities and powerful technologies to address complex global health issues”.

However, the language introduced in the Discussion Paper 4 suggests a negative and restrictive approach to the private sector, often identified as “health-harming” or responsible of “pervasive industry interference”. This appears to be in contrast with the 2018 Political Declaration of the High-Level Meeting on the Prevention and Control of NCDs, which identifies the private sector as a key partner for ensuring progress, and with the spirit of the very same Agenda 2030 for Sustainable Development. Also in this case, it would be appropriate that the language used be strictly compliant to that agreed in the latest political declarations and agreed strategies.

Several problems arise from the introduction in the paper, as one of the determinants of health, of the concept of “commercial determinants of health”. It must be stressed in this case that there is

no agreement among member States on such a definition, which results very broad, vague and inaccurate. Italy believes that such a reference should be therefore completely eliminated from the development of the GAP.

In the context of the “commercial determinants of health”, the paper cites again the so-called “STAX” (sugar, alcohol and tobacco taxes) and affirms that there is “evidence” of their “public health and economic benefits”. Please refer to the comments already made in the context of Discussion Paper 1 on this topic.

The above outlined examples show that the development of the Global Action Plan has gone beyond the mere intent of identifying strategies for a better and closer coordination among different organizations to accelerate progress in the achievement of SDGs but has instead tried to introduce principles and concepts that have never been agreed upon by member States and/or rejected during the negotiations of the last and most relevant political documents and strategies, also in light of their divisive and controversial nature. Italy believes that the GAP should refrain from introducing them before a broad and open consultation, review and approval process is completed with the involvement of all member States.

Directorate for Food Security and Nutrition
Ministry of Health
Italy

The burden of diseases associated with a poor diet continues to grow. The number of overweight and / or obese people has reached an epidemic level globally, due to an unhealthy diet and an inadequate lifestyle. This negative trend heavily involves children and adolescents.

Added to this are inadequate practices (such as the use of fossil fuels, intensive agriculture, alcohol abuse and tobacco consumption) that cause damage to health, significantly reduce production capacities and increase health care costs. These costs are borne more widely by the public sector and are reflected within families.

It is therefore important to encourage healthy behaviors and educate to conscious consumption at all times of life, but it is especially essential to promote prevention interventions that can counteract the negative consequences for health.

In this regard, providing policy coherence in the decision-making process can be an effective strategy, such as:

- *encourage decisive action to address relevant issues such as excess malnutrition, also taking into account the influence of economic policies and social inequalities on them*
- *provide for far-reaching measures in an attempt to counteract the negative consequences of overweight and obesity especially among children, supporting initiatives that, by creating effective interventions and involving selected partners, can move in the direction of inter-sectoriality, addressing not only the aspect nutritional but the wide range of health factors of the child first and then of the adult*
- *set up at national level Governance systems with the participation of the scientific world and non-governmental organizations that allow to monitor behavior in the different age groups of the population and to prepare interventions based on evidence, also collecting the input of stakeholders and consumers , which must also be represented in such systems (win win strategy)*
- *intervene on food reformulation, as it stimulates the mechanism of nutritional improvement by the industrial sector. It is necessary to identify intervention lines that allow the industry to introduce the planned improvement actions*
- *reduce the impact of marketing, especially on products intended for children, in order not to affect their choices in any way, interacting with the production sector, thanks to some basic principles set in the regulations*

- *develop a clear, proactive and effective strategy, avoiding unilateral, coercive policies, linked, for example, to evaluation systems for individual foods, based on nutritional profiles, or to increased taxation, which represent a defeat of preventive strategies;*
- *identify measures that can increase consumer awareness to enable them to take careful care of their health and lifestyle*
- *provide funding for experimental projects on the effects of the various measures adopted. Funding dedicated to monitoring the food consumption of the population is of particular importance, aimed at developing dietary styles adapted to the traditions and culture of each country (eg the Mediterranean diet), through a common commitment to ensure that the data collected are comparable, in order to to evaluate the adoption of targeted strategies, involving more countries.*

SDG3_Secretariat

From: Cillian.Quinn@dfa.ie
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To: SDG3_Secretariat
Cc: Emma.Warwick@dfa.ie; Anna.Cunniffe@dfa.ie
Subject: Comment on Accelerator Discussion Paper 4 - Global Action Plan for Healthy Lives and Well-being

Name	Anna Cunniffe, Emma Warwick and Cillian Quinn
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Date	25/06/2019
Type of comment	Accelerator Discussion Paper 4: Determinants of health

The Department of Foreign Affairs and Trade Ireland welcomes the opportunity to make a submission to the World Health Organisation in relation to the Global Plan for Healthy Lives and Well-Being. The Government of Ireland would like to express its appreciation for this impressive accelerator paper which clearly articulates the determinants of health. We particularly would like to commend the acknowledgment of the hardships experienced by marginalized groups such as LGBT+ people, people living with disabilities and migrants and the struggles they face in ensuring they lead healthy lives.

Although we support the language and content presented in this discussion paper we would ask that it goes further to discuss the issues faced by people trying to attain Sexual Reproductive Health and Rights. We would ask that in the section; *Table 1. Examples of potential areas of joint action by GHOs to support countries in line with national priorities*, there is an inclusion of language relating to SRHR. We would suggest a bullet point be included in the Structural Detriments section of the table that states: "Commit to making SRHR a reality for all which includes but is not restricted to; family planning services, comprehensive sexual education, maternal and child health services and safe abortion (where legal) services".

Again we thank you for conducting this impressive and valuable work on outlining the detriments of health and look forward to seeing the final document.

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Fógra Séanta Ríomhphoist

SDG3_Secretariat

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Cc: Emma.Warwick@dfa.ie; Anna.Cunniffe@dfa.ie
Subject: General Comment - Global Action Plan for Healthy Lives and Well-being

Name	Anna Cunniffe, Emma Warwick and Cillian Quinn
Title	Human Development Team, Policy Unit
Affiliation	Development Cooperation and Africa Division, Department of Foreign Affairs and Trade, Government of Ireland
Date	25/06/2019
Type of comment	General

The Department of Foreign Affairs and Trade Ireland welcomes the World Health Organisation online consultation in relation to the Global Plan for Healthy Lives and Well-Being. The Government of Ireland would like to express its appreciation to WHO for conducting such an important exercise. A coordinated and concise response to Global Health is essential to ensuring healthy lives and sustainable well-being for all.

The overall Global Action Plan and the seven accelerators presented are well structured and their goal to create momentum towards achievement of SDG – 3 is commendable. Of concern, however, is the absence of reference to the importance of ensuring Sexual and Reproductive Health and Rights for all. SRHR is an essential component to ensuring healthy lives and well-being for all. Ireland's new policy, *A Better World*, has committed to launching a new initiative around SRHR which will incorporate our partnerships for health and HIV and AIDs. We recognise that access to quality maternal and reproductive health care, supporting safe motherhood and allowing women to control their own fertility is central to women's empowerment.

We would request that SRHR is presented from the outset of the Global Action Plan as being congruent to achieving UHC and that the 12 signatories of the GAP commit to ensuring that SRHR is not eroded from future collective actions such as this. We feel this would be best placed in the section of the Global Action Plan; *1.3 Challenges and opportunities for collective action*. We encourage a bullet point on SRHR in this section along the lines of: *Ensure SRHR is a reality for all*.

Again we thank you for conducting this impressive work and look forward to seeing the outcome documents.

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Fógra Séanta Ríomhphoist

Commentary from Norway on the Draft Global Action Plan.

1. OUTLINE

We think the outline is much improved and demonstrates a genuine effort to listen to and respond to the concerns of partners. It is short, to the point, and coherent. The framework: ASSESS, ALIGN, ACCELERATE, ACCOUNT is useful as an organising principle. We are also encouraged by the Process of the GAP – getting many agencies to sit and work together has been useful in of itself.

- a. We note and accept the addition of **Assess** – but it requires greater work to define common assessment – leading to greater alignment.
- b. We are pleased to see greater attention towards **Alignment** of DAH with country priorities and processes (and less attention to alignment of corporate processes between aid agencies – although this remains a potentially useful avenue for enhancing efficiency and collaboration). section 4.3 is under development so we are unable to comment.
- c. We understand the **Accelerate** papers will provide inputs to the plan. We comment specifically on the accelerate papers below.
- d. We are mostly concerned with **Accountability**. We understand there is no intent to create new platforms (section 2.6).

We also recognise effort needs to be made for countries to feedback experiences with global actors and for these reports to be discussed within agency governance structures.

However, the monitoring framework is largely similar to an SDG 3 (target outcome oriented) progress report. Such a framework does not attribute or explore reasons for success or failure. If there is no specific attempt to sustain pressure on the 12 agencies to work constructively together and with countries to reduce costs/waste and ramp up progress, we are not convinced that the GAP will remain an effective tool for enhanced action over the years to come. We believe there needs to be a specific platform that GAP reports to in a light way to sustain accountable action and intent to partnership (with each other and with countries). This could entail expanding the H6 to H12 – but this would require some work to make such a platform effective. Additionally, it could report to other current platforms such as the “Leaders of Global Health Agencies” platform – regularly reviewing progress on both outcome and process indicators to ensure collective action.

We are not asking for an exhaustive process – a short report 1-2 times a year to such a body would keep the issue on the agenda of agency heads and funders. Table 1 page 6 would provide a format for such a report. This may be what is referred to in point 5.2 but the section is not clear.

- e. A last concern is that in several Accelerator papers it is proposed starting in a small number of pilot countries. We see GAP as an approach and a commitment to work together as opposed to a new intervention modality. Many of the issues to be worked on will take several years to bear fruit (domestic financing). Given the time frame of this paper – we do not have time to pilot – learn - and then scale. We think the GAP should avoid an implementation model that projectizes action and pilots it – but rather fosters a commitment to work differently by defining roles and responsibilities, reducing competition, aligning resources and processes, supporting country led development, building country capacity, and acting to transition responsibility for national health systems to partner countries (while upholding progressive realisation of UHC, enhancing well-being and life-expectancy, and combatting major diseases). The careful balance between subsidizing health service delivery,

capacitating local authorities and ensuring sustainability through domestic financing and strategic management needs to be better articulated.

2. ACCELERATORS

1. Finance:

The accelerator is extremely important and recognizes the increased urgency paid to this agenda. We do not disagree with the content of the paper. However, we would like to see a more purposeful and action-oriented agenda.

- Under innovative financing (figure 1) we would also like to see an exploration of country modalities that enhance better coordination and alignment (make DAH more effective and aligned), such as collective payment systems (pay for performance) and or collective investment in national systems (Data, HR, procurement/supply).
- Driver 2 More money for Health. The paper rightly determines the potential for increased DAH flows to LICs – where it is most effective and needed. However, DAH flows are associated to substitution/fungibility in some countries. Efforts by individual agencies to include specific items on health budgets is not an effective means to craft a well-structured and effective national budget. Partners should work together to agree country commitments for sustainable domestic financing and means to counter substitution and drive progressively enhanced domestic investment in health. **This is an urgent new agenda to explore and learn from.** Innovative financing modalities should focus on how to incentivize better domestic financing – both volumes, sources and allocation.
- The paper does not deal significantly with out of pocket expenditure – although this is the bulk of current finance in LICs. This is particularly important for access to PHC – see further comments under Accelerator 2.
- There is some discussion of Sin Taxes – but there should be a broader inclusion of general tax revenues and other means to raise public money to finance health and welfare.
- We believe enhanced country support for regulation, priority-setting and strategic purchasing are critical – getting TA right and ensuring it helps country build institutional capacity is critical. We are concerned at the potential transaction costs – and the ability to work at scale on these issues – and how expert networks on these areas fall under broader coordination such as P4H and UHC2030.
- There has been some effort to set financing target in the UHC HLM political declaration. Debates have focussed on ambition Vs feasible options. In the end, it is impossible to set a single target that encompasses all financing objectives. The financing accelerator should work to define more useful goals and targets and advice to partner countries – and continually work to enhance the global health expenditure database (WHO) which has been so useful in providing analysis under-pining recent debates. But needs to be improved in terms of completeness and quality (i.e. include a piece on national and global financing data and needed evolution).
- Lastly, we suggest the paper might include IMF as a partner and be more explicit how it will leverage IMF and WB macro-economic support to counties on behalf of health.

2: Primary Health Care:

Norway strongly supports emphasis on PHC and public health as the most cost-effective, equitable and feasible pathway to delivering UHC.

- We do not think the paper pays enough attention to private sector and out of pocket expenditure. The last GHE report indicates 57 USD per capita in LICs is spent on health. Only 7 USD is from public sources; 10 USD from aid and 40 USD out of pocket. PHC policies and practice have to reflect reality that (i) health is dramatically under-funded (ii) government has very limited discretionary expenditure and (iii) the majority of PHC services are procured directly from the private sector. This aspect is missing from the paper – pooling finance, regulating private provision, improving cost effectiveness of private services (i.e. cheaper better drugs).
- Additional to the point above, PHC is often defined normatively. But given inadequate public expenditure, what are the priorities for public investment? Are they primary, secondary or tertiary and how to ration their supply and access? How do you define the core (affordable) and then expand out?
- With regards to multi-sectoral action and population level interventions – most attention is placed on issues (tobacco, air pollution etc.). There is limited focus on the institutional landscapes and functional requirements to be able to determine the extent of a threat and how to advise all-of-government to stimulate cross sectoral aligned action (statistical offices, Institute of public health, etc.).
- There are references to a monitoring framework, a workplan and a progress report – but it is not clear who will drive the development of these products and how they will be used and discussed jointly. Norway would support this development – but it should happen rapidly – decisively and promote operational advances not normative standards.
- It would be useful to understand the distinctive roles of WHO, UNICEF and the WB in leading this agenda. We think all 3 are essential but roles are not explored.

3: Community and Civil Society Engagement

The accelerator paper rightly points to the fragmentation of support for engagement with civil society across issue-based silos within health. We support the need for creating a more singular engagement process and platforms. The big question is how – this paper does not define how.

- The paper takes a communitarian view on development engagement – focusing on CSOs and discussions with communities. The paper is far less strong on how to engage and balance legitimate inputs from interest groups – such as media, private sector, patient groups and professional associations. The view on who might be engaged and how needs to be expanded.
- CSOs have expressed concern a shrinking space for civil engagement – both through increased role of domestic authorities as well as changes in intl. donor preferences. Engagement and democratic accountability need to be seen not as a function of aid – and must be transitioned like other aspects of aid.
- Linkages need to be made with engagement platforms in health to other sectors critical for health outcomes (i.e. WASH, nutrition, education, gender etc.).
- The GAP establishes a partnership between 12 international agencies – this is without precedent and the H12 does not have an established way of working together. The processes of coordination will require opening to allow participation by civil society at global and country level.
- Civil society engagement is often driven conceptually and financially through DAH. This is problematic – both as it is not owned by government – and tends to reflect international concerns as opposed to domestic priorities and processes. Government should understand

the importance of consultation and engagement. Engagement needs to be part of transition thinking – and driven by domestic leadership.

4: Determinant of Health:

We are extremely supportive of a separate focus on determinants of health. We believe the agenda can be under-prioritised in favour of the organisation, financing and management of clinical service delivery. We believe there has been limited attention to the construction of public health functionality in developing countries and this must change.

Action to counter determinants of ill-health is generally cheaper, more equitable and more effective than trying to respond to ill-health created down the line. Additionally, costs are proportioned to where they should be located and not piled upon society.

- The paper is largely definitional. It is not clear what action will follow this paper.
- Mirroring comments in paper 3 we think there needs to be greater emphasis placed on the institutional landscape and public health functionalities at country level (and not just control of various risk factors – like tobacco or air pollution). Both to assess new emerging risk factors in situations – and to have established pathways for engendering multi-sectoral response.
- The operationalization of the accelerator can be done through stronger multisectoral governance, driven by country-level multi-stakeholder platforms. This was included in the draft dated 20 December 2019, and which also included a visualization for such an inclusive platform for multisectoral governance on country level (<https://www.who.int/docs/default-source/global-action-plan/accelerator4.pdf>) – but is now removed. We suggest that the importance of whole of Government approach is retained. The figure on multi-stakeholder platform from the lancet-UiO Commission available here: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2813%2962407-1>

5: Research and Development, Innovation and Access

Innovation is key to responding to new threats and driving down costs/ enhancing feasibility of action within lower resource settings. Expansion of UHC will require significant innovation. We share the paper's analysis that "the impact of research and innovation for health is undermined by a weak system - at national, regional and global levels - which fails to direct funding and activities towards addressing country health priorities effectively or coherently". It is therefore crucial to focus on the current biggest gaps for scaling innovations:

- Research and innovation must not be seen as an international contribution – all countries must be encouraged to invest in their own R+D capacities (and systems to establish priorities in national research agendas). Without domestic capacity to define priorities and drive forward efforts to locate and implement innovations – innovation gets stuck at the invention stage. Country capacity is urgently needed to ensure scaled adoption.
- Conceptual work must ensure legitimate priority setting for public investment in global public goods – as well as at national levels.
- The paper suggests establishing forums for national priority setting and coordination – but they seem aid focused. The forums will have to focus linking innovations to policy and financing at country level, as national ownership that underpins sustainability, is of essence.
- Product discovery and price setting activities are largely enacted for global work around vaccines and priority communicable diseases. Products and prices need to be reviewed cross

a broader range of health challenges to enhance state capacity to offer services to poor citizens at good quality and for an affordable price. This should include NCDs in the future.

- Focus should move from research on products to expanding use at scale – which will include market conditions as well as innovative processes and practices.

6: Data and Digital Health

Norway has held a strong focus on data and accountability for the past decade. We strongly believe data is required to establish priorities, manage interventions and assess outcomes. Strategic management and resource optimization is impossible without data.

- The paper outlines a list of collective actions. The actions are largely sensible. However, they do not differ substantially for previous analyses under CoIA and the Health Data Collaborative. Yet these initiatives have not delivered as hoped.
- We concur that there is a need to move from data collection and extraction for international programme management towards domestic system development and domestic data use. Additionally, we need to move beyond development of digital tools to digital platforms/systems that create ecosystems with users and developers linked dynamically. And lastly, we need to adopt and put into practice the various digital principles and comply with open source specification for digital public goods.

7: Innovative Programming in Fragile and Vulnerable Settings and for Disease Outbreak Responses.

UD may wish to consult HUM on this section.

The issues raised in the paper are extremely important.

- However, the paper tries to deal with too much differing content. Given the extensive breadth of the mandate, the paper reads like a comment on the field and a list of activities that are already ongoing and developed in greater detail elsewhere. It is not clear if this paper offers any significant contribution to the field.
- In emergency settings there are standards (like SPHERE and UNICEF minimum operating standards). However, these define what services to deliver and do not focus on the “governance replacing” roles of the UN and when to transition. There has been limited recognition of role differentiation between UN agencies and between the UN and NGOs/CSOs. This has led to competition for finance and overlapping activities, which persistently leads to competition and undermines UN leadership, coordination and effectiveness.
- The UN generally supplies material support to a wide range of CSO implementing partners. Provisions of vaccines, drugs kits, nutritional commodities define the service range that can be provided and should allow the UN a role as a strategic body – collecting information and ensuing equity and value for money – as well as driving system development in the short term (ie establishing new priorities for collective action as external scenarios shift).

Outline of the Global Action Plan

Overall comments:

- The UK welcomes the Global Action Plan and the explicit recognition that its value will be determined through action and impact at country level.
- We welcome the ambition but note that prioritisation and realism about what will be done and when will help to set out clearer steps.
- We believe the plan needs to continue to focus more on the 'how' the multilaterals will work better together rather than the 'what technically needs to be done' which is everyone's business. Some of the accelerators do this better than others.
- There also needs to be better linkages between each of the individual accelerators – currently there is no real oversight as to how these will all play out at the country level.
- There is a need for clearer accountability measures that do not just focus on the achievement of SDG milestones but drive and incentivize different ways of working to achieve the SDG3 goal.
- We believe that the WHO UHC country support plans would be a good tool to bring all the individual accelerator plans together. This would also help to bring government leadership and other actors into the picture, providing clarity and realism that the GAP is part of the picture of wider work on UHC, but does not cover everything.

1. What do you see as the key opportunities offered by *The Global Action Plan for Healthy Lives and Well-being for All*?

Key opportunity 1: country-level impact

- Enhanced alignment and coordination must translate into coherence and coordination at the country level that prevents duplication of efforts and additional administrative costs and maximises the contribution of external assistance to improving health and wellbeing, developing strong and resilient health systems, and building national capacity and capability.
- There should be clear links between the GAP and the UN reform agenda at country level and the role of the Resident Coordinators.
- We note that much of the important substance in the outline Global Action Plan has not been drafted yet and we look forward to this responding to our observations below. Similarly, we suggest that the GAP should consider how architecture will evolve and change as we move towards 2030.

Key opportunity 2: identify how multilaterals will work together rather than what technically needs to be done

- We are encouraged to see this plan evolve and it is clear from some of the accelerators that agencies are trying to look at practical ways to work differently. We believe this could be even more explicit throughout. Specifically, the Global Action Plan is an opportunity to state explicitly 'how' this will happen - for example, how will agencies come together to review and respond to national plans in country, how will this be kept under constant review, how will agencies know if this is working?
- We are expecting the plan to **identify areas of real change**. We would like to see alignment of effort but also partners working to their comparative advantage – so if it's better for one agency to act, rather than many to "align" that's what should happen, i.e. it doesn't always need to be collective action.
Having clearer multilateral roles and responsibilities would strengthen the paper and we recognise that this will need to be context specific and communicated to and agreed by country governments. It will also need to feed through to the global level to be fully upheld and endorsed.

- Linked to this point, we should recognise that changing the international system is challenging and there are questions of mandates, scope, and focus to be addressed. For example, how will agencies seek to agree changes to the ways that they work together through their respective boards, and how will this connect with broader UN reform processes?
- Some specific examples of the 'how' are emerging in the accelerators e.g. joint audit arrangements for pooled financing under the sustainable financing accelerator pillar, and joint situational analysis mentioned under PHC. Some remain more vague, such as 'engage' with or 'build' different initiatives.
- Having more consistency in terms of how each accelerator is outlined would be helpful. More focus of the papers should be on actions, principles and milestones, rather than the technical background on challenges and what is already agreed in global strategic documents..

Key opportunity 3: make the links across accelerators to maximise impact from greater coordination and collaboration

- The Global Action Plan needs to make the links between each of the individual accelerators and ensure oversight of activities across these at country-level. Referring to aid effectiveness principles is a part of this, but understanding how these are going to be translated into real action and change needs further consideration. We understand that these are being developed but we believe these will be the most important part of this plan and would welcome further consultation on this. We believe that this could include having a shared risk assessments and/or common partnership compact that is clearer on mutual accountability and responsibilities.
- We advise that caution will be needed in taking the proposed piloting of approaches in different countries i.e. financing in countries X, Y, Z while PHC in A, B, C. This will not help support better working across the accelerators if the focus in a country is only on one specific accelerator and not the others.

Key opportunity 4: understanding how change can happen to inform country-level engagement

- The accelerators, and the overall plan, should explicitly consider political economy analysis so that signatories can understand how to accelerate progress in different contexts through 'champions' (champions being people and/or institutions) and which signatories are best placed to work with these champions.

Key opportunity 5: putting in place accountability for increasing coordination and collaboration

- We welcome the explicit link to the SDG agenda and the focus on impact through the SDG 2023 milestones which we agree should calibrate and coordinate signatories' efforts.
- However, there is a need for clearer accountability measures that focus on performance to drive and incentivise different ways of working to achieve the SDG3 goal. We think that tracking joint outcomes is important and in addition to milestones, we would like to see some performance measures and actions to be measured against as part of 5.2. It also needs to be clear if there will be a single accountability approach for the GAP, or if there will be different structures for each accelerator.
- To support this, there could be 'process' types of indicators that incentivise collaboration and support monitoring of how effective areas of collaboration have been. An accountability mechanism based on the 'live' monitoring efforts of the UHC Partnership, might lend to more useful ways to monitor progress. Understanding how agencies will hold each other to account and where these discussions will be had will be an important component to include in the plan.
- In addition, understanding how learning across the different accelerators will also be shared will be important for broader multilateral reforms and this process for reflection and dissemination needs to be considered from the outset.

Accelerator: Sustainable Financing

Overall comments:

- We commend the agencies for outlining clear principles, drivers and joint actions to be taken under the accelerator. It remains an ambitious undertaking, but we do think a more coordinated approach in this space will reap rewards in terms of accelerating progress and reducing duplication.
- The vision of success is also extremely helpful and will be useful to identify ways to monitor progress. Would like to see measurable milestones that focus not on just achievement of stronger health financing systems but also **relate to improvements in ways of working between the multilaterals**.
- Clarity is still needed on what coordination mechanism is being proposed – can this work build on existing platforms e.g. P4H as part of UHC2020? How will the GAP address country-level architecture, including simplifying existing coordination mechanisms?
- Further clarification on who will do what i.e. playing to comparative advantages versus collective joint action would be helpful. We know that this will vary based on the context but would be good to understand whether clearer roles and responsibilities will be discussed as work on focus countries begins.
- There need to be clearer linkages with the other accelerators in terms of addressing health financing priorities that have been identified within these.

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

- **Driver 1:** all important areas to drive action. On scaling up national dialogue platforms it is unclear what will need to change. Is the proposal that you will bring the different community platforms, often established around specific diseases together? And take it this will be done using existing resources rather than requiring additional funding?
- **Driver 2:** all important areas for action. We will be interested to learn more about how and who will facilitate the technical dialogues between MoH and MoF. Do we have a measure of 'what success' in this area would look like? We agree more coordinated action to build institutional capacity is necessary and we believe that the health financing matrices will be a useful tool to support better planning of providing resources including technical assistance to countries.
- **Driver 3:** the 12 agencies will also need to align this work to technical assistance provided by other technical partners working in this space. This should link up for instance with the launch of the DECIDE platform.
- **Driver 4:** Strongly support bringing the ACTA work together under this pillar.
- **Driver 5:** The para on strengthening coordination of TA (bottom P8) seems out of place here as coordinated TA is needed for all the drivers. It is clear that we are trying to ensure that the consensus built from the latest evidence then needs to be translated at the country level but it seems out of place here.
- **Driver 6:** it is unclear how the agencies 'will expand' pooled funding mechanisms particularly as there is no mention here of how the agencies will work with other donors/funders on this driver.
- **Driver 7:** laudable to explore new innovative funding mechanisms but we need to make sure we gather evidence of what works and closely monitor and evaluate any new approaches. It is unclear the scale to which these new innovations will be taken to.
- **Joint actions:** we would suggest that alignment with 'other financial and technical partners' would need to occur from the start rather than being a medium-term goal.
- **Synergies with other accelerators:** stronger health financing reforms are needed to support nearly all of the other accelerators. It is unclear however how the links will be made to support some of the key challenges outlined under these sections i.e. on fragile states, funding for preparedness, a multi-sector response etc.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

- We are interested in understanding further what the global coordination unit would entail and would welcome understanding more about the vision of this. The figures 1&2 are quite confusing and so it is difficult to understand in full what implications this will have in terms of transactional costs. This needs to be light touch and doesn't create even more bureaucracy or duplicate efforts being made around broader coordination on health financing that includes a wider constituency.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

- The UK is providing substantial investments to many of the agencies involved with delivering on this accelerator e.g. GFATM, GFF, Gavi, WHO etc either through centrally managed mechanisms or bilaterally at the country level. We also provide funding to the International Decision Support Initiative that provides technical assistance on prioritisation and better decision making through building capacity to undertake health technology assessments.

Accelerator: Primary Health care

We agree strengthening primary health care is critical to achieving UHC and agree that coordination and guidance will support these efforts.

General comments

- Any specific plans for primary health care (PHC) need to be integrated into broader plans for health systems and achieving universal health coverage, recognising that the GAP is one part of wider efforts on UHC and that government leadership is essential. We should avoid PHC becoming a vertical approach.
- Further focus is needed on the 'how' and 'what will change'. We would like to see clearer roles and responsibilities outlined based on comparative advantage versus collective joint action.
- A clearer understanding of what milestones will be identified to measure changes in 'the ways multilaterals will work', alongside impact at the country level, will strengthen the paper.

Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

- The paper talks a lot on country ownership but does not reflect on how the accelerator partners will address getting high level commitment and buy in to push PHC more i.e. helping countries to make the case. The focus assumes that there is already good buy-in, but this may not always be the case.

1. Coordination section

- The paper mentions it will not establish a new global oversight body, but it would be good to be clearer about what mechanism will be used and what needs to be done to strengthen this. We are not clear if there is uniform endorsement of merging the Astana PHC group (with broader representation) and the SDG GAP PHC multilateral and what would this new configuration be called. Will there be some kind of formal launch of this as part of WHO's PHC initiative for example? Given that this existing platform involves more constituents, it needs to be clearer how the GAP activities then fit into these broader efforts – i.e. what is the added value of this accelerator and how will more joined up collaboration support the bigger vision.
- **Reframing support for country programs:** this section is unclear as it outlines what programmes/initiatives are already doing to support PHC or what more could be done, rather than what the 12 agencies will do collectively/differently to accelerate efforts to strengthen PHC in addition to these efforts.
- It also mentions that the existing initiatives 'should align' with the three components of PHC but the paper does not tell us what will be done to make this alignment happen.
- It is also unclear how the different agencies will help UHC2030 to develop a knowledge portal for PHC. We would like this document to be clear about whether they are supportive of UHC2030 taking on this role and specify how each agency will contribute to making this knowledge platform a success.
- On the broader communities of practice, it is unclear what the GAP partners will do to strengthen linkages between these other existing regional/country platforms.
- The paper mentions that there are agreed principles of engagement, but these are not clearly defined and laid out.

2. Global guidance section

- Having a single situational analysis and harmonised tools are important areas where agencies can come together. However, the accelerator already outlines how many different tools exist e.g. on page 9. There are also efforts to harmonise health facility assessment tools as part of one of the UHC2030 working groups. It is therefore not clear what the plan is to bring all these different tools together or whether the accelerator is suggesting creating something completely different. We would not support the creation of something different, and suggest the document needs to be clearer how these tools will be rationalised and what signatories will do in terms of carrying out joint analytical work on this.

- We agree the PHC operational framework will be useful. However, the purpose of the GAP should be to clearly articulate how different agencies will work together to support countries to operationalise this. The paper isn't clear what this will look like in practice i.e. who will lead on helping countries to adapt the framework and implement it.
- On developing a common framework – it is clear we need to bring together multiple efforts together. We would like to see more on 'how' signatories will do this. It would be good to be clear whether this will be led by one agency, or through an existing or new technical working group and how will the 12 agencies accelerate these efforts. A timeline would be useful.

3. Accelerating progress section

- We would have concerns about establishing new platforms at the country level. More needs to be done to consolidate and simplify the ones that already exist e.g. there are often child survival, immunisation, reproductive health, CCMs etc. However, if there is a real and important gap then a new platform may be required but we would suggest that signatories would all need to first understand what the gaps are before suggesting a blanket approach about establishing something new, and this needs to be within the context of UN reform and the role of Resident Coordinators. We would like to see more clarity about leadership of coordination efforts at the country level and what responsibility will each of the agencies take to strengthen these.
- We welcome joint situational analysis and suggest that the signatories build from this to take forward integrated analyses, that combine efforts to look at the whole health sector. In our view, this is needed even more so that countries do not have multiple agencies carrying out assessments on individual components of the health system. PHC efforts must not become stand-alone. The paper would be strengthened by also saying how these assessments will then be used and taken forward.
- Good metrics and measurements are clearly important, but these only make sense if these are incorporated into national health information systems and capacity is built to utilise data for decision making. The document should say more about how signatories institutionalise these and support countries to adapt/adopt these.
- We agree that ensuring there are strong components on PHC within national investment cases, but we would be concerned if the suggestion is to have a specific investment cases just on PHC. This will only fragment already complex planning processes at the country level.
- It is unclear what is being proposed by having a focal point person at country level. We would like to see more clarity about the composition and role of a PHC technical team and how different agencies would work with this team and/or individual. Would they be involved in mapping out the 12 agencies investments in PHC for instance and then making sure these aligned with broader national strategies and priorities?
- It is unclear how signatories will coordinate different technical assistance – having a national platform to discuss the specific direction of what needs to be done for PHC is a good basis for action, but then agencies then need to be more aware of what each is doing. This might be the proposed role of a focal point person.
- Efforts to support financing for PHC needs to be more clearly linked with efforts under accelerator 1. As is, the description implies a vertical approach which we would discourage.

Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

- We suggest that signatories bring the next steps actions under each of the themes you have under section C. This would help to highlight some of the detail on the 'how' that might otherwise be lost.
- The next steps section seems to focus more on planning rather than implementation. We need to acknowledge that PHC is not new. The paper could therefore highlight which specific aspects of PHC will be the exact focus for different agencies. While we appreciate that this depends on the country context, some ideas of what different agencies will do to support implementation and impact needs to be clearer i.e. we are surprised that there is relatively little mention of breaking down siloes, integration, working on multi-sectoral approaches, community engagement etc. Some of these issues are covered under

different accelerators but there needs to be a clearer understanding on how this will work – possibly as part of the introduction and overarching section of the plan.

- There is no real mention about engagement with CSOs and private sector and what efforts will be made to bring these constituents into the fold. We recognise that the civil society engagement is addressed in Accelerator 3 but, as per our overall comment on ensuring sufficient cross-referencing, we would like to see this explicitly drawn out here.
- We believe that this accelerator misses the opportunity about how agencies will **advance equity** in a collective manner. We support the principles but they are rather weak on advancing equitable access **within** countries beyond looking at financing.

Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

- The UK is providing investments to many of the agencies involved with delivering on this accelerator e.g. WHO, UNICEF, GFATM, GFF, Gavi, etc either through centrally managed mechanisms or bilaterally at the country level e.g. as noted we are one of the donors supporting the UHC partnership.

Accelerator: Community and Civil Society Engagement

1. General comments

- We welcome a specific accelerator on community and civil society engagement and the distinct approaches to country- and global-level engagement. We support the objectives and outputs identified and the second action on developing the capacity of local-based partners is particularly important.
- It is important that read-across to other accelerators is explicitly highlighted, for example as in Annex 3 on how community engagement can be built into the primary health care accelerator.
- We would like to see clearer, more tangible inputs emerge as further work is done on this accelerator and for clarity on how these translate to the outputs identified.

2. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

- We welcome Annex 3 on how community engagement can be built into the primary health care accelerator. The focus on Community Health Workers is important but signatories should also consider how their support for strengthening service delivery and accessibility can strengthen community engagement through local health authorities and other actors. This is likely to be a point of commonality for many investments and interventions supported by the signatories.
- We would also like to see greater emphasis on how the signatories can engage with communities that are most at risk of being left behind and build and maintain community trust and demand for services. There is read-across here to primary health care and the fragile states accelerators in particular, as trust in health services can be low and cause real harm to communities and wider populations through issues such as low take-up of immunisation and distrust of Government responses to health emergencies.
- We propose including more clarity on the funding for the outputs identified. Are all activities assumed to be based on existing available funding (and if so, what is this?) or will there be requirements for additional funding to enhance engagement with communities and civil society?

3. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

- **Action 1:** We support the outputs identified, but currently the link between proposed inputs and these outputs is not clear. There needs to be greater clarity on what signatories will do differently to what they are doing now. Collecting good practice and aligning with the UNDAF is a good first step but will not lead to the outputs identified without further clear actions on the part of the signatories. How, for example, will joint advocacy be taken forward by the signatories? How will country-level advocacy and global-level advocacy on civil society engagement be linked up?
- **Action 1:** The expansion and protection of civic space is essential. We would like the action plan to recognise the role of the signatories in piloting community engagement in countries where this is lacking to support country health coordination and community engagement. We would like signatories to articulate how they can contribute to strengthening spaces for civil society that will endure during and after transition processes from external assistance.
- **Action 2:** We would like to see a clearer articulation of whether signatories do provide such funding to civil society/community engagement, and how signatories will work with national governments to use accountability tools for the prioritisation and direction of health spending (domestic and external).
- **Action 2:** What is unclear in the strategy is how the signatories will bring together already existing civil society networks. For example, we know that there are relatively stronger HIV civil society networks but weaker networks in other health areas e.g. disability. What approach will be taken to utilise already existing capacity but broaden the scope to support the wider UHC agenda?
- **Action 3:** We would like to see articulation of whether signatories will take a common approach to civil society engagement to increase clarity and reduce transaction costs of engagement and, if so, how this

will be achieved. This action does not articulate a clear direction of change, and could be clearer about whether engagement needs to be refined or transformed.

- **Action 4:** We welcome strengthening of existing platforms rather than creating new ones and efforts to increase transparency of opportunities for engagement. We would like to see more detail on the second output on how signatories can reach civil society actors with limited access to the internet and/or computers – this is a very important point and linked to the capacity building of civil society organisations.
- **Action 4:** We recommend that the leads link up with the OECD DAC Community of Practice which is in the process of producing new DAC guidance on how best to support and work with civil society.
- **Annex 1:** We support the call for a clear, participatory accountability mechanism that measures how far signatories are engaging with communities and civil society.

Accelerator: Determinants of Health

1. **Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?**
 - **Making the case more strongly:** there are a lot of statements on the two-way linkages between the determinants and health outcomes without providing the evidence to back them up – for example on health as a driver of sustainable development. Bringing out the evidence for these links will incentivise broader development agencies to collaborate through demonstrating the value to their core mandates as well as health more narrowly.
 - **Highlighting opportunities as well as challenges:** e.g. around private sector financing vs. commercial determinants; of the opportunities provided by urbanisation as well as the challenges, and other areas.
 - **Including 'Health in All Policies' (HiAP):** this work has been hugely important in operationalising action on the wider determinants, and yet is not mentioned in this document. Leveraging the experience of HiAP would support closer collaboration between the 12 organisations through building on lessons learned around enablers and barriers to progress on addressing the determinants of health.
 - **Explicitly referencing nutrition:** there is no reference to nutrition in this document, despite the fact that it is a core part of health and driven by the exact same determinants (see: UNICEF conceptual framework for nutrition). This omission is particularly stark because unhealthy diet and malnutrition is the largest risk factor for death and disability in high- medium- and low-income countries, and making food systems more nutrition sensitive (and climate-resilient) is an essential 'determinants of health' action if we are to improve health outcomes. This specific focus would leverage closer alignment between a number of the 12 organisations who share the nutrition mandate (e.g. WHO, UNICEF, WFP), or for whom good nutrition is critical to achieving their institutional objectives (e.g. Global Fund, Gavi), or who play a major role in this agenda (e.g. World Bank, GFF).
 - **Explicitly referencing commercial determinants of health:** the food and beverage industry is global. Commercial determinants are an issue that goes beyond national boundaries and global institutions have a role in highlighting the lack of parity in the action of these companies. For example, the same products in different countries or regions can have different content of trans fats and sugars. Global institutions should articulate a clearer role for themselves in driving change on the commercial determinants of health and recognise that consumer choices are shaped by food and beverage industry offers and advertising.
2. **Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?**
 - **Examine mandates:** which GHOs have the mandate to engage different line ministries and other multilateral bodies to address the determinants of health – e.g. in energy / infrastructure, labour / economic transformation, and housing and urban development? We suggest there is a concrete action on reviewing all non-health programming for health impact, and exploiting opportunities to improve health through other sectors where appropriate – including through working with other line ministries.
 - **Set a very high threshold for introducing new governance structures:** wherever possible, use existing coordination platforms and work directly with line ministries rather than establishing new platforms – which are transaction cost-heavy – unless specifically driven by governments.
3. **Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?**
 - As a bilateral development agency, DFID provides funding to Global Action Plan multilateral organisations to accelerate progress toward the health-related SDG targets, including providing core funding that could be used by these organisations to align with the accelerator actions described.

- DFID programming and policy priorities also cover many of the accelerator actions described in table 1 – for example tackling gender inequality including in education, promoting resilient, nutrition-smart food systems, and supporting social protection that leaves no one behind.

Accelerator: Research and development, innovation and access

1. General comments

- The Accelerator for R&D, innovation and access is well written and represents many of the UK's priorities. The Global Action Plan will certainly help to identify and prioritise areas for investment including for research. However, it will be very ambitious to achieve and care should be taken not to overcommit, especially where actions relate to low-income countries that have capacity constraints.
- We welcome that innovation has been used with a broad scope, going beyond just biomedical products, to also include interventions in the social sciences, service delivery and other related areas, although this could be reflected more strongly in the text.
- The actions have several bullet points below them of plans to implement these actions and as a result it is hard to tell which will actually be implemented. In general, we agree with the overall ideas of the goals and the actions.

2. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

- Overall, the paper could be strengthened by identifying more what different agencies will do, individually and together based on their comparative advantage as it is mostly WHO that is mentioned.
- The key opportunity is to identify incentives for the agencies to work better together. We think this could be improved substantially, as there has been increasing overlap of roles/areas of work, for example between UNICEF and UNFPA.
- The Global Action Plan needs to address how the signatories will work and coordinate across Government ministries and other sectors beyond health. The section of the paper that recognises the importance of partnerships and coherent policy and regulations does address this, but we would like to see this emerge more distinctly as an area for the Global Action Plan to address.
- The national priority setting approach outlined will be useful for UHC and NCDs, though NCDs do not feature other than for diagnostics/screening in the current text. To expand this, it would be useful to reflect alignment with the Global Action Plan on NCDs beyond 2020.
- To ensure the health-related SDGs are met, it would be useful if the paper recognised the One Health agenda where innovations in the animal or environmental health space can have a drastic impact on human lives. This is particularly true for AMR, where antimicrobials are used inappropriately in e.g. farming practises or being discharged into the environment from drug manufacturing plants.

3. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

- **Action 1:** We would like to add that multilaterals could have a role in advising partner governments about the risks of allowing too many innovations to be introduced in projects. There should be a common platform or a way of ensuring that different applications or data are compatible (but recognise that this may be covered under Action 2).
- **Action 2:** We welcome this action but note that it is ambitious. It is not clear there is a natural home for these forums in many countries (i.e. R&D is often scattered amongst universities with weak government involvement/ leadership) but this could be used to bring research and development and innovation up the agenda.
- **Action 3:** We agree that this is sensible from an AMR perspective given the need for the urgent development of new antimicrobials.
- **Action 4:** This is a useful point but the current drafting does not clarify the signatories' role in this is.
- **Action 5:** We suggest that leads consider whether there is a role for WHO to provide support to countries, as required, to adopt and implement innovations.
- **Action 5:** While access of innovations is vital, it is also important that these innovation are used appropriately. Therefore, it would be useful if stewardship is also considered when scaling up innovations. This is in particularly true for antimicrobial resistance (AMR) in order to prevent further resistance from occurring.

Accelerator: Data and Digital Health

1. General comments:

- DFID agrees that there is significant scope for digital technologies and improved data capacity to act as important catalysts towards delivering inclusive, sustainable development in an increasingly digital world.
- Further focus is needed on the 'how' and 'what will change' in terms of ways of working between the multilaterals rather than on the technical areas where improvements are needed. We would like to see clearer roles and responsibilities outlined based on comparative advantage versus collective joint action.
- Clearer linkages with the other accelerators e.g. PHC and broader health systems strengthening efforts would strengthen the approaches outlined.

2. Suggestions for improvement to further leverage the potential of closer collaboration and alignment between the 12 organizations:

- We support the aims to focus the five key areas including building country capacity to utilise, as well as collect, data to inform better decision making and prioritisation. The proposed collective actions align well with commitments on Digital Health and we are content that they represent a viable course of action that is consistent with the global Principles and standards described above.
- However, without working to agreed principles and standards and building strong policy and regulatory environments, new data and digital innovations will not deliver on their potential. Including actions to support this would strengthen the paper.
- The main issue is that many of the activities outlined in the accelerator are already happening and what is not clear is what agencies **will do differently to bring together their collective efforts and investments** i.e. beyond applying the principles of digital development. How for instance will the agencies use their current investments on digital and data differently? At the country level, how will agencies work better together? How will each hold each to account to uphold the principles or improve greater collaboration i.e. will you work from a joint work plan on data and digital? How will technical assistance be coordinated from the different agencies?
- It will be important to ensure good coherence between the work of the data and digital health accelerator and the other proposed accelerators, especially those on primary health care and fragile and vulnerable contexts.
- It will also be important for the work on digital and data to be linked more broadly with other areas of system strengthening i.e. will activities that fall under data and digital be included as part of the UHC country support plans? What efforts will be made to link data systems required for strategic purchasing be brought together and what responsibility will each of the agencies have to bring these things together.
- There are also issues to do with other investments that donors/Foundations also make either bilaterally or through central mechanisms – what will the 12 agencies do to bring these investments together.

3. Suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs:

- Covered above.

4. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

- The UK invests in strengthening national health information systems such as through the Global Funds, and direct investments to WHO's Global and National Health Observatories and the Health Data Collaborative. DFID's Inclusive Data Charter Action Plan details our strengthened ambition to move the inclusion agenda forward within our own organisation and through the global system – with a focus on

disaggregating data by sex, geography, disability and age, following our commitment to the Inclusive Data Charter vision and principles.

- Our approach to scaling up the use of digital technologies in developing countries is outlined in DFID's Digital Strategy 2018-2020: "Doing Development in a Digital World". We will build capability and capacity in people, skills, tools, systems and culture, prioritising digital safety and security, and actively learning from what works.
- The UK was an early participant in the process to develop the Principles for Digital Development, built adherence to the Principles into our procurement processes and encourages other organisations to endorse and put the Principles into action. We will be working closely with the stewards of the Principles – the Digital Impact Alliance (DIAL) – and DIAL founding partners to build global capability in these 'gold standard' design principles.
- The UK was also part of the donor community that developed the more recent Principles of Donor Alignment for Digital Health, a set of 10 "living guidelines" designed to address a lack of coordinated investment in digital health. We will work to build on this commitment by donors to support the coordination, design and implementation of digital health interventions to enable countries to pursue an integrated approach to strengthening health systems and to enhance and extend the delivery of quality health services.

Accelerator: Innovative Programming in Fragile and Vulnerable Settings and for Disease Outbreak Responses

1. General comments:

- The Global Action Plan agencies should look for opportunities to build upon the principles set out in existing texts including the DAC Recommendation on the humanitarian-development-peace nexus, fragile states principles, humanitarian principles etc.
- The 'Spotlights' risk drowning out the problem statements and actions/commitments, and do not add sufficient value to justify their prominence in the document. Reducing them would make space to draw out the actions/commitments more emphatically.
- Needs to further focus on the 'how' and the comparative advantage that each agency has in terms of individual versus joint action.
- Suggest stronger language on integration.
- Needs to be clearer linkages with other accelerators i.e. civil society accelerator with links on building trust and health financing accelerator on sustainable financing for preparedness, health workforce etc.

2. Suggestions for improvement to further leverage the potential of closer collaboration and alignment between the 12 organizations:

- Greater clarity is needed on how agencies will effectively work together, including through joint delivery plans. We would like to see more on **aligning approaches** (particularly in section 1), including:
 - a. Coordinating TA to maximise synergies and ensure that it enhances rather than overwhelms government capacity and systems.
 - b. Alignment with local administrative systems
 - c. Alignment across agencies in relation to staff incentives, joint procurement etc.
- There is a risk that improved collaboration amongst GAP signatories will take place at the expense of improved coordination across the system at large:
 - a. Signatories should commit to coordinating closely not only amongst themselves but also **with other health and nutrition donors and actors**. There should be acknowledgement that health crises often involve **multiple sectors** (such as protection, livelihoods etc) and agencies.
 - b. Signatories should commit to **working with the humanitarian architecture** where relevant (including RCs and HCs), for example to support multi-sector and multi-agency approaches to health crises and to enable joint needs assessments and planning.
- Agencies should aim for **joint resourced emergency preparedness plans** that identify roles and responsibilities. These should be led by country governments, be developed in close coordination with the RC/HC where relevant and draw upon the relevant disciplines including social sciences.
- **Mapping of existing partnerships** will be key and needs to be wholly inclusive. The focus should be on identifying gaps and on maximising and complementing what already works well at local, country, regional and national levels. Sustainability needs to be built in at the start, including of financing.

3. Suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs:

- We would like to see actions to **integrate health and nutrition**, especially as WFP and UNICEF are included. Nutrition references are limited to problem statements and the 'spotlights', with no mention of nutrition in the actions. There is a specific opportunity to build nutrition into the EPHS.
- We would also like to see commitment to a **conflict sensitive approach** in all they do, drawing upon and sharing evidence and experience, and in liaison with relevant actors and including the RC/HC. What changes need to be made in current approaches would be helpful to highlight how this commitment will be translated.
- Social science expertise should be used to ensure that **community perspectives and needs** are placed at the centre of preparedness and response plans, with a view to building trust between agencies and populations, among populations themselves and between populations and the state. The Ebola outbreaks in DRC show that strategies to engage and gain the trust of communities is key to success.

- Joint action plans to overcome barriers to access / support better access to services should specifically address **marginalised groups** such as women and girls, people with disabilities, refugees, IDPs, crisis affected people and host communities, leveraging where possible the influence of IFIs and bilateral donors.
 - On page 9, reference is made to ‘health information systems to provide a common method of recording service delivery and monitoring information’. This is a welcome but could be reinforced. Partners should strive to use **joint data systems**, aligned with national systems where possible. Explaining what steps are required to do this would strengthen the paper.
 - Similarly, **joint supply chains and procurement processes** should be used and aligned with national systems where possible. Medical and other supply chains need to be coordinated and integrated, and supply chains should be transitioned to sustainable models as early as possible if alternative models are used during an initial emergency response. Again what actions will be taken to make this happen?
 - There are excellent references on ensuring **healthcare worker salaries** and building government capacity in this domain– but less on the how to do this. This is important for ensuring routine service delivery and UHC and to enable health systems to prevent, detect and respond to outbreaks. It needs to be done well before a crisis emerges to prevent crises in the first instance and because it is difficult if not impossible to address this problem adequately during a crisis. It requires strong coordination and a harmonised approach to supporting salaries including through the avoidance of parallel systems and top-up payments – especially in view of the issues identified in the very good problem statement at the bottom of page 2. It is something that needs to be linked with the health financing accelerator.
 - Sustainable, multi-year flexible financing should reach **downstream partners**, with a focus on building the capacity of local partners.
 - The EPHS is a useful concept. However, it needs to be made clear how these relate to similar packages of services in routine (ie non-outbreak situations), and on what scale they would be delivered during outbreaks (whether to the whole country or to affected areas only) and how. This is important to avoid paradoxical situations in which superior levels of service are delivered in some locations or during outbreaks than is routinely the case, and if parallel systems of delivery are to be avoided or minimised.
- 4. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?**
- The UK is committed to the Sustainable Development Goals (SDGs), and has an important role to play in supporting their achievement. Progress towards the SDGs contributes to but also depends upon the ability to address infectious disease threats including in fragile and vulnerable settings. This is directly reflected in SDG3 (Ensure healthy lives and promote well-being for all at all ages), and most specifically in its target to “strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks”. However, the relevance of GHS goes well beyond SDG 3, as linkages with GHS can be identified across all the SDGs.
- 5. Additional specific points:**
- Page 8 ‘WHO’s medical response’: GAP agencies’ support to WHO has gone beyond the medical (ie clinical treatment) component of the response and includes others such as WASH, community engagement, psychosocial care etc. We suggest simply referring to ‘response’ rather than ‘medical response’ to avoid confusion.
 - Page 8 ‘Supporting and maintaining access in fragile settings’: it is unclear here whether ‘access’ refers to access to health services or to agencies’ own access to insecure areas.

Swiss Agency for Development and cooperation SDC

General comments on the Global Action Plan:

1. What do you see as the key opportunities offered by *The Global Action Plan for Healthy Lives and Well-being for All*?

The proposed strengthened **coordination and alignment** around agreed action lines for accelerators at country and global level according to national priorities is a key catalyst for advancing UHC and SDGs. We share the perspective stated in section 3 of the outline document: **"the value of the commitments made in the Global Action Plan will ultimately be determined through action and impact at country level"**. The value of this plan comes from recalibrating and intensifying collaboration between signatory agencies in areas that have been identified by countries themselves as needing targeted-gaps and priorities for which they require coordinated support.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

We see for example targeted, well-structured and managed sector wide approaches (SWAP) as an appropriate modality to strengthen improved coordination and donor alignment with country needs and priorities. A strong joint policy and advocacy work beyond the collaboration on specific technical issues is however central for the success and impact of such approaches. SDC works on health using different modalities (global programs, bilateral programs, humanitarian interventions, contribution to NGOs programs, etc.) to better leverage efforts, i.e. evidence and results achieved at country level feed the policy and advocacy work at global level.

In our opinion, the global network for health financing P4H can be considered a good practice. The network comprises not only major bilateral donor agencies but also multilateral agencies such as the WB, WHO and ILO, with the TGF and GAVI being associated. At national level, these agencies coordinate their support to countries based on demand. In some of these countries, P4H focal points facilitate the exchange and alignment of partners and also involve all national ministries relevant to the development and implementation of effective health financing strategies.

Comments on the accelerator discussion papers:

Across accelerator papers, the level of detail and finalization still varies with some being more advanced than others. Therefore, the next step towards finalizing the plan is to ensure coherence across all of the papers with regard to their level of detail and make sure that they are all action-oriented, complementary and fit together as an ensemble. During that exercise, the following elements can be considered:

- **Building on existing initiatives:** the starting point for the SDG 3 Action plan was the need for more coordination among existing health initiatives/agencies/organizations and better use of their respective capacities to deliver more health for money to countries both benefiting as well as those supporting them. We support in particular the emphasis on building and capitalizing on the wealth of existing partnerships and the expertise and knowledge that they have generated, including examples of what does not work.

- **National exchanges (Country level coordination platforms/country-level dialogue/ initial countries where actions will be implemented):** Several papers mention this and it necessary to coordinate and make sure that there is a single entry point for all accelerators of the plan in order to avoid duplicating efforts and further fragmenting at country level.
- **Choice of countries:** this should be ideally countries which are already supported by some of the existing platforms/initiatives used by the signatory organizations; moreover, ideally these countries should benefit from activities anchored in different accelerators.
- **Links between accelerators.** Some of the accelerators (or activities therein) are cross-cutting in nature and when that is the case, appropriate links should be made to the other accelerators (the PHC paper is a good example where this is already well integrated).
- **Alignment to UN-reform efforts** can be strengthened throughout all accelerator papers. For example, how will UN country teams and the UN Resident coordinator be linked/informed of actions undertaken by SDG GAP partners at country level before they are launched? Similarly, some more information can be added regarding collaboration with other international organizations that are not signatory to the GAP (for ex: humanitarian actors in the case of accelerator 7).
- **Common denominations/vocabulary across all accelerators:** It is crucial that the concepts that are being used within the respective papers are anchored in the corresponding recognized frameworks and norms that exist internationally. This should then be harmonized across all accelerator papers (an example of discrepancy is the conceptualization of determinants of health which is not the same in all papers).
- **Community and civil society engagement:** There is a separate accelerator for community and civil society engagement but this is a cross-cutting element that has to be integrated into the actions of each accelerator. The paper on financing already captures this element well by presenting community and civil society engagement as a key determinant of the successful implementation of planned actions, this is true for all accelerators.

Comments on the different accelerators:

Sustainable financing

The quality of the paper is impressive and reflects the work invested into providing a solid frame for future collaboration. We appreciate the broader perspective of health financing, by also focusing on how to better spend the existing (domestic) resources. This is the question of how to **efficiently allocate funds based on national priorities and evidence** (from health technology assessments etc.) as well as on strategic purchasing approaches linked to benefit packages etc. We also support the focus on identifying aid channeling mechanisms and incentives that may be less susceptible to substitution of domestic resources.

We strongly support the principle of leveraging existing partnerships and, in the context of the sustainable financing accelerator, believe all future actions must build on existing networks for collaboration and coordination at country, regional and global levels. In this regard, we do not support the proposal contained in Annex 1 of creating a new global coordination unit that will carry the responsibility for delivering the drivers. It is our understanding that the responsibility of delivering the drivers comes from the commitment made by the 12 agencies in 2018 and providing resources within each agency is part of a prioritization of inter-agency collaboration. For example, at least part of the proposed drivers and related activities can be undertaken by

the existing P4H network. The network already provides what is describes in driver 2, i.e. fostering the inclusion and alignment of all key ministries when designing and implementing national health financing strategies. Moreover, it has also become the platform for knowledge sharing about what works and what does not in the field of sustainable health financing for UHC, e.g. through its web-based platform that includes over 30 country cases where P4H provides some sort of coordinated technical support of at least two of its members.

Switzerland's development cooperation has a long track record of supporting health financing strategies in a number of bilateral programmes, including supporting overall health financing and sector reform, providing sector budget support, introducing PBF, introducing or optimizing formal social health protection mechanisms). Additional to this, through its global development cooperation, Switzerland supports policies and initiatives fostering sustainable health financing and targeted health systems strengthening as main drivers to gradually advance universal health coverage in low and lower middle-income countries. The main initiative we support for this goal is the P4H Network, including the P4H coordination desk at WHO and the WB.

Primary Health Care

The emphasis of the paper on alignment of work and deliberate collaboration is welcome. This paper makes many links to the work foreseen within the other accelerators and proposes to join efforts wherever possible. This is an important principle to apply across all accelerators. The embeddedness of proposed actions within the framework of the 2018 Astana Declaration, and WHO policies and guidance on PHC more generally, is a central element to guide future work of this accelerator. The proposed approach rightly focuses on strengthening PHC for Health Systems Strengthening (HSS). It promotes integrated and person-centered PHC and addresses both individual behavior change and community/societal engagement for better health outcomes and healthier environments. In view of the increasing burden of NCDs, we would also insist on considering the need to take a **multilevel approach**. It consists, beyond care levels in terms of structures/facilities where care is provided, in ensuring proper referrals (from primary health care (PHC) to secondary level) and back-referrals (from secondary to PHC level), while still consolidating PHC and addressing performance, efficiency and quality issues at hospital level.

At bilateral level, most of SDC programs aim at strengthening HSS with a strong focus on integrated PHC. In Eastern Europe and Central Asia, NCDs prevention and management is at the core of SDC programs (Poland Czech Republic, Hungary, Bulgaria, Romania, Kosovo, Albania, Bosnia and Herzegovina, Ukraine, Moldova, Tajikistan, Kyrgyzstan). In Southern and Eastern Africa regions and East Asia, SDC bilateral health programs mainly address communicable diseases prevention and treatment as well as mother&child health. SDC work at country level is leveraged by a strong policy dialogue addressing main structural issues for advancing health reforms. To do this, SDC and its implementing partners work at all levels (be it central, provincial, districts and community). Evidence gathered at country level constantly feeds policy and advocacy work at global level and vice versa.

Community and Civil Society Engagement

We recognize that good practices for meaningful engagement with communities and civil society exists across signatory agencies and we support efforts to leverage these practices to the level of the GAP (see also our point on this under general comments). Furthermore, we fully agree that there is room to strengthen community and civil society engagement on cross-cutting health issues.

At bilateral level, engaging with community and civil society is fully part of SDC's HSS approach. As our programs mainly address health promotion and disease prevention,

engaging with communities and CSOs is key. Beyond the awareness and behavior change component in relation to major risk factors (i.e. for NCDs), communities, citizens and society are key to hold authorities and service providers, as well as other stakeholders which can determine our health and well-being (i.e. food production systems), accountable to provide good services and to create an enabling environment for healthy living (i.e. healthy food choices, green spaces, etc.). Civic engagement for health is a major governance issue we address in our health portfolio.

Determinants of health

In comparison to other papers, this paper does not seem to have reached its full potential yet. We note that the wording on DoH is not the same as that used in other accelerator papers (and especially Financing, PHC, and Community and Civil Society Engagement). Links to existing related norms and frameworks are missing, as well as to existing national plans in relation to SDGs. Given the crosscutting nature of DoH, the paper needs stronger references to the other accelerator papers. An agreed narrative and language would be beneficial. We abstain from more detailed comments on this paper at this point but are happy to engage on the topic in future.

Research and Development (R&D), Innovation and Access

We welcome the stated vision of promoting needs-driven R&D based on national and global health priorities, while ensuring access considerations are included in all aspects of the R&D pathway. In light of the fact that the signatory organizations do not include some of the major global and national R&D funders in global health (e.g. BMGF, Wellcome Trust, US-NIH), it is logical that this accelerator discussion paper places the main emphasis on how to support countries in early adoption and scaling validated and effective innovations and ensuring access to them for the population in need. Moreover, the paper focuses on the need to strengthen local research and innovation capacities, including the capacity to set national research priorities and needs. Despite major funders or key players in R&D not being GAP signatories, we encourage to include or invite them to participate in the planned actions of the accelerator paper. It could be useful to add an annex that gives a general mapping of some of the major actors in this field (ex: PDPs).

While the aspects highlighted previously are very relevant, we feel that adding more emphasis on the following elements would benefit the paper:

1. National and International resources available are limited, and many research gaps remain. At the same time, there are many health challenges which numerous low and middle-income countries have in common (HIV, TB, malaria, NTDs) or which are even a global threat (anti-microbial resistance, highly infectious diseases etc.). Against this background it seems logical that the signatory agencies not only coordinate action at national level to scale up innovations like medical products but also share a **common agenda of global health R&D priorities and coordinate efforts**. Even if they do not fund global health R&D, they all have the same interest, i.e. innovative products for addressing the priority health needs of people in low and middle-income countries. WHO even has the role of providing evidence-based priorities in global health R&D based on needs and potential public health impact. The newly launched Product Profile Directory is a first of its kind that summarizes major global health R&D targets and their characteristics. This evidence can help countries to set their national research agenda and also major R&D funders to focus their efforts on the main unmet priorities. This role is implicitly mentioned with regard to the Global Health R&D Observatory, but is not very prominent even though the problem statement mentions “lack of coordination of stakeholders in global research

and innovation for health". The work done by WHO, TDR, Duke University and g-finder on analyzing current R&D pipelines for global health products, existing gaps and current resource allocations and needs should be the basis for further action. Moreover, leading PDPs have started analyzing their R&D portfolio with the help of a new tool developed by WHO/TDR etc. to check whether they invest in high-impact products in their respective disease areas.

2. The second relevant aspect that is mentioned but not prominently enough is the **strengthening of regulatory systems for medical products**, including the capacity to evaluate and timely approve new products and innovations. In this field, a continental African initiative is leading the way (African Medicines Regulatory Harmonization initiative), by harmonizing standards and guidelines within a regional economic community, by strengthening joint evaluations and manufacturing site inspections and by promoting work sharing and mutual recognition.
3. Thirdly, when thinking about how to link some of the work of the different accelerators, an obvious link or entry point for common action for the accelerators 1 and 5 is **health technology assessment**. The latter is needed to guide efficient and effective health investments and financing policies, at the same time it is crucial for international funding mechanisms to decide which technologies and products to finance (four Gs).

While global health product R&D is mainly organized globally even if it should be informed by (cross-)national health priorities and needs, the area of implementation research incl. social science needs to be guided by national context and agendas. Here the signatory organizations could support countries in building capacities to formulate their needs as well as inform global health R&D organizations what type of specificities need to be taken into account when designing products and thinking of access to them from the early research stage. TDR, HRP and the Alliance for Health Policy and Systems Research as well as national funders of implementation research could align and bundle efforts.

SDC engages in advancing the global framework for research and development of and access to global health products for diseases disproportionately affecting people in low and lower middle-income countries, with a focus on neglected tropical diseases and malaria. This is done through three workstreams:

- Support to Product Development Partnerships (PDPs) with focus on vector control tools, medicines and diagnostics to fight against malaria and neglected tropical diseases. Most PDPs aim to strengthen research capacities in affected countries (e.g. clinical trials management)
- Support the strengthening of medicine regulatory systems and building of effective regulatory networks to improve access to efficacious, safe and quality medical products for people in low and middle-income countries, especially in sub-Saharan Africa.
- Support to WHO's special project in scaling up the elimination of the five most prevalent neglected tropical diseases in Africa by strengthening the last mile in the supply chain of medicines, with focus on strengthening countries' capacities.

Data and digital health

Our perception is that this paper would benefit from some conceptual clarity to better frame the objectives and action lines for this accelerator. Our understanding is that "digitalization" is mainly meant here for the management of health data. However, in the actions lines, it also refers to technologies for health (biotech, medtech, infotech). Because of this, it is not clear to what extent the proposed action lines will contribute, beyond the management of data, to strengthen health systems. In a matter of clarity and agreed language for all, we would advise to align with the report of the UN Secretary-General's High-Level Panel on Digital Cooperation.

SDC does engage already on this topic. Currently we are in a process of redefining our institutional understanding of digital health, to have more conceptual clarity and to map existing ad'hoc and "dispersed" initiatives. Our intention is not to further fragment the current digital health landscape and to define the most appropriate initiatives to be supported which are HSS oriented and have a global and country outreach. At country level, our support to HIS is fully part of our HSS approach and is not addressed as a separate sub-sector.

Innovative programming in fragile and Vulnerable Settings and for Disease Outbreak Responses

We welcome the inclusion of this aspect which concerns all GAP signatories. Some suggestions we have to further strengthen the paper are:

- The paper is missing a focus on delivering **quality** health services. This should be part of the aim from the beginning in the same regard as ensuring provision and access.
- The Leave No One Behind perspective could be strengthened (with a special focus on disabled people, women and girls, migrants, elderly, minorities...)
- Focus on building capacity of local institutions should be considered.
- Identify one GAP agency to take the lead and be in charge of the coordination in fragile contexts (at global and local level). Include coordination with humanitarian actors.
- Accelerate the **use of technology** in healthcare delivery and programming as it helps generating fast and reliable data and can create synergies among different programs (provided that interoperability of software and databases is ensured). Integrate links to the digitalization accelerator.
- Promote more **research specifically on fragile contexts** for evidence-based and synergistic decision making and programming
- GAP agencies should **increasingly collaborate in a coherent and organized way with local private sector and civil society organisations** in fragile contexts (in addition to local authorities and public healthcare providers). Indeed local entrepreneurs navigate more easily in complex/fragile environments compared to international donors and governments. They have a comparative advantage. The private sector can also more easily have transboundary coverage.
- Support the government to promote **pluralistic health systems**.
- **Make better use of data as well as mobility of data**, as people are constantly on the move.
- Elaborate **investment case studies** that attract more (private) investors in fragile contexts.
- In addition to a needs assessment, GAP agencies should also do a mapping of current local health service providers (before engaging in any context in order to avoid disrupting the community coping mechanism put in place)

By leveraging public-private partnerships, SDC is engaged to work with and support the local private sector in fragile context in order to strengthen and sustain the health system (in particular in the Horn of Africa region).

Sustainable Development Goal 3 Global Action Plan (GAP) Outline and Accelerator Papers

United States Comments – July 2, 2019

General Comments:

- We very much appreciate this process of opening up the SDG3 GAP for comment. While the Action Plan is meant to be carried forward by 12 organizations, its implications are far-reaching, thus we would encourage continued opportunity for updates and robust exchange with all stakeholders.
- This document is presented as an inter-agency plan defining concrete, collective actions of 12 organizations to support countries in accelerating progress toward the health-related SDG targets. As we noted during the 72nd World Health Assembly, this is not a Member State-agreed document; using a title other than “global action plan” may alleviate confusion, as the World Health Assembly often does negotiate or approve documents so titled. Referring to this document as a “Country-level Global Collaboration Plan” or something similar may both alleviate confusion as to its status as an internal, rather than Member State document, while underscoring and framing collaboration, coordination and engagement at country level as a driving purpose.
- We welcome the general effort for these 12 organizations to coordinate more closely, especially in areas related to coordinating on operations in-country including on program design, implementation, and reporting when appropriate and possible. More detail on plans to increase operational efficiencies would be appreciated.
- The GAP should address areas of convergence and joint action to address opportunities to improve health, but it goes well beyond that, and introduces some concepts that Member States have not endorsed in governance documents or negotiations including “commercial and structural determinants of health.” The GAP and its seven “Accelerators” contain specific, prescriptive policy and regulatory recommendations, rather than leaving these decisions to the appropriate decision-makers: national governments.
- Further, policy recommendations are included without adequate grounding or evidence to demonstrate that the recommendations would lead to improved public health outcomes.

- There's an extreme imbalance in how civil society and private sector are referenced in the GAP and its accelerators. We are concerned that characterizations of the private sector as "health harming" do not advance the discussion and provide little means for joint action or dialogue. The executive summary begins with a section titled: "Advancing the joint commitment to work together", yet the document itself and its Accelerators lay out a foundation which could be seen as discrediting and isolating the private sector from meaningful engagement with regulators and public health officials. Both the GAP and its accelerators should include more references to the positive role the private sector can play in advancing the GAPs objectives including through public-private partnerships.
- It would be helpful to understand how the SDG GAP links to other coordination frameworks, including strategies to accelerate progress on the SDGs through many of the same partners. How will this new process enhance existing efforts?
- Pg. 8 of the rollout plan mentions "expansion of country engagement" and "collective country actions". It is not clear which countries are already engaged/committed, which countries are being prioritized (and why/how), and what is meant by "collective country actions". Priority countries are mentioned in some of the individual Accelerator Frames but not all. Further detail on how this will be rolled out in countries would help to clarify and enhance the plan.
- Across the various accelerator frame documents, there is mention of plans to create tools or exchange platforms. In some of these areas, tools already exist, thus we strongly suggest a focus on advancing or scaling or what has been initiated as well as a commitment to efficiency as a top priority for the GAP.
- We are pleased the GAP acknowledges the significance of environmental risk factors for public health. WHO estimates that 12.6 million deaths each year are attributable to unhealthy environments, including about seven million deaths from exposure to air pollution.
- As expressed by a number of participants in the WHO-hosted side session on the GAP on the margins of the May 2019 World Health Assembly, the GAP was developed by the IOs through an opaque process without input from Member States or other stakeholders. This is potentially appropriate if the plan is essentially an internal document related to operationalizing policy and technical agreements made by each of the participating organizations in service to SDG 3.

- The Seven Accelerators are described as providing “specific focus for potential joint action by the 12 signatory agencies”. Given the central focus on the seven accelerators, substantive concerns regarding content in these documents should be addressed and documents revised prior to the UNGA. Further, Member States and other stakeholders should be allowed another opportunity for consultation after Section 4.2 is finalized.
- For the United States, the value in this exercise is in more effective and coordinated UN system support to countries at country level, not in the roll out of another global plan. With that in mind, we hope that WHO and other participating agencies will be driven by that same focus and not by calendars and side events. If more time is needed, and based on the current state of some of the document, we think it might be, we do not believe this plan should go to UNGA in the fall for any kind of roll out or endorsement.

Accelerator 1: Sustainable Financing

- There is currently a \$134 billion annual investment gap for the health SDGs in low and middle income countries (roughly the size of all official development assistance combined) and by 2030, the estimated gap is projected to be \$371 billion. Successfully attracting private capital to support development goals will be crucial to fill the gap, yet the entire paper has only one bullet point regarding the private sector. The accelerator needs to make private sector investment and blended finance a core part of its strategy if it hopes to play a role in achieving SDG3.
- We support the goal of better coordination of development partners and alignment of assistance to national health priorities. Accelerator 1 initially focuses on support for “a country led, demand driven and evidence-informed agenda on sustainable” but quickly shifts toward prescriptive recommendations such as “global advocacy” for “public health-related taxes”. Tax policy decisions are best left to national governments and should be considered in the context of SDG 8: Decent Work and Economic Growth. Further, “tax avoidance” is a complex issue and unrelated to health financing. Recommend removing the reference from this accelerator.
- We cannot assume that the net-benefits to health of taxes are positive. Each country should be encouraged to do an assessment that considers its specific market and socio-economic conditions. In addition, beyond the health benefits from best buys like tobacco and alcohol taxes, the “double-win” is not realized unless Governments actually direct revenue generated to health system strengthening and we would like to see guidance in this area strengthened.

Accelerator 2: Primary healthcare

- We applaud the strong focus in this accelerator on primary health care through empowering people, families and communities and while we urge a thorough scrub of the document to ensure that language used is consistent with WHO and other agency policies and resolutions, we believe this accelerator is well-positioned to have a significant impact at country level if fully implemented.
- This Accelerator could further emphasize the need for *quality* primary health care to maximize value for the resources invested. This should start with measuring outcomes and costs at the patient level longitudinally across a care pathway and across care settings (community, primary health center, etc.), using this data to adapt and deliver better care, and potentially rewarding providers who are able to achieve better results.

Accelerator 3: Community and civil society engagement

- This is another essential accelerator for the plan to have the impact and success we all hope for and need to see. As noted, the SDGs recognize the imperative of multi-stakeholder decision-making, that neither governments nor the UN alone have all the answers and capacities needed to reach our shared goals. The accelerator references inclusive, participatory decision-making (16.7), multi-stakeholder partnership (17.16) and public, public-private and civil society partnerships (17.17). However, the paper solely then focuses on a part of the stakeholders concerned, communities and civil society.
- The private sector, in all its diversity and contributions also needs to be brought into the discussion as they will contribute to and benefit from the engagements leading to shared public health goals, and then can be more effectively held to account if they do not deliver.
- Partnerships should be looked at first from the perspective of the national or country-level health priority that needs to be addressed, an analysis of the gaps preventing achievement of that goal, and then what partners are available to work together to achieve the goal.
- Strong protections against conflict of interest, promoting transparency in any partnership, and assuring full commitment to the health goal in question need to be in place, but this accelerator needs to be further developed to realize its full potential for health.

- Within communities, it is noteworthy that Faith Based Organizations provide 40-70% of health care delivery in many developing countries, especially in parts of Sub-Saharan Africa. They enjoy community trust, have access to individuals and family information that may not be shared with others (trust), are most often there for the long-term, and their work is often low-cost but high impact. Their inclusion is an essential part of this document and needs further mention.
- This accelerator is fairly comprehensive in scope, however, it only references youth as beneficiaries, not as partners in the CSO space. It is critical to meaningfully engage with youth, especially when they are the majority of the population in most of the countries in which WHO works. Including youth voices and perspectives would make the Accelerator more relevant and useful in the long run. This should also be measured, that is, include indicators related to youth participation and meaningful engagement in the process, as well as for country progress.

Accelerator 4: Health Risk Factors

- On multiple negotiated documents and over many years Member States have used the terms social, economic, and environmental determinants of health. These documents introduce a different paradigm (environmental, commercial, and structural) of health determinants) without any clear explanation or rationale, which are not consensus terms and do not enjoy a common understanding among Member States. We strongly oppose this framing and the specific reference to “commercial and structural determinants of health” The GAP should build on the common understanding of Member States, rather than advancing alternative concepts not endorsed by Member States through the relevant governance processes.
- In short, as drafted, this accelerator is a recipe for rejection of this whole plan at country level and the extreme policy views being shown in this draft text put at risk the very goals of health promotion and ensuring that no one is left behind, both of which we strongly support.
- The United States reiterates its call for participating agencies to do a full scrub of this accelerator paper to ensure that all language is taken from agreed sources, particularly where they involve sensitive or controversial topics, to ensure maximum buy-in by countries and by relevant stakeholders to secure the needed changes and the hoped for improved health outcomes.

- With so many different types of determinants, the text actually introduces mixed messages around action, and certainly is well beyond the mandates of the 12 UN agencies involved.
- The document also references “pervasive lobbying,” “industry interference in policymaking”, and “health harming practices”, setting an adversarial tone before concluding that public-private partnerships are needed. The section is incongruous and should be revised to remove the unnecessarily adversarial and biased categorization of private sector activities.
- In addition, while not diminishing the changes that need to happen from some industry actors to achieve the SDGs, this paper completely ignores the positive impacts that the private sector has, large and small on health outcomes from their roles as employers and health insurance providers in many countries, to the products they produce from life-saving medicines to the sports equipment that gets us out of our homes and offices and moving around.
- It would be a missed opportunity if this Action Plan did not include efforts to more effectively engage with the whole range of non-State actors. We recommend that this Accelerator tailor its framing to clarify that countries should work with the private sector to define common interests within organizational priorities with national policies. Regarding conflict of interest provisions (p.5), IOs should not create additional barriers to engagement for any sector beyond tobacco and arms for exclusion. There should also be clearer links shown across accelerators and in particular between this one and that for community and civil society engagement.
- Under “Multi-sectoral governance” (p.5), IOs should not dictate to collaborating countries which stakeholders should be included or excluded from participating in various initiatives. Members should always be conscious of their international trade obligations when considering regulatory changes.
- This accelerator also contains broad generalizations without justification or evidence (e.g. that burning of fossil fuels and sugar sweetened beverages are a “drag on the economy”). This should be removed.
- We encourage the plan drafters to consider additional joint actions to be taken to address environmental determinates of health and to specifically address health risks from air pollution. For example, the coalition could collaborate with the UN

Environment Programme to address health risks from air pollution. One potential “area of joint action by GHOs to support countries in line with national priorities” is to encourage regional cooperation to address air quality concerns and the sharing of best practices on strategies to address air pollution.

- We would like to see more reference to disability in this section. Disability is a significant risk factor for poor health. For example, today, over one billion people need at least one form of assistive technology, such as wheelchairs, eyeglasses, hearing aids, prosthetics, and personal assistance devices. By 2030, this number is expected to grow to more than two billion people. Over 90% of this population does not have access to the AT they need, creating significant consequences for individuals, their families, and society at large. This lack of access can limit educational attainment, care-seeking behaviors, and income generation to support healthy habits, to name just a few.

Accelerator 5: Research and development, innovation and access

- No mention of intellectual property was made in Accelerator Paper 5: Research and Development, Innovation and Access. Was IP not mentioned because no contribution was made regarding IP? If submissions were made regarding IP, it would be helpful to understand why a discussion of IP was excluded.
- Consider including support for complementary methodologies in research and development, such as design thinking or human-centered design, to contribute to better health outcomes. Through its people-centered and iterative approach, design thinking is increasingly recognized as an approach that can improve uptake and adherence; strengthen strategy and implementation planning; introduce new capabilities and collaboration models; and boost buy-in and ownership across all levels of health systems.
- Support for innovations needs to be equally focused on scale. Global health innovations in high-income countries often reach their coverage targets within five years. In low- and middle- income countries, it can take decades, if at all, to reach coverage targets. While not an apples-to-apples comparison, increased focus on strategic introduction and scale planning and market shaping can help increase the likelihood of successful scale-up for global health innovations in LMICs.

- We note that WHO prequalification can be a critical step for introduction of tools in low and middle income countries, but that these processes could benefit from more strategic prioritization.
- In Goal 4, we appreciate the note that implementation science has not received enough attention and that this creates a barrier to scale. Nonetheless, there should also be clear efforts to disseminate evidence. The Global Observatory on Health R&D simply existing is insufficient if it is underutilized. The group should prioritize dissemination through various media and at the country and regional level through WHO offices.
- In Action 5, WHO should seek broader inclusion in curating their repository of 'evidence-based innovations that could be scaled. Research funders should be included in the key stakeholder groups from the onset because most such technologies will have fallen within their research portfolios at some point.

Accelerator 6: Innovative programming in fragile and vulnerable states and for disease outbreak responses

- Natural disasters role in creating vulnerable and fragile contexts is largely left out of this document. It should be considered as natural disasters grow in number and strength due to climate change and cause a large number of humanitarian crises that require an emergency humanitarian response. There should be a greater focus on disaster risk reduction, early warning systems, and surveillance. There can be better attention drawn to the need for private sector partnerships to increase health systems' resilience.
- The accelerator does not include the voice or representation of health program beneficiaries, that is, conflict affected/vulnerable communities. To make the design and implementation of the services more effective and appropriate to the community needs, the accelerator should include community representation in all components of the work and in all phases.
- The accelerator should address 1) sexual and gender-based violence (SGBV) and the importance of including screening and treatment services within health care facilities, outreach services, as well as links to mental health services; 2) the continuum of care needed for beneficiaries and how to develop/facilitate the continuum for people who are on moving from place to place due to conflict or natural disasters; 3) the need to train and support beneficiaries with providing more self-care; including first aid, ORS, emergency contraception; contraception; HIV and other chronic disease treatment, etc.

Accelerator 7: Data and Digital Health

- We are pleased to see this Accelerator frame: data will be a driver of value in the coming years and decades, multiple stakeholders will generate data of value, and bringing disparate data sources together will amplify the value.
- In order to harness the most value, the GAP partners should adopt a data vision that calls out data for public health as a common good, one that should be freely shared, and not held by any single institution.
- The GAP should also welcome additional stakeholders, such as IHME to the table in order to generate more value from analyses of existing data.

REGIONAL GOVERNMENT

From: Spanoghe Sander <sander.spanoghe@buza.vlaanderen>
Sent: Friday, June 28, 2019 4:46 PM
To: SDG3_Secretariat
Subject: Input general comments linked back to the accelerators

Dear,

Congratulations with this important initiative!

Overall, a bigger focus on how we need to organize ourselves to maximize the impact of our progressive evaluation towards UHC should be aimed at. In my view, the ultimate impact we are looking for is improved health and wellbeing for all by increasing the scope, number and quality of the promotive, preventive, curative, rehabilitative and palliative services that are delivered to all those who are in need of those services. This implies:

- 1) Under the accelerator Community engagement: a strong recognition that communities also need to be involved/recognized as service-deliverers under a task shifting and burden sharing model and for reaching those marginalized and stigmatized population we have been leaving behind. The AIDS-response is a good example.
- 2) Under the primary health care accelerator: a clearer definition of which services within what service bundles could be easily confided to the primary health care level, unburdening the expensive and inefficient hospital-approach and to what SDG's and targets -also beyond the SDG3 and its targets this could contribute. Here a case should be made for primary health care as an important instrument for delivering universal access to a comprehensive range of SRHR-services, while stating that the oversight and promotion of community-led service delivery in this SRHR-bundle and beyond will also form part of this PHC-accelerator
- 3) Under the determinants accelerator: include the fight against stigma and discrimination within the health system based on gender, sexual identity, social class... also at the center of this accelerator as an example to other sectors of the economy/society and as a first barrier to clear to address the structural barriers that prevent progress towards UHC for girls, women, LGBTI, disadvantaged communities, people who use drugs...
- 4) Under the accelerator of research and (societal) innovation: include research on intelligent integration of services so that integration in the end is not conducive to avoiding seeking access to services, e.g. young women avoiding ante natal care contacts out of fear of being (forcibly) tested for HIV by the same health worker and research on the social, economical and health impact of services that are not provided within the service packages or that are offered at a higher cost. Put more emphasis overall on the need for rigorous evidence based approaches to inform responses of the health system under any circumstance, also health emergencies, combatting ill-inspired public opinion and fake news and offering all services that are needed to tackle the health problem(s) under review, including for example access to safe abortion in the case of potential adverse effects on fetal development

Best Regards,

Sander Spanoghe
Policy Officer / PCC-Chair

Government of Flanders
FLANDERS DEPARTEMENT OF FOREIGN AFFAIRS

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INDIVIDUALS

From: Badenschier, Franziska [REDACTED]
Sent: Friday, June 28, 2019 5:13 PM
To: SDG3_Secretariat
Subject: Comment on Accelerator 4 - Determinants of Health // Invitation for public comment: Global Action Plan for Healthy Lives and Well-being

To whom it may concern,

please find below my personal comments regarding the Accelerator 4 on Determinants of Health, thank you.

Name:

Franziska Badenschier

Affiliation:

individual capacity

Feedback on Accelerator 4 - Determinants of Health:

Acknowledging the role of Universal Health Coverage: Linkages between UHC, particularly financial risk protection, and certain aspects, interventions, actions may be made more explicit, e.g. on p 7, para "increase access to quality health services".

Strengthening occupational health: Occupational health is missing in the document in general, and in particular when it comes to the joint actions. Since this accelerator specifically refers to the WHO definition of social determinants of health, i.e. including "conditions in which people (...) work", occupational health may be added, including example(s) of potential areas of joint action, e.g. with reference to safe physical and psychosocial work conditions.

Emphasizing health promotion: Health promotion is barely mentioned, least to say explicitly (besides referring to "media"), though social determinants of health also rely on education, health literacy and the like. Thus, the accelerator may benefit from adding health promotion as important action.

Involving partners beyond the health sector: In order to effectively and comprehensively address determinants of health, the accelerator needs to involve partners beyond Global Health Organizations (GHO). Synergies and co-benefits with other sectors (such as economy, education, energy, employment, infrastructure) as well as agendas (e.g. for planetary health, for adaptation to and mitigation of climate change, against health-harming private sector) should be prioritized. To that end, GAP signatories should build strategic partnerships and involve relevant partners. Also, evidence-informed policy-making may be emphasized, i.e. political decision-making based on available and sound scientific evidence.

Clarifying, distinguishing equality and equity: The paper may benefit from a brief definition or explanation regarding the difference between equality and equity, preferably at the beginning of the document; and then, either the one or the other term may be used precisely and concisely in order to achieve clarity and unambiguity as well as to avoid misunderstandings that could arise from the synonymic use of equality and equity.

Thank you.

With best regards

Franziska (Frances) Badenschier

SDG3_Secretariat

From: Sunil [REDACTED]
Sent: Friday, June 21, 2019 9:26 AM
To: SDG3_Secretariat
Subject: Safety of Doctors In India

Respected sir/ madam,

We Doctors from India facing lot of issues regarding safety in hospitals
As Govt is not making any strong law against accused. As anybody comes and beat on duty Doctors, kindly see recent incidents and make some rules and regulations all over world

Thank you

SDG3_Secretariat

From: Sameer Zade [REDACTED]
Sent: Friday, June 21, 2019 8:51 AM
To: SDG3_Secretariat
Subject: About doctor safety...

We are doctors from india, we would request you to help us as India will not let doctor to survive as lot of security issues in hospital, irresponsible journalism and irony is government not even look the root of problems.
We feel insecure here, so help us and let us live...
Thanks, sameer

Plan de Acción Mundial para Vidas Saludables y Bienestar para todos.

**Aporte de Dr. Paulo Valderrama Erazo – Cardiólogo Pediatra
Hospital Clínico de la Pontificia Universidad Católica de Chile - Chile**

El trabajo realizado es excelente, con puntos y metas claras. Así como se menciona en el texto, es necesario alinear los esfuerzos conjuntos para las necesidades y prioridades de todos los países incluidos.

Siguiendo este mismo orden de ideas y considerando alguno de los “**Hitos provisionales para el 2023 (Recuadro 4)**”:

1. Reducir en un 30% el número de niños menores de 5 años con retraso del crecimiento.
2. Detener y empezar a revertir el aumento del número de niños con sobrepeso (0-4 años) y obesidad (5-19 años).
3. Reducir la razón de mortalidad materna en un 30%.
4. Reducir en un 30% las muertes evitables de recién nacidos y niños menores de 5 años.
5. Reducir en un 20% la mortalidad prematura por ENT (enfermedades cardiovasculares, cáncer, diabetes o enfermedades respiratorias crónicas).
6. Aumentar al 50% la cobertura de la vacuna contra el virus del papiloma humano entre las adolescentes (9-14 años).
7. Aumentar al 66% la proporción de mujeres en edad de procrear (15- 49 años) que tienen satisfechas sus necesidades de planificación familiar con métodos modernos

Es necesario mencionar y reconocer los factores de riesgo de cada una de estas metas sobretodo, aquellas que son compartidos, por ejemplo:

Respecto al **Retraso de crecimiento y muertes evitables en menores de 5 años (Punto 1 y 4)**: los factores de riesgo mencionados en las últimas publicaciones (1, 2) son: edad materna (ideal entre 20 y 40 años) (**Punto 7**), el lugar de residencia (urbano 44,27% v/s rural 74,71%), nivel socioeconómico, nivel educacional tanto materno como paterno, el tipo de nacimiento (único o múltiple), el lugar y el modo de parto. Además que madres con virus papiloma humano positivos tienen un riesgo aumentado de tener retraso de crecimiento intrauterino y especialmente de recién nacidos con muy bajo peso de nacimiento independiente de otros factores de riesgo (3) (**Punto 1 y 6**). Muchos de estos factores son además factores de riesgo de mortalidad materna (**Punto 3**).

Respecto a **Detener o reducir niños con sobrepeso u obesidad o enfermedades no transmisibles (Punto 2 y 5)**: Madres con sobrepeso u obesidad (antes o durante el embarazo) generarán hijos con mayor sobrepeso o con obesidad, mayor resistencia insulínica,

enfermedad cardiometabólica en la infancia (4, 5) incluso, la mal nutrición por exceso periconcepcional de ambos padres generará mayor riesgo de síndrome metabólico en sus hijos (epigenetic imprinting) (6). Por otro lado, el aumento excesivo de peso precoz entre los 0 y 18 meses (ajustado por peso / talla) (7) también genera sobrepeso infantil (1.7x), obesidad infantil (2x), exceso de adiposidad central (1.5x), hipertensión arterial, aumento de parámetros inflamatorios y mayor grosor de pared arterial, todos factores de riesgo para enfermedades cardiovasculares, cancer y diabetes. Además, el sedentarismo por si sólo se relacionan a hipertrigliceridemia (3.4x), obesidad central (2.6x) y obesidad gral (1.9x)(8) y constituyen un factor de riesgo cardiovascular y metabólico independiente de niveles de actividad física (9) y la inactividad física se relaciona a mayor obesidad (1.4x), diabetes (1.9x), hipertensión arterial (1.7x), síndrome metabólico (1.3x) (10)

De modo que, las medidas más importante de intervenir y alinear para acelerar los procesos serían un embarazo programado en cuanto a la edad materna, lugar de residencia, nivel educacional y políticas públicas que interfieran y produzcan un impacto en los hábitos de alimentación, sedentarismo, actividad física y de composición corporal previos al embarazo. Junto con ampliar la cobertura de la vacuna contra el virus del papiloma humano.

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SDG3_Secretariat

From: [REDACTED]
Sent: Wednesday, June 26, 2019 6:11 PM
To: SDG3_Secretariat
Subject: Comments:GLOBAL ACTION PLAN DRAFT OUTLINE.

Follow Up Flag: Follow up
Flag Status: Completed

Dear SDGs Secretariat,

I am commenting on the GLOBAL ACTION PLAN DRAFT OUTLINE.

The Action plan shows a commitment to collectively achieving the SDG 3 with its crosscutting goals, targets and indicators. Below are my thoughts on the Action Plan.

While the background outlines those main areas that are "closely linked" to SDG 3, I think the fundamental areas of *gender equality* and *sustainable cities* which speaks to housing and living situations are such an important determinants for health. While No poverty is mentioned, the context within which it is addressed in the Global Goals does not speak broadly to "where you live" an important determinant to the "life cycle approach" as it could determine your health later in life -Health in later years.

I would also like to focus on the Challenges and Opportunities for collective action.

With the advent of globalization and its impact on the movement of human capital, I think its imperative that included in the challenges should be "human resource for health". Especially with the global shortage of health care workers it is more so in developing countries this brain drain to larger countries with better compensation. In leaving no-one behind the distribution of skilled workforce should be examined. The MDG focused on skilled workforce for the administration of care in maternal and child health and while this goal was partially and in some instances and countries, fully met, the focus now has to be broader on other specialised area such as geriatric - with the world's aging population, critical/ intensive care, neonatology among others. Recognizing not just the categories but the skilled force available and the distribution.

The value of development assistance for undeveloped countries cannot be over emphasized. With the furthering of Universal health Coverage some countries will be unable to meet their health needs. Recognising that inmost instance creating universal access is a more reachable target however, delivering the efficient service after access is the challenge because efficient services requires much more. The demand will become greater than the supply. Although Universality is subjective within countries, there is still need for the increase in developmental assistance for infrastructure equipment but most importantly streamlining of services. These areas must be addressed simultaneously work with the joint accelerators.

The crosscutting nature of the SDGs is an asset but it also has implications for financing as achieving one is in much instances very dependent on the achievement of another as is the case for the Health Goals.

Kind Regards

Denese McFarlane
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Population and Health Unit
Social Policy, Planning and Research Division
Planning Institute of Jamaica (PIOJ)
Tel.:935-5186
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NOTICE OF CONFIDENTIALITY

SDG3_Secretariat

From: Nuwamanya Alex <alexbantura@gmail.com>
Sent: Friday, June 28, 2019 10:49 PM
To: SDG3_Secretariat

Nuwamanya Alex.
Youth leader Uganda .
Primary health care.

By and large Uganda like any African nation has not afforded enough support to mental health despite its place in the elements of PHC.

The vacuum between our resource commitments and mental health occasioned death are quite appalling.

To consolidate the achievements registered in the region of sdg 3 , and to decimate the effects of the hiv and aids scourge..

It's relevant that mental health and Hiv related services are treated in tandem.

Having had the chance of working on HIV and aids within impoverished communities,

The biggest facilitator of poor drug ARV adherence among marginalised communities is mental health related outcomes.

This has not only detriment to the sdg 3.3 target, but could equally sabotage the global agenda to end aids by 2030.

I admonish that forthcoming action plan, leverages on WHO and UNAIDS mental health schemes to buttress a stronger link between aids and mental health gap.

From: Behrendt, Thorsten [mailto:thorsten.behrendt@glz.de]
Sent: Friday, June 28, 2019 5:26 PM
To: SDG3_Secretariat
Subject: General comments on the GAP and comments on the sustainable financing accelerator

To whom it may concern,

in response to the public consultation on the Global Action Plan for healthy Lives and Well-being, I would hereby like to submit the following comments in the capacity of an individual:

1. General comments on the Global Action Plan:

Key opportunities offered by the Global Action Plan for Healthy Lives and Well-being for All:

- The key opportunity offered by the Global Action Plan is the alignment of global health actors behind clearly defined goals and approaches to reduce fragmentation of activities. This will only be possible if all organizations involved commit to putting the needs of people to achieve SDG 3 before the needs of their respective organizations.

Previous collaborations across the signatory agencies that have proven to be effective:

- The P4H network has long-standing experience in implementing health financing reforms bringing together Ministries of Health and Financing. Collaborating signatory agencies are WHO, WBG, GFF, the GF and potentially also Gavi in the near future. There are currently 11 so called P4H focal persons at country level working on UHC related reform processes.
- The Health Data Collaborative has proven as a conducive mechanism to both contribute to the development of new tools and to the alignment of global health actors in the field of digital health.

2. Comments on the sustainable financing accelerator discussion paper:

- The use of existing structures and networks for implementation: We suggest clarifying which existing platforms and networks will be used for coordination and collaboration at country, regional and global levels (page 3). The P4H network and its in-country focal persons have a long-standing experience in designing and implementing health financing related reforms in countries and thereby involving relevant national and international stakeholders. We thus highly support the idea of using P4H for the implementation of the Sustainable Financing Accelerator. It should become clearer that the network is not yet another entity, but that WHO, WBG, GFF, the GF and potentially also Gavi in the near future are all P4H members that can use the network and change it in a way that meets the needs for more ambitious harmonization of approaches (figure on page 13 and throughout the text).
- Improving the joint working between budget and health officials: Experience shows that the partnering of health and finance ministries is crucial for UHC and related DAH programmes should be designed accordingly. We suggest making the link to the Japanese G20 Presidency where health financing is discussed in the health-working group and the finance track. Moreover, we encourage mentioning that without an increase in public spending UHC will not be achieved in many countries by 2030. Not more than 20 per cent of THE should be financed by OOP as it is generally acknowledged that with higher amounts UHC (i.e. the provision of quality health care and financial risk protection for all) is not possible. DAH could be linked to increases in public spending in order to avoid the mentioned problem of substitution. In this context, the narrative for more domestic resources for health should include that

investments in health lead to increased productivity, employment and a multiplier effect that positively affects the wider economy.

Thank you and with kind regards,

Thorsten Behrendt

Thorsten Behrendt

Adviser
Universal Health Coverage
Economic and Social Development Division

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SDG3_Secretariat

From: Tariro Kutadza <[REDACTED]>
Sent: Tuesday, June 18, 2019 9:26 AM
To: SDG3_Secretariat
Subject: Community and Civil Society Engagement :General Commend

Without a Community Systems Strengthening Framework with traceable indicators we are going forth and back as communities . Most of terminology used for Communities engagement are not SMART and its just mainstreaming communities work in the bigger spectrum of UHC



Tariro Kutadza
HIV/TB Partnership, DAPP in Zimbabwe
+263 497620 | +263 773 103624 | [REDACTED]
[REDACTED]



Create your own email signature

SDG3_Secretariat

From: Kelly Mitchell [REDACTED]
Sent: Thursday, June 20, 2019 7:15 PM
To: SDG3_Secretariat
Subject: General Comments

Individual Capacity

There is no solution to your concerns. Everyone must do their part, and good health is a limited commodity. The rate of devastation from conflict has left an aging generation to REBUILD and CARE for both prior and new generations of increasingly illiterate populations. There is little health in that. We wanted to grow strong hearts and minds, but masses of people just want to fight and slaughter.

Please know that without even basic general health in the USA, our capacity to assist is limited.

I hope you are able to have peace throughout your deliberations, and resolve the concerns you have expressed.

Good luck and best wishes -

Kelly Mitchell M.B.A.

SDG3_Secretariat

From: lou compernolle [REDACTED]
Sent: Monday, June 24, 2019 3:02 PM
To: SDG3_Secretariat
Subject: Outline of the Global Action Plan

Dear

I read with interest in the Global Action Plan for Healthy Lives and Well-being.

It came as a surprise to me that hundreds of pages can be missing without highlighting the importance of targeting youth and adolescents both as actors and beneficiaries in achieving the health-related SDGs.

Young people are tomorrow's leaders and any sustainable change will happen thanks to them. It is a missed opportunity to not have highlighted their importance throughout the document. And look at ways how to optimally capitalize on that limitless resource for our and their own benefit.

In addition I am convinced that if the amount of talk these days about involving youth meaningfully would be matched by actual funding to youth-led organizations, we would see a sea-change not only in terms of impact in our field of public health but also a societal change where young leaders are given the space and resources to become the architects of their own and their countries' future.

I hope the final document will do youth justice and give them the space and attention they deserve.

Thank you

Lou Compernelle

LOU

COMPERNOLLE

Consultant Public Health

[LinkedIn](#)

SDG3_Secretariat

From: Esther Werling [REDACTED]
Sent: Friday, June 28, 2019 4:41 PM
To: SDG3_Secretariat
Subject: Primary Health Care

Dear SDG3 Global Action Plan Secretariat,

in response to the public consultation on the Global Action Plan for healthy Lives and Well-being, I wish to submit the following comments on **Accelerator 2 on Primary Health Care** in the capacity of an individual.

Ensuring coordination and harmonization at global level: We welcome the proposal to explore a key role for UHC2030., which could facilitate a global community of practice, leverage synergies with the G7 Primary Health Care Universal Knowledge Initiative, and involve the UHC2030 Civil Society Engagement Mechanism. By partnering with the UHC-Partnership, UHC2030 should establish strong links between national PHC/UHC reforms and global advocacy efforts.

Improving country programs: We welcome the proposals to reframe support for country programs. Resources of disease-specific global health initiatives (GF, Gavi, GFF) to PHC at country level need to be harmonized and synergized based on national plans, priorities and strategies for UHC and PHC. In this context, the signatory agencies and additional partners should use existing networks and mechanisms such as PHCPI, UHC-Partnership, UHC2030 and the Joint Learning Network, to ensure coherent support.

Front-runner countries for developing programmes of intensified support should be chosen based on transparent criteria, including national demand and the presence of relevant country-level networks. Country ownership will be key to successful implementation and national governments should steer in-country leadership groups.

Best regards,

Esther Werling

Comments on the Global Action Plan:

The document recognises the importance of working on several targets of 14 SDGs in order to achieve SDG 3. However, the document focuses on SDG3- perhaps as a starting point and because actions for SDG3 and especially UHC are critical.

Q1: What do you see as the key opportunities offered by The Global Action Plan for Healthy Lives and Well-being for All?

- Getting the multilateral agencies to relinquish power and resources for countries health systems is the key opportunity for this plan to succeed. The plan needs courage from all involved to do so and to put health outcomes and health systems before the agency's logo. Donors need to support and encourage joint agencies' work also to avoid competition for funding.
- The GAP seems to be limited to coordination of activities by multilateral health institutions and UN agencies. It is unclear how the GAP would align with governments' strategies and plans.
- The framework should avoid creating a burden on countries such as setting up specific coordinated bodies or working to a different national strategic plan.
- It is unclear who would report on the milestone monitoring (point 5.1) and whether it would be an addition to current reporting load on the countries.
- Global health is crowded by multilateral institutions (non-UN agencies). Are there plans to review the need for all these institutions and their functions given the changing health horizon post SDGs?

Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

How is this action plan different from previous attempts at coordination e.g. IHP? What lessons are learnt including identifying and overcoming the barriers to coordination, using country systems and processes, strengthening health systems and involving civil society.

Global Action Plan

Name: Alain Blaise Tatsinkou

Title: MD, Public Health and Emergency independent consultant

Country: Cameroon

Affiliation: Individual contributor

a- General comments on the Global Action Plan

The Global Action Plan is a good opportunity and a valuable tool to strengthen the overall efforts to meet the 2030 SDG's goals with a focus on Low- and Middle-Income countries.

1. What do you see as the key opportunities offered by *The Global Action Plan for Healthy Lives and Well-being for All*?

There are many opportunities offered by the GAP, below, we have highlighted some of them:

- The GPA is a "joint" vision and commitment of 12 multilateral global health and development organizations and therefore it is a common platform for implementation and decision-making,
- The Implementation of the GPA will create synergies between signatory agencies and contribute to shape new ways of collaboration tailored to accelerate SDGs goals
- Empowering country-focused approaches and interventions in a more coordinate
- Strengthen the country stewardship and accountability for public health interventions in general,
- A good tool to monitor progress towards SDG's goals and take corrective measures.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

One of the fundamentals of the GPA is to try and optimize the existing platform and mechanisms, according to the current situations increasing number of fragile settings, the cluster approach that took its root from the Humanitarian coordinating system set by the resolution 42/82 of the General Assembly seems for me a good example of collaboration that can be used.

b- Accelerator Discussion paper 7

- 1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?**

For the accelerator 7, I think the working group should be looking into how the use health cluster coordination mechanisms for implementation of interventions that are country-centered with a major and substantial improvement of monitoring and evaluation framework or tools that is tailored the context. Governance and accountability

No more suggestion for now.

Name: Ebenezer Opeyemi, ANIFOWOSE

Title: *Scientific Officer*, National Biosafety Management Agency, Nigeria and *Founder*, Healthucate Nigeria (Individual Capacity)

Re: INVITATION FOR PUBLIC COMMENTS ON THE GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING

KEY OPPOTUNITIES

What if, we could reduce the number of new cases of preventable diseases to almost zero? If this was possible, it will help us achieve the health related SDGs faster.

One of the key opportunities I see here with this collaboration birthing the Global Action Plan for Healthy Lives and Wellbeing is the opportunity to concert and aggregate efforts to truly prevent diseases that are preventable.

While we work hard to manage disease and epidemics, a lot of attention should be given to heath promotion which can evoke positive behaviour change to improve health outcomes.

To make this actionable, high impact and sustainable, there will be need to specially focus on health promotion programming that targets children. This is important because children are the future. By 2040, current 5 year olds will be 26, and current 15 year olds will be 36.

If we want to ensure healthy lives and well-being for all, then children are a vital part of this puzzle. It will be our only chance to reduce government healthcare spend in the post 2030 era.

PREVIOUS COLLABORATONS THAT HAVE PROVED EFFECTIVE.

The National Supply Chain Integration Project (NSCIP) in Nigeria, with a goal to effectively and efficiently integrate Health Disease Programs' Supply Chain Management activities for optimal PSM services, is a collaborative initiative between the **Global Fund**, **USAID**, **UNFPA** and the **Bill and Melinda Gates Foundation**.

NSCIP has proven effective with a streamlined coordination of the PSM processes of the various programs to ensure that health commodities are always available at health facilities.

In Ogun State where I had a working relationship as Catholic Relief Services'(CRS) M&E focal person on the Global fund Malaria project in 2017, the state ministry of health housed all partners in a shared office which included the Logistic Management Coordination Unit of the ministry and staff of NSCIP, GFM- CRS, and Malaria Consortium. The close working relationship made information sharing easy and the partners could leverage on one another's work plan to achieve more (i.e monitoring visits, on the field support, data collection) with limited resources.

The close working relationship in the shared office also facilitated frequent casual reviews and discussion of data findings which increased the use of data to address bottle necks and program issues.

This kind of partnership and working relationship adopted by the NSCIP and state government in Ogun State, Nigeria is scalable and the Global Action Plan of the 12 agencies could see how to replicate and scale such a partnership.

SDG3_Secretariat

From: Rachel Thompson [REDACTED]
Sent: Tuesday, July 2, 2019 9:11 PM
To: SDG3_Secretariat
Subject: General comments on the GAP

Comments from Rachel Thompson, Policy Fellow at World Obesity Federation.

Please note that these are personal comments and do not reflect the view of my organisation.

The GAP 'does not provide a roadmap to achieving SDG 3'. Yet is this not what it should be doing? Is this not what is needed? Instead it focuses on the efforts of 12 agencies. As a result the plan feels very top down and at odds with the movement in global health towards country capacity for UHC and PHC. The GAP can thus be seen as a reaction by these agencies, who may be feeling increasingly threatened in the new age of country led prioritisation for UHC. Indeed, the lack of mention of UHC overall is telling and makes the plan seem out of touch with the wider context.

In terms of the challenges and opportunities for action, the fact that NCDs and obesity are not mentioned explicitly is incongruous with the global burden of disease. Again, this suggests the plan may be oriented to helping health security and infectious disease focused organisations remain relevant as the epidemiological transition continues. The GAP seeks to avoid new creating platforms, but it seems unclear how this can be avoided.

Overall the plan is clearly full of good intention but ultimately fails to convince how it will avoid being a waste of valuable resources that could be plugged into existing and future country led initiatives. We have the SDGs, and we have multiple action plans for global health within the SDG framework already. The concept of accelerators is a good one but the proposed outcomes and actions feel very mundane and unambitious in nature. Obesity, a major risk factor for many NCDs, is rising in every country - yet we see no mention of this threat.

While the 12 agencies involved have much to contribute to SDG3, they must focus on supporting countries to sustainably meet targets. This means less fancy accelerators and more building basic public health systems, more investing in health workforce, more listening to country priorities, and less dictating the terms from Geneva.

Many thanks

Rachel Thompson

SDG3_Secretariat

From: Gisela Abbam [REDACTED]
Sent: Tuesday, July 2, 2019 6:22 PM
To: SDG3_Secretariat
Subject: Public comments on the Global Action Plan for Healthy Lives and Well-being

Dear All,

First of all, congratulations on developing a Global Action Plan for 12 signatory organizations. This is the momentum that is needed to make bigger strides towards achieving SDG 3 and Universal Health coverage.

General comments on the Global Action Plan are:

In addition to developing the midpoint milestones for 2023 could this be done yearly or at least every two years? This will enable gaps to be highlighted and enable re-prioritisation at the country level if necessary.

I suggest that joint impact measurement should be developed across all the 12 agencies so that certain activities are done by all to ensure that the key performance indicators are achieved. Other stakeholders at the country level could use those impact measurement indicators as their benchmark for developing new health programmes.

I also suggest that a Steering Committee representing the 12 organisations plus government should be set up in low-to-middle-income countries (LMICs) with populations of over 50 million/ and countries with the greatest gaps in attaining SDG 3. (That is if it is not possible to do it in all LMIC's.). This should include coordination with other Development Agencies who already have and are also planning new programmes in those countries. This would enable a more effective and coordinated implementation in health and reduce the number of silo projects.

Comments on the Accelerator on Sustainable Financing

It cannot be overemphasised that at country level, the Ministries of Health and Finance should work in collaboration on health budgets and prioritisation of resources. This should include engagement with the 12 agencies.

Key actions to enable sustainable financing should include Implementation templates with examples of key activities to demonstrate impact, key performance indicators and a framework for prioritising health programmes.

Ms Gisela Abbam FRSA

Global Goodwill Ambassador
[REDACTED]

Title: Accelerator Discussion. Determinants of Health: Providing regulatory space to promote safe international Internet pharmacy practice in furtherance of SDG 3.8 as it applies to access to affordable medicine.

Author: Gabriel Levitt. Affiliations: president and co-founder of PharmacyChecker.com; founder and president of Prescription Justice; president emeritus of the United Nations Association Brooklyn Chapter; Board of Advisors, Business Initiative for Health Policy. [REDACTED]

In SDG 3.8, the international community envisions access to affordable medicine by 2030 for everyone. Access barriers to medicine is a problem that affects almost two billion people.¹ In many cases the obstacle is affordability for governments and individual patients.² This problem is most acute in the poorest countries, but middle and high-income countries are also impacted.³ Among high-income countries, the United States is a troubling outlier with exceedingly high rates of cost-related prescription non-adherence.⁴

In support of SDG 3.8, the Internet, via international online pharmacies, has helped tens of millions of Americans obtain medicines from pharmacies in other countries.⁵ In many of those cases, patients would otherwise not be able to obtain a prescribed medicine because price often determines access.⁶ In recognizing that price is an obstacle to access to medicines, Global Health Organizations can play a more constructive, forward-thinking role by promoting an open Internet through which regulated medicines can be purchased across borders both safely and at lower cost.

While the World Health Organization has recognized the potential benefits of online pharmacies, it has mostly focused on the risks posed by rogue actors that sell falsified and substandard medicines.⁷ The WHO's reports on this topic have yet to highlight the medicine affordability and access benefits of properly credentialed online pharmacies that sell across borders. The safety of properly credentialed international online pharmacies is clear in the relevant peer-reviewed literature.⁸

The issue of online access to safe and affordable medicine is inextricably intertwined with conflicting pharmaceutical regulations among UN member states relating to international trade. In an exporting country, such as Canada, it may be legal to dispense prescription medicine internationally to a patient in the U.S.; whereas, the patient doing the importing in the U.S. may be violating national laws.⁹ Within the U.S., "illegal" imports for personal medication treatments are not deterred through prosecution—despite the technical illegality.¹⁰ In Australia, in contrast, personal imports of most medicines are expressly legal, with important exceptions.¹¹

In many cases, patented products are imported by patients where there is no intellectual property violation. In other cases, patients seek lower-cost generic medicines that are unavailable locally from foreign countries through online pharmacies. In those instances, Article 60 of the WTO's Trade Related Intellectual Property Rights agreement strongly discourages enforcement actions against such personal imports.¹²

Recommendations

1. Create a taskforce to identify the safest international online pharmacy practices, the demographic of patients most benefiting from personal medicine imports ordered online, and policy suggestions for the Global Action Plan to promote online access to safe and affordable medicine.

2. To further the agenda above, participating multilateral global health and development organizations should consider adopting the [Brussels Principles on the Sale of Medicines over the Internet](#). The Brussels Principles encapsulate a human rights framework to promote the greatest possible online access to safe and affordable medicine. Much of its normative intent mirrors the goals articulated by the UN High-Level Panel on Access to Medicine.

¹ Ten years in public health, 2007–2017: report by Dr Margaret Chan, Director-General, World Health Organization. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

² United Nations Secretary General's High-Level Panel on Access to Medicines, see <http://www.unsgaccessmeds.org/news-blogs/2015/12/21/united-nations-secretary-generals-high-level-panel-seeks-inputs-on-increasing-innovation-and-access-to-medicines> [Last accessed 6/24/2019].

³ Ibid.

⁴ Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C., MD. (2016, November 16). In New Survey of 11 Countries, U.S. Adults Still Struggle with Access to and Affordability of Health Care | Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/publications/journal-article/2016/nov/new-survey-11-countries-us-adults-still-struggle-access-and?redirect_source=/publications/in-the-literature/2016/nov/2016-international-health-policy-survey-of-adults.

⁵ Bluth, Rachel, "Faced With Unaffordable Drug Prices, Tens Of Millions Buy Medicine Outside U.S.," Kaiser Health News, December 20, 2016. See <https://khn.org/news/faced-with-unaffordable-drug-prices-tens-of-millions-buy-medicine-outside-u-s/> [Last accessed 6/23/19].

⁶ Morgan SG, Lee A Cost-related non-adherence to prescribed medicines among older adults: a cross-sectional analysis of a survey in 11 developed countries BMJ Open 2017;7:e014287. doi: 10.1136/bmjopen-2016-014287

⁷ WHO Global Surveillance and Monitoring System for substandard and falsified medical products.

Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

⁸ Bate, Roger, Ginger Zhe Jin, and Aparna Mather, "In Whom We Trust: The Role of Certification Agencies in Online Drug Markets," The B.E. Journal of Economic Analysis & Policy. December 2013, Volume 14, Issue 1, Pages 111–150, ISSN (Online) 1935-1682, ISSN (Print) 2194-6108, DOI. See 10.1515/bejeap-2013-0085.

⁹ Elliott A. Foote, "Prescription Drug Importation: An Expanded FDA Personal Use Exemption and Qualified Regulators for Foreign-Produced Pharmaceuticals," 27 Loy. Consumer L. Rev. 369 (2015). See <http://lawcommons.luc.edu/lclr/vol27/iss3/2> [Last accessed 12/11/2016] and Gabriel Levitt, "Online Pharmacies, Personal Drug Importation and Public Health: Ill-Considered Enforcement Prevents Access to Safe and Affordable Medication" February 2015. See <https://www.pharmacychecker.com/online-pharmacies-personal-drug-importation-public-health.pdf> [Last accessed 12/11/16].

¹⁰ Sable-Smith, Bram, "Americans Cross Border Into Mexico To Buy Insulin At A Fraction Of U.S. Cost," Kaiser Health News, February 12, 2019, see <https://khn.org/news/americans-cross-border-into-mexico-to-buy-insulin-at-a-fraction-of-u-s-cost/> [Last accessed 6/23/2019].

¹¹ Therapeutic Goods Administration, Department of Health, Australian Government, Personal Importation Scheme, see <https://www.tga.gov.au/personal-importation-scheme> [Last accessed 6/23/2019].

¹² Article 60 of TRIPS: Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994)

SDG3_Secretariat

From: Hilda Imali Ngusale [REDACTED]
Sent: Tuesday, July 2, 2019 10:22 AM
To: SDG3_Secretariat
Cc: THULKANAM, Michelle; [REDACTED]
Subject: Accelerator Discussion Paper 1: Sustainable Financing

Dear SDG 3 Secretariat,

My name is Hilda Imali Ngusale from Kenya, I work as the International Advocacy Officer in East Africa i.e Kenya, Uganda and Tanzania supporting policy reviews and financing for UHC. I am also a student in USIU and Summer Bergen University and my focus is financing UHC

The aforementioned paper is remarkable given that LMIC and LIC states tend to depend on OOPS for health care. The following are my recommendations Governments should seek to reduce and remove taxes on health commodities that are on demand, this will help to reduce the costs of OOPS given that implementation of UHC policies will take time and so will the infrastructure needed to secure it.

LICs and LMIC should seek to increase the patient to doctor ratio as opposed to increasing health facilities. This is because doctors can always be made mobile and in the long run might be useful to have a doctor ratio to municipalities as opposed to health facility ratio. The latter will need more time while the former may be faster.

Finally driver number 2 should be skewed more to women because DHS mortalities are largely women and hence they should n given priority in advancing UHC programming specifically on pre and antenatal care

Feel free to reach me via my whatsapp line [REDACTED]

SDG3_Secretariat

From: [REDACTED]
Sent: Tuesday, July 2, 2019 9:51 AM
To: SDG3_Secretariat
Subject: Response to Innovative programming in fragile and vulnerable states and for disease outbreak responses

Dear Sir/Madam,

I strongly believe that the One Health has to become a crucial accelerator for the achievement of the Global Action Plan of SDG3. Let's pay high attent to this aspect. Many thanks for your attention.

Ning Xiao

--

MD, PhD, Professor, Deputy Director
National Institute of Parasitic Diseases,
China CDC based in Shanghai, China

SDG3_Secretariat

From: Harrison, Wendy E [REDACTED]
Sent: Tuesday, July 2, 2019 4:00 PM
To: SDG3_Secretariat
Cc: Winkler, Andrea; john.amuasi@arntd.org
Subject: Accelerator Discussion Paper 4 : Determinants of Health GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL

Dear SDG3_Secretariat,

As a Commissioner of Lancet One Health commission I would like to provide feedback on the GAP alongside the two co-chairs: Dr. Dr. John Amuasi (Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR) at the Kwame Nkrumah University of Science and Technology (KNUST) and Prof. Dr. Dr. Andrea Winkler (Centre for Global Health (CGH) at UiO, Norway, and CGH at the Technical University of Munich, Germany).

Environmental determinants: I consider it to be a significant omission that environmental determinants does not include proximity to animals, particularly livestock. With 75% of all emerging diseases being zoonotic; human animal interactions have a very significant impact on human health. Coupled with over a billion people being reliant on livestock for their livelihoods zoonotic disease also poses a very real economic threat that can further impact on communities abilities to access health care and services. Tackling these issues requires action across multiple sectors (such as agriculture and veterinary public health) and a holistic approach to planning, budgeting and execution of control measures.

It is challenging that the FAO and the OIE are not signatories of the GAP as they play fundamental roles in developing and implementing a One Health approach.

I would therefore very strongly advocate for the inclusion of the animal/human interface as an important environmental determinant of health.

Thank you for considering this issue

Dr Wendy Harrison

Executive Director Schistosomiasis Control Initiative, Imperial College London
Commissioner, Lancet One Health Commission
Honorary Professor, Pathobiology and Population Medicine, Royal Veterinary College, London
Vice Chair, Royal Society of Hygiene and Tropical Medicine
Past Chair Neglected Tropical Disease NGO Network

Dr Wendy Harrison BVetMed MPH PhD MRCVS
Executive Director
Schistosomiasis Control Initiative, Imperial College London
T: +44 (0) 20 7594 3418 | Skype: [REDACTED] | W: schisto.org



SCI is recommended as a top non-profit initiative by [GiveWell](#) and [The Life You Can Save](#) in the USA.

Global action plan on SDGs, WHO (Feedback)

Suraj BHATTARAI, MD, MSc, DTM&H

Global public health specialist, Tropical Medicine physician

Affiliation:

Global Institute for Interdisciplinary Studies (GIIS), Kathmandu, Nepal

Global Young Academy (GYA)- Global Health Working Group

Email: [REDACTED]

General comments

Outline of the Global action plan:

Table 1.

We may fit Urban Health somewhere in the first column. Improving urban health is crucial for achieving UHC. The SDG 3 marries well with SDG 11 (Sustainable cities and communities) in this prospect.

5.1

In addition to mid-point milestones related to existing health-related SDG targets, additional milestones have been included to address emerging challenges not included in the SDG framework, including antimicrobial resistance, personalized or precision medicine, and novel diagnostics that include point of care/impact tests. Some of the global threats identified by WHO could also be included here.

6. Towards 2030- Roll out plan

Additional key steps could be:

- promoting an interdisciplinary approach to achieve UHC
- facilitating regional engagement involving academies

(explanation: academies could be the national academies, a network of national academies, young academies or the universities active in global health activities. In the past, the collaboration of academies has been effective not only for the mobilization of local and regional experts but also for channeling the resources through development agencies to international projects. Inter Academy Partnership www.interacademies.org is an example.)

Suraj BHATTARAI, MD, MSc, DTM&H

Global public health specialist, Tropical Medicine physician

Affiliation:

Global Institute for Interdisciplinary Studies (GIIS), Kathmandu, Nepal

Global Young Academy (GYA)- Global Health Working Group

Email: [REDACTED]

Accelerator 2: Primary health care

The problem and the solution: Why we need PHC now?

3. At community level: add the comment-

Referral systems are not pragmatic in many of the LMICs. Regulation of drugs and pharmacies selling them is not scientific enough.

Reframing support for country programs-

e. USAID has leveraged investments in some countries for strengthening health systems, for example in Nepal they have been running a project 'Strengthening Systems for Better Health (SSBH)' through Abt. Associates Inc.

other activities-

Inter Academy Partnership (IAP for Health) in partnership with the Academy of Medical Sciences, UK invited around 40 global health leaders in London in May 2019 to participate in workshop 'Improving UHC in LMICs: Role of Quality of Care Research'. The participants were divided into Asia, Africa and Americas groups which discussed the current state of play of UHC in respective countries, challenges gaps faced by each country and shared by regional counterparts, and potential short-term and medium-term solutions.

(comment provider was one of the participants, representing Nepal in the meeting)

C. Accelerating progress through action at country level

National and subnational coordination platforms- we could also add professional societies such as medical association, nursing association, midwife association, public health association, etc

Next steps-

4. establishment of in-country leadership group, and possibly nominate a UHC ambassador in each country (it could be an in-country young physician or public health leader identified through various global networks)

Suraj BHATTARAI, MD, MSc, DTM&H

Global public health specialist, Tropical Medicine physician

Affiliation:

Global Institute for Interdisciplinary Studies (GIIS), Kathmandu, Nepal

Global Young Academy (GYA)- Global Health Working Group

Email: [REDACTED]

Accelerator 4: Determinants of Health

It is not clear where SDG 11 fits in, environmental or structural determinants? Nature and scope section keep this in environmental determinants whereas Joint actions as well as Table 1. keep this in structural determinants section (disability friendly infrastructures and services)

Environmental determinants-

Energy, economics, industry, transport, housing and smart cities,

Action area-

involve professional and actionable societies such as International Society for Urban Health, Green earth projects such as POP movement, and youth groups

Accelerator 5: R&D, Innovation and Access

Goal 2: Better coordination and alignment of research priorities

For this, there is a need of establishment of a country-level association or union of Implementing partners (NGOs, INGOs, Government, private sector). The committee of that association could liaise with donors so that common research priorities are identified in time and overlapping of research projects and health programmes is discouraged. The idea of HIRO, mentioned in Action 3 is, very relevant and crucial.

Table A-

Probably add to the list:

- healthy homes for aging population (SDG 11),
- disabled-friendly housing and transport (3.8),
- promoting and scaling up minimally invasive tissue sampling (MITS) technique followed by rapid diagnostics to determine cause of death both ante-mortem and post-mortem. This helps a lot in generating mortality evidence and understand local burden of disease. (commenter is a principle investigator of MITS research project in Nepal)

SDG3_Secretariat

From: Popescu, Christian [REDACTED]
Sent: Friday, June 28, 2019 4:48 PM
To: SDG3_Secretariat
Subject: Innovative programming in fragile and vulnerable states and for disease outbreak responses

To whom it may concern:

Name: Christian Popescu
Affiliation: In an individual capacity

Please find below my comments on the Accelerator discussion paper 7, Innovative programming in fragile and vulnerable states and for disease outbreak responses

- I agree that further alignment between agencies in responding to emergencies in fragile and vulnerable settings is needed, especially in terms of planning, decision-making, risk assessment and management, external communication, and budgeting. For emergencies, existing structures within the Inter-Agency Standing Committee and the Cluster Approach should be used.
- What I am missing is the fact that innovative programming in fragile states is far more than ensuring emergency preparedness and response. Fragile states display specific challenges regarding efforts to strengthen health systems towards UHC and we would welcome the paper to put a stronger emphasis on how to best support health systems strengthening towards UHC in fragile settings. Making use of national systems and strengthening these instead of substituting these with parallel donor-driven systems will be crucial in this regard.
- I would welcome concrete proposals on how inter-agency coordination can be harnessed to address the challenge of engaging with non-state armed groups (NSAGs) in fragile and vulnerable settings, an important lesson from the current Ebola outbreak in the DRC, in order to keep the health work force safe and allow access to insecure areas.

Christian Popescu

NON
STATE
ACTORS

FIA Response to WHO Global Action Plan for Healthy Lives and Well-being: Strengthening Collaboration Among Multilateral Health Organizations to Accelerate Country Progress on The Health-Related Sustainable Development Goals (SDGs)

Introduction:

Food Industry Asia (FIA) wishes to thank the World Health Organization (WHO) for the opportunity to comment on the proposed Global Action Plan for Healthy Lives and Well-being for All (the "Global Action Plan" or "GAP") and provide feedback on behalf of the food industry in Asia.

FIA is a non-profit industry association established in Asia to represent the view of the food industry as a trusted partner for multi-stakeholder dialogue. The goal of FIA is to harness the expertise of major food and beverage companies and respond to the region's complex challenges in food safety, regulatory harmonisation and health & nutrition. Our members share common values on the responsible promotion of balanced diets and lifestyles.

Together, we work with a broad range of stakeholders in Asia to promote the role of public-private partnership (PPP) as a cost-effective mechanism for delivering positive socio-economic outcomes. At the heart of our philosophy lies a belief that the private sector can play a more positive role in civil society on many of the complex challenges associated with health & nutrition. To this end, FIA is committed to working collaboratively with governments, policymakers, civil societies and academia throughout Asia, either directly or through existing local industry groups.

Specific Comments on the Guidelines

The GAP's original intention to align the processes and workstreams of multiple United Nations (UN) agencies and multilateral organisations, as well as to streamline the relationships and ways of working with partners, should be commended. However, we note that the draft GAP outline published, along with the revised Accelerators, appear to reach beyond this original objective to include policy recommendations. We question the intention of detailing policy recommendations in the GAP, as such recommendations are intended as guides for implementation by UN Member States. If the final version of the GAP will include policy recommendations, it is important that Member States – who are ultimately responsible for the implementation of these recommendations within their own national contexts – should have ample opportunity to review and approve them, as they would with any other Global Action Plans.

The development of the GAP has failed to include and acknowledge the tone and language adopted by the Member States composing of the UN and the signatory agencies, including that in the 2018 Political Declaration for the UN High-level Meeting on Non-Communicable Diseases (UN HLM on NCDs). This

Political Declaration represents the latest Member States' consensus on how to accelerate progress on NCDs. The current GAP, as submitted for consultation by interested parties, does not seem to take into account the tone encompassed in the Political Declaration which is seen by many stakeholders as a way forward.

In addition to the above, FIA would also like to make the following recommendations for consideration by the GAP Secretariat.

- Ensure that all language contained in the GAP is aligned with the multi-stakeholder partnership vision of the 2030 Agenda for Sustainable Development.
- The GAP's original purpose of streamlining collaboration among health-related global and multilateral organisations should not be undermined by the introduction of policy recommendations to Member States that do not reflect the latest global political consensus.

We would like to suggest for the GAP Secretariat to revisit the discussion papers on Accelerator 1 and Accelerator 4, by focusing on aligning multi-stakeholder partnership to achieve the health-related goals of the 2030 Agenda. Our comments on these specific sections are as follows.

Comments on Accelerator Discussion Paper 1 (Sustainable Financing) and Accelerator Discussion Paper 4 (Determinants of Health)

Multi-stakeholder partnerships are critical to achieving the transformative change called for in the 2030 Agenda. However, the language used in Accelerator Discussion Paper 4 is at odds with SDG 17 around the important role partnerships will play in achieving that goal and with the Political Declaration for the UN HLM on NCDs.

While we appreciate the added reference to the importance of PPPs in relation to SDG 17 in the draft GAP, the discussion paper generally seems to present a negative approach toward engagement with the private sector – this is at odds with directives from the signatory agencies' leadership. One of the signatories, the Director General of WHO, has repeatedly stated the importance of partnerships in achieving the SDGs. Despite such comments, the paper arbitrarily labels certain industries as "health-harming" and targets "pervasive industry interference" rather than recognizing the private sector as a legitimate stakeholder who should have a seat at the table. The paper also makes reference to the food industry's advertising budget as evidence of "pervasive industry interference" in policymaking to "win" public opinion. We would recommend that language inspiring the final version of the GAP to reflect that the private sector is an important stakeholder, and to avoid editorial comments or opinions suggesting that the marketing of products and advertising budgets have a direct correlation to contributing to industry influence on policymaking.

We believe that the policy recommendations included under Accelerator Discussion Papers 1 and 4 have been generated with minimal consultation with Member States, after comparing their tone with the language considered and rejected during Member State negotiations for the Political Declaration for the UN HLM on NCDs. For example:

- Accelerator Discussion Paper 1 and 4 explicitly encourage Member States to adopt taxes on sugar-sweetened beverages, which remains a controversial topic among Member States and was accordingly rejected during Member State negotiations over the Political Declaration for the UN HLM on NCDs.
- There is no Member State consensus for the term “commercial determinants of health” (found in Accelerator Discussion Paper 4), which has been specifically excluded from Member State-negotiated texts due to its ill-defined, negative connotations towards the private sector.
- Accelerator Discussion Paper 4 also includes new policy suggestions and recommendations that have not been considered by the signatory agencies’ governing bodies, including determinants of health related to climate change, enforcing regulations related to reducing carbon emissions, fossil fuel use and agriculture, in general. These policy issues, amongst others that were raised, would benefit from Member States’ inputs before their final adoption.

FIA is of the view that the original purpose of the GAP was to streamline collaboration among health-related international organisations, which we feel is a useful objective. However, we do not support the view that the GAP should also serve as a tool or guide for policy recommendations for Member States.

In conclusion, we commend the action and effort that has gone into producing this GAP. We thank you for the opportunity to submit feedback on behalf of the food industry in Asia. In our continued engagement with all stakeholders, including governments in Asia, we are very mindful of the responsibility businesses have in contributing to global health and well-being. Industry is, and remains, committed to working in partnership with the signatory agencies and a wide range of stakeholders to seek collaborative solutions for health-related SDG goals. We trust you will give due consideration to our feedback.

Sincerely,

Steven Bartholomeusz
Policy Director
Food Industry Asia



FIA Response to WHO Global Action Plan for Healthy Lives and Well-being: Strengthening Collaboration Among Multilateral Health Organizations to Accelerate Country Progress on The Health-Related Sustainable Development Goals (SDGs)

Introduction:

Food Industry Asia (FIA) wishes to thank the World Health Organization (WHO) for the opportunity to comment on the proposed Global Action Plan for Healthy Lives and Well-being for All (the “Global Action Plan” or “GAP”) and provide feedback on behalf of the food industry in Asia.

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Together, we work with a broad range of stakeholders in Asia to promote the role of public-private partnership (PPP) as a cost-effective mechanism for delivering positive socio-economic outcomes. At the heart of our philosophy lies a belief that the private sector can play a more positive role in civil society on many of the complex challenges associated with health & nutrition. To this end, FIA is committed to working collaboratively with governments, policymakers, civil societies and academia throughout Asia, either directly or through existing local industry groups.

Specific Comments on the Guidelines

The GAP's original intention to align the processes and workstreams of multiple United Nations (UN) agencies and multilateral organisations, as well as to streamline the relationships and ways of working with partners, should be commended. However, we note that the draft GAP outline published, along with the revised Accelerators, appear to reach beyond this original objective to include policy recommendations. We question the intention of detailing policy recommendations in the GAP, as such recommendations are intended as guides for implementation by UN Member States. If the final version of the GAP will include policy recommendations, it is important that Member States – who are ultimately responsible for the implementation of these recommendations within their own national contexts – should have ample opportunity to review and approve them, as they would with any other Global Action Plans.

The development of the GAP has failed to include and acknowledge the tone and language adopted by the Member States composing of the UN and the signatory agencies, including that in the 2018 Political Declaration for the UN High-level Meeting on Non-Communicable Diseases (UN HLM on NCDs). This

From: Enrico Frabetti - FIAB <e.frabetti@fiab.es>
Sent: Thursday, June 27, 2019 5:14 PM
To: SDG3_Secretariat
Subject: FIAB reply to the WHO Consultation on a "Global Action Plan for Healthy Lives and Well-being"

Dear Sir or Madam,

FIAB is the Spanish Food and Drink Industry federation and is pleased to submit the following feedback on the proposed Global Action Plan for Healthy Lives and Well-being for All (the "Global Action Plan," or "GAP"):

Comments on the Global Action Plan Outline and Plan Development:

We appreciate the GAP's intent to align the processes and workstreams of UN agencies and multilateral organisations and streamline collaboration with partners. The draft outline published, along with the revised Accelerators, appear to reach beyond this effort to include policy recommendations intended for implementation by Member States. If the final version of the Global Action Plan will include policy recommendations, it is important that Member States (ultimately responsible for the implementation of these recommendations nationally) should have sufficient opportunity for review and approval.

The development of the GAP does not include and acknowledge language adopted by the Member States composing the UN and the signatory agencies, including the 2018 Political Declaration on the UN High-level Meeting on NCDs. That Political Declaration represents the latest Member States consensus on how to accelerate progress on NCDs. Its vision is not reflected in the current GAP, as submitted for consultation. Therefore, we put forward the following comments:

- The GAP Secretariat should ensure that all language contained in the GAP is aligned with the multistakeholder partnership vision of the 2030 Agenda
- The GAP's purpose of streamlining collaboration among health-related International and Multilateral Organisations should not be undermined by also introducing policy recommendations for Member States that do not reflect the latest global political consensus.

We suggest GAP Secretariat revisiting the discussion papers on Accelerator 4 and Accelerator 1, by focusing on aligning multistakeholder partnership to achieve the health-related goals of the 2030 Agenda. Our comments on these specific sections can be found here below.

Comments on Accelerator Discussion Paper 4, "Determinants of Health" and Accelerator Discussion Paper 1, "Sustainable Financing":

Multistakeholder partnerships are critical to achieving the transformative change called for in the 2030 Agenda, yet Accelerator Discussion Paper 4 currently employs language that is inconsistent with Sustainable Development Goal 17 around partnerships for the goals ("SDG 17") and the UN HLM Political Declaration on NCDs.

While we appreciate the added reference to public-private partnerships and their importance to SDG 17 in this draft, the discussion paper generally takes a narrow and negative approach toward the private sector which is at odds with directives from the signatory agencies' leadership. The Director General of WHO, to take one of the 12 signatory agencies, has repeatedly affirmed the importance of partnerships in achieving the SDGs, yet the paper arbitrarily labels certain industries as "health-harming" and targets "pervasive

industry interference” rather than recognizing the private sector as a legitimate stakeholder. The paper also refers to the food industry’s advertising budget as evidence of “pervasive industry interference” in policymaking to “win” public opinion. Language inspiring the final GAP should reflect that the private sector is an important stakeholder, and that marketing of products does not equate to any kind of contribution to policymaking.

Collaboration with industry, as was recently demonstrated when industry at global level announced its support for the WHO package on industrial trans-fat elimination or the Spanish reformulation Plan , can deliver public health benefits. Failing to include public-private partnerships as a key component of a whole-of-society approach is a missed opportunity, and language chosen from this discussion paper for inclusion in the GAP should align with the multistakeholder partnership vision of the 2030 Agenda.

Accelerator Discussion Papers 1 and 4 include policy recommendations generated with very little consultation from Member States, which feature language considered and rejected during Member State negotiations for the High-level Meeting on Non-communicable Diseases, such as:

- ✓ Accelerator 4 and Accelerator 1 explicitly encourage Member States to adopt taxes on sugar sweetened beverages, which remains a controversial topic among Member States and was accordingly rejected during Member State negotiations over the Political Declaration on NCDs.
- ✓ There is no Member State consensus for the term “commercial determinants of health,” (found in Accelerator 4), which has been specifically excluded from Member State negotiated texts due to its ill-defined, negative connotations towards the private sector.

Accelerator 4 also includes new policy suggestions and recommendations that have not been considered by the signatory agencies’ governing bodies, such as determinants of health related to climate change, enforcing regulations related to reducing carbon emissions, fossil fuel use, and agriculture generally. These and other raised policy issues would benefit from Member State input before their final adoption. The GAP purpose of streamlining collaboration among health-related International Organisations should not be disrupted by also introducing policy recommendations for Member States.

Thank you for taking into account these comments, kind regards



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FEDERALIMENTARE

Federazione Italiana dell'Industria Alimentare

Global Action Plan for Healthy Lives and Well-being

GENERAL COMMENTS

Federalimentare welcomes the advancement of the “Global Action Plan for Healthy Lives and Well-Being for All” and appreciates some of the provisions contained in the working papers subject to public consultation. However, in the view of our associates, many points of the document presented for public consultation, in particular in the paper “Accelerator 4” on determinants of health, would need serious reconsideration.

Among the positive points, we welcome the encouragement of a wider use of public-private partnership for health and development, in line with SDG17 and the 2030 Agenda. Such partnerships can provide more efficiency and additional resources to the activities aimed at achieving sustainable development and at reducing poverty as a fundamental mean to achieve good health for all. As the GAP paper repeats many times, there is a direct correlation between poverty and poor health. Poverty eradication must therefore be one of the first objectives of any plan aimed at ensuring global health. In this regard, the Italian private sector is willing to do its part and believes that public-private partnerships can be very effective in delivering results.

ACCELERATOR DISCUSSION PAPER - 4. Determinants of Health

However, we have been very surprised by the content of Accelerator 4 on determinants of health, which caused the utmost disappointment among our members, as its revision did not go in the direction pointed out in previous engagements.

The language used to depict the private sector is still extremely harsh and surely not consistent either with the UN High-Level Political Declaration on Non-communicable diseases, approved on 27 September 2018, or to other parts of the “Global Action Plan for Healthy Lives and Well-Being for all” itself. It is also far away from many provisions set in SDG17, in particular 17.16 and 17.17, which encourage multi-stakeholder approaches and public-private partnerships to support the achievement of sustainable development, especially in developing countries.

In accelerator 4 the private sector is labelled as an evil entity, whose only aim seems to be making profits by harming people with unhealthy products, which is a totally unacceptable view. Talking about “health-harming private sector strategies, approaches and activities” sounds extremely ideological and far away from reality. The private sector in Italy makes high-quality food products related to the Mediterranean diet, and contributes to the traditionally healthy diet followed by most Italians, which is one of the main factors of Italy’s excellent ratings in most health indicators, included life expectancy, which is very close to 83 years.

Specific assumptions presented in Accelerator 4 are also very questionable, to say the least. It is utterly unacceptable that sugary products and alcoholic beverages are put on equal footing with fossil fuels, intensive and chemically driven agriculture and tobacco, as both sugary products or alcoholic drinks are perfectly safe if consumed in the appropriate, very moderate amount.

“Ultra-processed food” is another expression whose definition has never been clarified and lacks a solid scientific foundation. As it is, it only sounds ideologically-based and against the food industry as a whole. The paper also strongly encourages the adoption of the so-called STAX (Sugar, tobacco and alcohol tax) mentioning an alleged (and inexistent) “evidence of the public health benefits of STAX.”

First of all, we insist on the inappropriateness of mixing up food and tobacco in any policy regarding health. The main point, however, is that STAX was rejected by Member States during the negotiations that led to the UN High Level Meeting on Non-Communicable diseases (September 2018). Moreover, no scientific evidence whatsoever confirms STAX's alleged benefits on public health. On the contrary, authoritative studies prove that taxes on consumption goods, especially food taxes, strongly damage the poorest families and depress the economy as a whole. Adopting such tax would therefore go against the object of reducing poverty and could severely damage the poorest sectors of developing countries' populations.

A similar argument can be raised for the actions that the GAP draft suggests to "the signatories" (which are 12 UN Agencies) to support Member States in the implementation of the plan. Among such actions figures the adoption of an "effective taxation of sugar". Besides the above-mentioned considerations on the negative effect of taxing foods or food commodities, fiscal policies are an exclusive prerogative of governments, which should not be unduly pressured by a UN paper that concerns much wider topics and does not take into consideration any specificity of each State's economic and fiscal situation. This argument has been acknowledged in the UN Political Declaration on NCDs, art. 21, which regarding legislative and regulatory measures says "including fiscal measures as appropriate". Such definition, which does not talk specifically about taxes (fiscal measures can be referred to incentives as well), limits such interventions "as appropriate", because every Member State has its own economic and fiscal environment.

The request to the signatories to pressure Member States for the review of their codes of conduct and conflict of interests rules regarding "health harming" private sector actors is also very questionable, because the definition of "health harming", in the view of the proposers, means producers of foods rich in salt, saturated fats or sugar, which are often very high-quality products, whose moderate consumption is not only perfectly compatible with a healthy diet, but even advisable. By using the suggested approach, producers of extra-virgin olive oil, a universally recognized high-quality food which provides evident benefits to health, would be classified as "health harming producers". The classification of foods in "healthy" or "unhealthy" is not supported by solid scientific evidence, especially if made with arbitrary thresholds based on 100 grams and not on real portions. Only diets and consumption patterns can be described as "healthy" or "unhealthy", not single foods.

As Federalimentare, we kindly request the modification of the document to keep it fully in line with the UN High-Level Political Declaration on NCDs, approved by Heads of State and Government, with the spirit of the SDG and with the 2030 Agenda. Specifically, the attention should be focused on how to "empower the individual to make informed choices", as requested by the UN Political Declaration, and not on the discrimination of foods into "healthy" or "unhealthy", or industries in "good" and "evil". In particular, we request the removal of any ideological language relative to the private sector, which undermines any attempt by industry and institutions to establish a frank, honest and fruitful collaboration. In Italy, such collaboration led to the reformulation of a great number of products and to many improvements in the working practices of the whole food supply chain, including on sustainability.

We also request that any provision regarding actions that could potentially damage economic growth be advised only if the benefits of its introduction are supported by high-quality scientific evidence.

June 29, 2019

VIA email to SDG3_Secretariat@who.int

Comments on the proposed Global Action Plan for Healthy Lives and Well-being for All

The German Federation for Food Law and Food Science (BLL) appreciates the opportunity to comment on the proposed Global Action Plan for Healthy Lives and Well-being for All. The BLL represents the German food sector, both in Germany and at the European level. In this role, it represents the food sector throughout the entire production chain, "from farm to fork", i.e. the areas of agriculture, food processing, food trades, and food sellers.

We appreciate that the overall intent of the Global Action Plan is to accelerate progress on UN Sustainable Development Goal 3 and we share the view that a concerted effort and a participation of all stakeholders, including civil society, the private sector, academia, and other international, national, and local is needed. However, especially with regard to "Accelerator 1" and "Accelerator 4" but also regarding the process of stakeholder engagement we would like to express our following concerns:

Both, Accelerator 1 (Sustainable Financing) and Accelerator 4 (Determinants of Health), encourage Member States to adopt taxes on certain products or nutrients like for example sugar or sugar-sweetened beverages, which is from our point of view not an effective way to combat obesity and non-communicable diseases.

The impact of introducing a tax can be wide-ranging and highly uncertain and depends on many variables. Few studies provide a robust and complete account of the impact of such taxes on public health, and there is no sound evidence that such food taxes lead to a healthier diet and have any impact on reducing obesity or other lifestyle-related diseases so far. Rather food taxation may have various negative impacts like an additional inflationary pressure and a decreased consumer purchasing power. Furthermore such taxes would penalise all consumers, regardless of

how balanced one's diet is and negatively impact low-income consumers as well as the competitiveness of the industry. Those negative consequences are clearly demonstrated by the abolition of the Danish Fat Tax in 2012 (one year after introduction) and Finland's decision to scrap the tax on confectionary and ice cream (introduced in 2011).

In 2014 the European Commission conducted a comprehensive study entitled "Food taxes and their impact on competitiveness in the agri-food sector". The independent consortium concluded that taxes on high sugar, salt and fat products do not necessarily reduce the consumption of the targeted ingredients and that they can affect the competitiveness of the agri-food sector. Furthermore, evidence from academic literature is inconclusive and sometimes contradictory. Against this background more research is needed in order to assess more extensively the impact of these measures on the competitiveness of the agri-food sector.

The causes of obesity are multi-factorial whereupon a number of lifestyle-dependent and lifestyle-independent factors play a role. Apart from diet, physical activity plays a decisive role. Therefore, the German Government for example follows, amongst others, an approach based on education and the promotion of physical activity with its initiative IN FORM (Germany's initiative for healthy eating and more exercise) which started in 2008. Current data from the school enrolment examinations of individual German states showed that the prevalence of overweight and obese children starting school is no longer increasing and has even declined in nearly every German state. Absolute decrease of prevalence rates was up to 3% for overweight and 1.8% for obesity. These positive developments support the effectiveness and the importance of an holistic approach and the role of education and physical activity instead of fiscal measurements.

Besides this, we would like to comment on the general tone of "Accelerator 1" and "Accelerator 4" toward the private sector. Both documents refer to the private sector as "health-harming" rather than recognizing that the private sector is a legitimate stakeholder. The German food industry for example ensures that over 82 million citizens in Germany and a large number of people worldwide can enjoy safe food and food of high quality every day. The medium-sized food industry with numerous family businesses offers a variety of 170,000 products at affordable prices. It provides jobs for 12% of the working population and is continuously investing in the future of the labor market.

Finally, we were wondering why the communication with all stakeholders, including civil society, private sector and Member States has been limited, as far as we know, to a one-day civil society consultation, a short technical briefing offered by WHO on Member States and this consultation exercise so far. As the proposed Action Plan includes several policy recommendations, it is important that Member States – who were ultimately responsible for the implementation of these recommendations within their own national contexts – should have adequate opportunity for review and verification.

San José, 24 de junio de 2019

**Comentarios sobre “*Global Action Plan for Healthy Lives and Well-being for All*”:
Comentarios sobre el borrador, el Acelerador 1 y el Acelerador 4**

La Alianza Latinoamericana de Asociaciones de la Industria de Alimentos y Bebidas (ALAIAB) es una organización regional, formalmente establecida y conformada por veintitrés asociaciones empresariales de la industria alimentaria y de bebidas no alcohólicas, representativas de catorce países¹.

ALAIAB agradece la oportunidad a la Organización Mundial de la Salud (OMS) para participar en la consulta en línea sobre la “*Global Action Plan for Healthy Lives and Well-being for All*” (GAP por sus siglas en inglés): comentarios sobre el borrador y el Acelerador 1 y 4 a fin de ser considerada por los Estados Miembros.

ALAIAB reconoce la realidad mundial en torno a la problemática de sobrepeso, obesidad y enfermedades no transmisibles (ENT's), motivo por el cual apoya todos aquellos programas públicos, sociales, privados y multisectoriales de formación, educación e información orientados a promover hábitos alimentarios correctos y la práctica cotidiana de actividad física.

Como siempre, ALAIAB se pone a la mejor disposición de organismos multilaterales y gobiernos, para fomentar el diálogo que promueva avances en la construcción de marcos normativos equilibrados, basados en la ciencia y que agreguen valor a la población.

¹ **Organizaciones empresariales miembros de ALAIAB:** Argentina: Coordinadora de Productores de Alimentos (COPAL) y la Cámara de Industriales de Alimentos (CIPA); Uruguay: Cámara de Industriales de Alimentos (CIALI); Paraguay: Cámara de Empresas Paraguayas de Alimentos (CEPALI) y la Cámara de Alimentos y Bebidas de Paraguay (CABE); Chile: Asociación de Empresas de Alimentos (Chilealimentos) y Alimentos y Bebidas de Chile (ABChile); Brasil: Asociación Brasileña de las Industrias de Alimentación (ABIA) y Asociación Brasileña de Bebidas Refrescantes y No Alcohólicas (ABIR); Perú: Asociación de la Industria de Bebidas y Refrescos no Alcohólicos (ABRESA) y Sociedad Nacional de Industriales (SNI); Colombia: Cámara de la Industria de Alimentos y Cámara de la Industria de Bebidas de la Asociación Nacional de Empresarios (ANDI-ALIMENTOS y ANDI-BEBIDAS); Venezuela: Cámara Venezolana de la Industria de Alimentos (CAVIDEA); Ecuador: Asociación Nacional de Fabricantes de Alimentos (ANFAB) y la Asociación de Industriales de Bebidas no Alcohólicas (AIBE); Costa Rica: Cámara Costarricense de la Industria Alimentaria (CACIA); Guatemala: Cámara de Industria de Guatemala (CIG) y la Cámara Guatemalteca de Alimentos y Bebidas (CGAB); México: Consejo Mexicano de la Industria de Consumo Masivo (CONMEXICO) y la Asociación Mexicana de Refrescos y Aguas Carbonatadas (ANPRAC); Estados Unidos: Grocery Manufacturers Association (GMA); República Dominicana: Asociación de Industrias de Bebidas Gaseosas de República Dominicana. (ASIBEGAS)

I. Resumen Ejecutivo

ALAIAB solicita a la Secretaría del GAP:

- Asegurar que todos los mecanismos de gobernanza sean adecuados, incluyendo la consulta robusta y el compromiso con los Estados Miembros. Los mecanismos de proceso no deben ser apresurados o ignorados para cumplir con un plazo de lanzamiento de la Asamblea General de Naciones Unidas (AGNU) en septiembre.
- Garantizar que el lenguaje contenido en el GAP y los Aceleradores estén alineados con la ***Declaración Política de 2018*** sobre las ENT's y el Objetivo de Desarrollo Sostenible 17 (por sus siglas en inglés SDG 17).
- Garantizar que no se desvíe en las áreas de formulación de políticas, como es la prerrogativa de los Estados Miembros. El GAP no debe promover recomendaciones de políticas que no han sido aprobadas por los Estados miembros, o que no hayan sido considerados por éstos.

ALAIAB señala que estas preocupaciones de gobernanza, surgen por el contenido de borrador publicado hasta la fecha, que indica que este GAP es un vehículo para recomendaciones de política pública, particularmente en cómo se relaciona con el sector privado. Los contenidos desarrollados hasta la fecha van más allá de un ejercicio de alineamiento y por consiguiente entra en el espacio donde se justifica la revisión de los Estados Miembros.

II. Este GAP Requiere una gobernanza robusta y un compromiso de los actores

ALAIAB solicita que el GAP sea elevado a los Órganos de Gobierno de OMS para una adecuada y exhaustiva revisión acorde con los procedimientos de gobernanza de OMS. ALAIAB reconoce que la Secretaría haya abierto un período de consulta sobre el GAP. Sin embargo, creemos que este ejercicio —que es la primera consulta en línea—, sería mejor tomarlo como punto de partida para el compromiso de las partes interesadas. La Secretaría del GAP de OMS ha reiterado su intención de lanzar el Plan Final en la AGNU en septiembre 2019, por lo que solicitamos se emprenda una revisión de procesos y procedimientos que garanticen la participación de las partes interesadas en todos los elementos del GAP, no sólo en el esquema, que se plantea para el futuro cercano.

Adicionalmente, como se explica más abajo, el producto del trabajo desarrollado hasta la fecha contiene recomendaciones de política pública que van más allá de lo que los Estados Miembros han considerado, y en algunos casos revive recomendaciones de política que los Estados Miembros han rechazado explícitamente. Observamos que en respuesta a la pregunta "¿cómo y cuándo los órganos de Gobierno podrán participar?," el sitio de Preguntas Frecuentes (FAQ) de OMS afirma que:

*"En caso de que las acciones recomendadas requieran un cambio de políticas, estos cambios sugeridos serían llevados a la atención de los órganos rectores relevantes y la discusión puede ocurrir cuando proceda y según los procedimientos de los distintos órganos de gobierno implicados." ("In case recommended actions should require a change of policies, these suggested changes would be brought to the attention of the relevant governing bodies and discussion can occur where relevant and according to the procedures of the different governing bodies involved."*²⁾

Si bien ALAIAB entiende que el GAP pretende ser un ejercicio de alineación interna para las agencias de la ONU y otras organizaciones mundiales de salud, el trabajo publicado en el Acelerador 4 y en el Acelerador 1, como se detalla a continuación en las secciones III, IV y V, reflejan un esfuerzo por utilizar el GAP como un vehículo para nuevas recomendaciones de política destinadas a ser implementadas por los Estados Miembros. Por lo tanto, de acuerdo con el proceso descrito en las FAQ del sitio web de OMS, creemos que la discusión debe ocurrir con los órganos rectores a través del proceso correspondiente, incluyendo la colocación en las agendas de la Reunión de Junta Ejecutiva del 2020 y de la Asamblea Mundial de la Salud (AMS) del 2020, hasta que pueda ser adoptado por una resolución de los Estados Miembros. Invitamos a la Secretaría del GAP de OMS a que continúe buscando oportunidades para la participación de las partes interesadas, incluyendo eventos alternos durante la AGNU para dialogar sobre el borrador del plan. Sin embargo, la noción de que un plan final deba presentarse en la Asamblea sin haber sido objeto de una amplia, profunda y significativa revisión por parte de los Estados Miembros es desde nuestra perspectiva un desafortunado desacierto de una buena gobernanza y del debido proceso de un tema crítico.

A. La comunicación del GAP ha sido insuficiente y no está en concordancia con prácticas pasadas

La comunicación con todas las partes interesadas, incluyendo la sociedad civil, sector privado y los Estados Miembros hasta la fecha no ha sido extensa:

- Una consulta de un día a la sociedad civil, durante el cual se formularon preguntas por los participantes acerca del propósito y el proceso. *El borrador del GAP no había sido liberado aún en este momento.*

² Ver WHO's FAQ on the Global Action Plan: <https://www.who.int/sdg/global-action-plan/frequently-asked-questions#question9>

- Una reunión técnica de dos horas ofrecida por OMS a los Estados miembros, con tiempo muy limitado para las intervenciones de piso y de los participantes. *El borrador del GAP no había sido liberado aún en este momento.*
- Este ejercicio de consulta de menos de dos semanas, que se realiza a sólo tres meses antes del lanzamiento previsto del Plan de Acción Global (GAP) en la Asamblea General de las Naciones Unidas en septiembre de 2019. *El borrador del GAP no había sido liberado aún en este momento, solo un outline.*

Además, este GAP ha estado ausente de la agenda durante las reuniones claves de OMS, incluyendo la de Junta Directiva del 2019 y la de la Asamblea Mundial de la Salud. No hay ningún indicio de que la OMS o cualquiera de las organizaciones de salud mundial se enlistaron para llevar a cabo consultas regionales sobre el contenido del GAP antes del lanzamiento en la AGNU, realizaron consultas separadas con los Estados Miembros, compartieron el borrador con miembros de sus Juntas Directivas, o buscaron tener el GAP oficialmente adoptado mediante resolución en la AMS (o reuniones similares). Esto hace un contraste importante con el proceso de consulta para el *Plan de Acción Global en Enfermedades No Transmisibles (ENT) 2013-2020*, que según nuestras cuentas realizó 15 consultas, publicó varios borradores del plan y fue incluida por la OMS en las agendas de la Asamblea y Comité Ejecutivo de la OMS, y en última instancia formalmente adoptado por la resolución de los Estados Miembros. El proceso de consulta para el *Plan de Acción Global de las ENT* fue tan extenso y fue visto de una manera tan importante que se ha conservado con detalle en el sitio web de la OMS.³

La Secretaría del GAP de la OMS ha tomado la posición que este Plan de Acción Global difiere de los anteriores Planes de Acción Globales porque es simplemente un "ejercicio de alineamiento" entre agencias de la ONU. Si ese fuera el caso, y este GAP quedara estrictamente en el ámbito de ejercicio de alineación interna — entonces ALAIAB retiraría sus objeciones al proceso. Sin embargo, el propósito y la intención de este GAP a este punto no está bien definido, y los materiales publicados hasta la fecha se mueven sólidamente en el ámbito de la formulación de políticas. En última instancia, significa que es más adecuado tratar este GAP como cualquier otro Plan de Acción Global — merecedores de aprobación y revisión de parte de los Estados Miembros.

³ https://www.who.int/nmh/events/2013/consultation_process/en/

B. Los Cuerpos Directivos de la OMS son el mejor lugar para dirigir el compromiso de los Estados Miembros en este Plan de Acción Global (GAP)

ALAIAB cree que, como mínimo, deben ser los órganos directivos de la OMS quienes deben estar comprometidos con este proceso:

- La carta de abril del 2018 de los Jefes de Estado de Alemania, Ghana y Noruega fue dirigida al Director General de la OMS y solicitó que la OMS condujera el desarrollo de este GAP.
- OMS actuando como la Secretaría de este GAP: en esta función aloja toda la información relacionada con el GAP en su página web, opera este periodo de consulta, probablemente está utilizando fondos del presupuesto de WHO para supervisar y desarrollar el espacio del GAP y lo más importante tiene responsabilidad de supervisión y coordinación relacionados con el GAP.

Por lo tanto, creemos que dado el papel de liderazgo que la OMS está cumpliendo con respecto a este GAP, deberían ser los órganos directores de OMS con quienes debe consultar la agencia – no sólo informar – como procede con el desarrollo. Si otras agencias de la ONU tienen interés rector en el GAP, ALAIAB no tendría objeción de que se incluyan en el proceso, ya que creemos que los procesos sólidos de consulta, pueden conducir a consensos significativos. Sin embargo, nos opondríamos a cualquier afirmación que el proceso de gobernanza deba ser limitado simplemente porque el número de agencias de la ONU involucrados lo hace difícil. Cuando un GAP se mueve en el ámbito de la formulación de políticas, no debería ser capaz de evitar la gobernanza de los Estados Miembros. – tal acción sentaría un preocupante precedente. Una vez más, observamos que este desafío a la gobernanza se presenta porque el GAP ha cambiado su enfoque de simplemente ser un ejercicio de alineación interna para uno que busca conducir nuevas políticas o hasta políticas rechazadas por los Estados Miembros.

III. Comentarios sobre el Acelerador 4 y el Acelerador 1: contenido inconsistente con la *Declaración Política* adoptada por la Asamblea General de las Naciones Unidas en la *Reunión de Alto Nivel de Naciones Unidas sobre Enfermedades No Transmisibles (ENTs)*.

Específicamente, ALAIAB observa que ambos el Acelerador 4 (Determinantes de Salud) y el Acelerador 1 (Financiamiento Sostenible) incluyen recomendaciones políticas que fueron ya consideradas y rechazadas durante la negociación con los Estados Miembros en la Reunión de Alto Nivel.

- La frase "*determinantes comerciales de la salud*" del acelerador 4 ha sido excluido específicamente de los textos de las negociaciones de los Estados Miembros y nunca se ha discutido oficialmente dentro del contexto de la OMS o de la ONU, y como resultado no hay consenso de los Estados Miembros en este término.
- En el acelerador 1 y el acelerador 4 explícitamente alientan a los Estados Miembros a adoptar impuestos al azúcar, la cual ha sido discutida entre los Estados Miembros y por consiguiente rechazada explícitamente durante las negociaciones de la *Declaración Política*. Cabe señalar, que los impuestos a las bebidas azucaradas también fueron excluidos del reporte "*Time To Deliver*" que realizó la Comisión Independiente de Alto Nivel para ENTs de la OMS, no está incluido en las *Best Buys de la OMS* como una intervención a las ENTs, y según CHOICE, el propio análisis de la OMS, no alcanzó resultados positivos para la salud.

IV. Comentarios sobre el Acelerador 4: El tono general es inconsistente con el Objetivo de Desarrollo Sostenible 17, "Alianzas para lograr los Objetivos"

ALAIAB encuentra que el tono general del Acelerador 4 es incoherente con el Objetivo SGD17, "*Alianzas para Lograr los Objetivos*". Si bien apreciamos que se ha añadido algunos textos de referencia a que las alianzas público-privado son importantes, el enfoque con respecto al sector privado es negativo. El Acelerador 4 se refiere al sector privado como "dañino para la salud" y hace referencia a "interferencia generalizada de la industria" en la formulación de políticas, en lugar de reconocer que el sector privado es un actor legítimo. Como ejemplo de "interferencia de la industria" en la formulación de políticas, el Acelerador 4 argumenta que el presupuesto de publicidad de la industria alimentaria evidencia de "las interferencias de la industria" en la formulación de políticas para "ganar" la opinión pública. En otras palabras, no hay ningún reflejo que 1) el sector privado es un actor adecuado en formulación de políticas; y 2) el marketing de los productos no es *prima facie* un mal acto. Finalmente, se deja el mensaje de que la única manera de interactuar con el sector privado para lograr los ODS es a través de "imponer, restringir, regular". Este es un enfoque desalentador considerando el llamamiento de las Naciones Unidas a la acción del sector privado. El ODS 17 se fundamenta en la idea de que "[a] una agenda de desarrollo sostenible exitosa requiere alianzas entre gobiernos, sector privado y sociedad civil". Este lenguaje de inclusión contrasta con el tono del Acelerador 4.

V. Conclusión

ALAIAB agradece la oportunidad de presentar estas observaciones y esperamos que se tenga en cuenta nuestra petición para asegurar que cualquier Plan de Acción Global (GAP) se desarrolle con la robusta participación de las partes interesadas y unas prácticas de gobernanza fuertes. Creemos que, con los procedimientos apropiados, podemos trabajar

conjuntamente para desarrollar un Plan de Acción Global que sea significativo, con acciones concretas y alcanzables.

Saludos Cordiales,



Mario Montero
Presidencia ALAIAB



ABIA/P-019/19

São Paulo, June 28, 2019

Honorable

WHO Secretariat

E-mail: SDG3_Secretariat@who.int

RE.: The Brazilian Food Industry Association Comments on the Global Plan Outline

The Brazilian Food Industry Association (ABIA) is pleased to submit its comments to the Global Action Plan for Healthy Lives and Well-being. We appreciate and support WHO's effort to align action among partners and more effectively support countries in achieving the health-related targets of the 2030 Agenda for Sustainable Development.

ABIA represents over 80% of the processed, pre-packaged food sector in Brazil, accounting for nearly 60% of demand for the country's agricultural production and 1,6 million jobs. We appreciate the recognition importance of multisectoral collaboration and leveraging shared gains across the SDGs.

Our commitments to prevent and treat NCDs

We would like to present the importance, feasibility and efficiency of voluntary initiatives that ABIA and its members had started in partnership with the Brazilian Government.

In order to develop a National Plan for Healthy Living that includes healthy eating, physical activity and nutritional education, a Technical Cooperation Agreement between the Ministry of Health of Brazil and ABIA was signed on November 29, 2007. In June 2017, this Agreement was renewed until 2022.

In 2008, ABIA attended the Pan American Health Organization/World Health Organization's International Conference on Trans Fatty Acids, whose goal it was to identify mechanisms that

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accelerate the process of eliminating trans fat in the Americas. ABIA joined as a signatory the “Trans Fat Free Americas” document that resulted from the conference, which establishes, among other recommendations, target values of trans fat in processed foods, oils and margarines. As a result of the efforts made by Brazilian industry, approximately 310,000 tons of trans fat were eliminated in this process (until 2016).

Regarding sodium reduction, according to a study entitled *Sodium Consumption Scenario in Brazil* conducted by ABIA and based on data by the Brazilian Institute of Geography and Statistics (IBGE), most of the large sodium intake in Brazil is due to table salt, which represents 59.7% of food consumed in households, 11.8% of food eaten out of home, and 4.7% of fresh food, totaling 76.2% of the sodium consumed by Brazilians.

Despite being responsible for only 23.8% of the sodium consumed by Brazilians, the food industry has entered into four agreements with the Ministry of Health to voluntarily reduce sodium in 35 food categories.

The agreements support the strategy developed by the Brazilian government to reduce salt consumption to less than 5 g salt (2 mg sodium) per person per day by 2020, by reducing the sodium content of priority categories of prepared and processed foods, according to WHO's goal.

The initiative by the Brazilian industry has already yielded positive results and has become an innovative action model in Latin America to reduce salt in processed foods. Considering the results of the four agreements that already have been monitored, results show that 17,254 tons of sodium have been removed from processed foods (until 2017).

ABIA have also started a voluntary process for the reduction of sugar in industrialized foods, which should be started soon, following the successful experience in reducing sodium.

Monitoring performed to date shows in what extent industry is committed to population health. They also demonstrate the efficiency of public-private partnerships for voluntarily reformulation and innovate products in line with public health goals.

Comments on the Global Action Plan Outline and on Accelerator Discussion Paper 4 and 1

We appreciate the GAP's intent to align the processes and workstreams of UN agencies and multilateral organizations and streamline collaboration with partners.

Furthermore, ABIA reiterates International Food & Beverages Alliance (IFBA)¹ comments, sent on June, 2019.

Sincerely,



João Dornellas

Executive President

¹ <https://www.abia.org.br/vsn/temp/z2019628IFBAPROGRESSREPORT.pdf>



June 26, 2019

VIA email to SDG3_Secretariat@who.int

Re: Global Action Plan for Healthy Lives and Well-being For All: Comments on the Draft Outline and Accelerator 4

Dear Sir or Madam:

The International Council of Beverages Associations (“ICBA”) is pleased to submit these comments regarding the proposed Global Action Plan for Healthy Lives and Well-being For All (the “Global Action Plan” or “GAP”). We appreciate and support that the intent of this Global Action Plan is to accelerate progress on UN Sustainable Development Goal 3, and as outlined below our industry is actively contributing to this Goal. We appreciate that the WHO Secretariat and related GAP working groups have undertaken a good amount of work in a short amount of time. However, in part due to the relative shortness of the timeframe, we have significant concerns regarding process, governance and substance, set forth below.

By way of background, ICBA is an international non-governmental organization established in 1995 that is the voice of the global non-alcoholic beverage industry. The members of ICBA include national and regional beverage associations as well as international beverage companies that operate in more than 200 countries and territories and produce, distribute, and sell a variety of non-alcoholic beverages. ICBA is a recognized observer at the Codex Alimentarius (“Codex”).¹

I. Executive Summary: Our Requests

For the reasons set forth below, ICBA makes the following requests:

- The WHO GAP Secretariat pause work and regroup to ensure that all appropriate governance mechanisms are in place, including robust consultation and engagement with Member States. Process mechanisms should not be rushed or ignored, especially given that the September deadline for an UNGA launch is self-imposed.
- The WHO GAP Secretariat please ensure that all language contained in the GAP and the Accelerators is aligned with the 2018 Political Declaration on NCDs and SDG 17. Currently that is not the case with Accelerator 4 and parts of Accelerator 1.

¹ For further information, please see www.icba-net.org.

- The WHO GAP Secretariat please ensure that the GAP does not stray into areas of policymaking, as that is the prerogative of Member States. The GAP should not promote policy recommendations that have not been approved by Member States, or that have not been considered by Member States.

We note that these governance concerns have arisen due to the published content of the work to date, which indicates that this GAP is far more of a vehicle for controversial policy recommendations, particularly as it relates to the private sector, than had been described at the outset. If this GAP had truly remained as an “internal alignment exercise” among UN agencies, then we would withdraw our process concerns. However, the content developed to date goes far beyond an alignment exercise, and accordingly enters the space where we would encourage Member State review. These Accelerators are ultimately intended for implementation by the Member States. We note – and hope – that the content areas of our concern (specifically Accelerator 4 and Accelerator 1) can be adjusted in a manner that allows a productive path forward for all stakeholders.

II. This GAP Would Benefit From More Robust Governance and Stakeholder Engagement

A. ICBA Requests that the Secretariat Elevate the GAP to the Relevant Governing Bodies

ICBA is reiterating its request made to the GAP Secretariat on 15 May 2019 that this GAP be elevated to WHO’s governing bodies for appropriately broad and thorough review in keeping with WHO governance procedures. ICBA appreciates that the WHO Secretariat has opened a short consultation period on the GAP. Nonetheless, we believe that this exercise – which is the first online consultation on the GAP-- is best viewed as a starting point for stakeholder engagement. The WHO GAP Secretariat has reiterated its intent to launch the Final Plan at UNGA this September. Yet we are more than halfway through June, and we have only been provided with the written *outline* of a global action plan. We accordingly request that the WHO Secretariat pause work on the GAP until it undertakes a review of process and procedures to ensure fulsome stakeholder engagement on all elements of the GAP, not just an outline, is planned for the near future.

Furthermore, as is explained further below in Sections III-V, we believe that the work product developed to date contains policy recommendations that go beyond what Member States have considered, and in some cases resurrects policy recommendations that Member States have explicitly rejected. We note that in response to the question “how and when will governing bodies be involved?,” WHO’s FAQ website states that

“In case recommended actions should require a change of policies, these suggested changes would be brought to the attention of the relevant governing bodies and discussion can occur where relevant and according to the procedures of the different governing bodies involved.”²

While we understand that this GAP was intended to be an internal alignment exercise for UN agencies and other global health organizations, the work published in Accelerator 4 and Accelerator 1, as

² See WHO’s FAQ on the Global Action Plan: <https://www.who.int/sdg/global-action-plan/frequently-asked-questions#question9>

detailed in Sections III, IV and V below reflects an effort to use the GAP as a vehicle for new policy recommendations intended for implementation by Member States. Therefore in accordance with the process described in WHO's FAQ website above, we believe that discussion should occur with WHO's governing bodies through the appropriate process, including placement on the 2020 Executive Board and 2020 World Health Assembly agendas until and if such time it can be adopted by a Member State resolution. We would encourage the WHO GAP Secretariat to continue to find opportunities for stakeholder engagement, including potential side events at the UN General Assembly in order to further dialogue on draft Plans. However, the notion that a Final Plan should be presented at the UN General Assembly without having undergone broad, thorough and significant Member State review is from our perspective an unfortunate short-circuiting of good governance and process on a critical issue.

B. The Communication to Date on the Global Action Plan Is Not In Keeping With Past Practices for Global Action Plans.

The communication with all stakeholders, including civil society, private sector and Member States to date has not been extensive:

- A one-day civil society consultation, during which questions about purpose and process were raised by a number of participants.
- A two-hour technical briefing offered by WHO on Member States, with very limited time for floor interventions and participant questions.
- This less than two-week consultation exercise, which is being held only three months before the planned launch of the Global Action Plan at the UN General Assembly in September 2019. Notably, a draft of the GAP itself still has not been released, only an outline.

Furthermore, this GAP has been absent from the agenda during key WHO meetings including the 2019 Executive Board and World Health Assembly. There is no indication that WHO or any of the global health organizations listed as joining the GAP plan to conduct regional consultations on the contents of the GAP prior to the UNGA launch, hold separate consultations for Member States, share drafts with Members of their executive boards, or seek to have the GAP formally adopted via resolution at the World Health Assembly (or like meetings). This stands in significant contrast to the consultation process for the 2013-2020 Global Action Plan on NCDs, which held by our count 15 consultations, published multiple draft plans, and was included by WHO on both the WHA and WHO Executive Committee agendas, and ultimately formally adopted by Member State resolution. The consultative process for the NCD Global Action Plan was so extensive and viewed as so important that it has been preserved in detail on WHO's website.³

The WHO GAP Secretariat has taken the position that this Global Action Plan differs from previous Global Action Plans because it is simply an "internal alignment exercise" among UN agencies. If that were the case—and this GAP stayed strictly within the realm of internal alignment exercise—then ICBA would gladly withdraw its objections to the process. However, the purpose and intent of this GAP is at this point not clearly defined, and the materials published to date move solidly into the

³ https://www.who.int/nmh/events/2013/consultation_process/en/

realm of policymaking with Member States ultimately responsible for implementation of recommendations. Which ultimately means it is most appropriate to treat this GAP as any other Global Action Plan – serious and deserving of Member State review and approval.

C. WHO's Governing Bodies are Best Placed to Lead Member State Engagement on This Global Action Plan.

We believe that it is most appropriate for WHO's governing bodies to be engaged with this process:

- The April 2018 letter from the Heads of State of Germany, Ghana and Norway was directed to the Director General of WHO and requested that WHO lead the development of this GAP.
- WHO serves as the Secretariat of the GAP. In this function it hosts all information related to the GAP on its website, it operates this consultation period, is presumably using funds from WHO's budget to oversee and develop the GAP, and most importantly has oversight and coordination responsibility related to the GAP.

Therefore, we believe that given the leadership role that WHO is fulfilling regarding this GAP, it must be WHO's governing bodies with whom the agency should appropriately consult – not just inform – as it proceeds with the development. To the extent other UN agencies would have a governing interest in the GAP, ICBA would have no objection to their inclusion in the process as well, as we believe robust consultation can drive forward meaningful consensus. We would, however, object to any assertions that the governance process should be short-circuited simply because the number of UN agencies involved makes it challenging to do so. When a GAP moves into the realm of policymaking, it should not be able to circumvent Member State governance in doing so – such an action would set a troubling precedent. Again, we would note that this governance challenge arises because the GAP has shifted its focus from simply being an internal alignment exercise to one that seeks to drive new or unproven or even previously Member State rejected policies intended for implementation by Member States.

III. Comment on Accelerator 4 and Accelerator 1: Certain Content Is Inconsistent with the UN High-Level Meeting on NCDs Political Declaration, Adopted by the UN General Assembly.

The Accelerators are ultimately intended for implementation by Member States in order to drive progress on Sustainable Development Goal 3. While this is a laudable goal, we question why they are proceeding without acknowledgment of or reliance on the UN High-Level Meeting on NCDs ("HLM") and its accompanying Political Declaration. This HLM, which was held less than one year ago and was the culmination of months, if not years, of work, resulted in a roadmap for accelerating progress on NCDs – the Political Declaration – wherein Heads of State committed to thirteen new steps to tackle NCDs. The Director-General of WHO applauded world leaders for taking "a set of landmark steps to beat NCDs.... These add up to a historic opportunity to promote health, save lives, and grow economies."⁴ It is therefore unclear why the WHO and related UN agencies have undertaken

⁴ See WHO Media Statement on HLM: <https://www.who.int/news-room/detail/27-09-2018-heads-of-state-commit-to-lead-response-to-beat-noncommunicable-diseases-promote-mental-health>

a separate, independent effort to develop guidance for UN agencies and Member States on how to accelerate progress on NCDs. Nor is it clear why the WHO has deemed it appropriate to launch this independent effort at the UN General Assembly only one year after the HLM.

Specifically, we would note that both Accelerator 4 (Determinants of Health) and Accelerator 1 (Sustainable Financing) include policy recommendations that were considered and rejected during Member State negotiations for the HLM:

- The phrase “commercial determinants of health” (found in Accelerator 4) has been specifically excluded from Member State negotiated texts and has never been officially debated within a WHO or UN context, and as a result there is no Member State consensus on that term. It is a matter of concern that UN agencies should be asked to address something that is unspecified and undefined by Member States.
- Accelerator 1 and Accelerator 4 explicitly encourages Member States to adopt sugar beverage taxation, which remains a controversial idea among Member States and was accordingly considered and explicitly rejected during Member State negotiations over the Political Declaration. Of note, sugar-sweetened beverage taxation was purposefully excluded from the WHO Independent High-Level Commission on NCDs landmark report “Time to Deliver,” it is not a WHO “Best Buy” NCD intervention, and by WHO’s own CHOICE analysis it did not yield positive health outcomes.

IV. Comment on Accelerator 4: The Overall Tone is Inconsistent with Sustainable Development Goal 17, “Partnership for the Goals.”

We find the tone of Accelerator 4 toward the private sector to be discouraging and not aligned with the UN Sustainable Development Goal 17 around partnerships for the goals (“SDG 17”). While we appreciate that some language has been added to reference public-private partnerships as important to SDG17, the overall approach toward the private sector remains unwelcoming to this goal. This Accelerator refers to the private sector as “health harming” and references “pervasive industry interference” in policymaking, rather than recognizing that the private sector is a legitimate stakeholder. As an example of “pervasive industry interference” in policymaking, Accelerator 4 makes the case that the food industry’s advertising budget is evidence of “industry interference” in policymaking to “win” public opinion. In other words, there is no reflection that 1) the private sector is an appropriate stakeholder in policymaking; and 2) marketing of products is not *prima facie* a bad act.

SDG 17 is founded upon that notion that “[a] successful sustainable development agenda requires partnerships between governments, the private sector and civil society.” This language – inclusive and encouraging—remains in distinct contrast to the tone of Accelerator 4.

V. Comment on Accelerator 4: It Raises New Policy Issues that Has Not Been Considered by the Appropriate Governing Bodies.

Some of the content in Accelerator 4 moves into the area of new policies that have not yet had an opportunity for consideration by WHO’s governing bodies, focusing on determinants of health related to climate change, enforcing regulations related to reducing carbon emissions, fossil fuel use and agriculture generally. While Accelerator 4 restrains from offering specific policy recommendations in these areas, it is raising new policy issues that would benefit from Member State input prior to final

practices. We believe that with the appropriate processes in place, all stakeholders can work collaboratively to develop a Global Action Plan which is meaningful, actionable, and achievable.

Respectfully submitted,

Katherine W. Loatman
Executive Director

28 June 2019



Dear Sir or Madam:

The International Food and Beverage Alliance (IFBA) is pleased to provide feedback on the proposed Global Action Plan for Healthy Lives and Well-being for All (the “Global Action Plan,” or “GAP”). IFBA is an international non-governmental organisation established in 2008 by the CEOs of leading food and non-alcoholic beverage companies to empower consumers to eat balanced diets and live healthier lives, in support of the World Health Organisation’s efforts to improve global public health.

A belief in the power of partnership is one of the fundamental principles underpinning the work of the International Food & Beverage Alliance, and we appreciate and support this effort to align action among partners and accelerate progress on UN Sustainable Development Goal 3. On behalf of IFBA, I would like to share the following comments:

Comments on the Global Action Plan Outline and Plan Development:

We appreciate the GAP’s intent to align the processes and workstreams of UN agencies and multilateral organisations and streamline collaboration with partners. The draft outline published, along with the revised Accelerators, appear to reach beyond this effort to include policy recommendations intended for implementation by Member States. If the final version of the Global Action Plan will include policy recommendations, it is important that Member States – who are ultimately responsible for the implementation of these recommendations within their own national contexts – should have ample opportunity for review and approval, as they would with any other Global Action Plan.

The development of the GAP has failed to include and acknowledge language adopted by the Member States composing the UN and the signatory agencies, including the 2018 Political Declaration on the UN High-level Meeting on NCDs. Upon adoption of that Political Declaration, the WHO Director General applauded Member States’ efforts and called it a “historic opportunity to promote health, save lives and grow economies.” That Political Declaration represents the latest Member States consensus on how to accelerate progress on NCDs. Its vision is not reflected in the current GAP, as submitted for consultation.

For these reasons and those set forth below, IFBA makes the following comments:

- The GAP Secretariat should ensure that all language contained in the GAP is aligned with the multistakeholder partnership vision of the 2030 Agenda
- The GAP’s purpose of streamlining collaboration among health-related International and Multilateral Organisations should not be undermined by also introducing policy recommendations for Member States that do not reflect the latest global political consensus.

We invite the GAP Secretariat to revisit the discussion papers on Accelerator 4 and Accelerator 1, by focusing on aligning multistakeholder partnership to achieve the health-related goals of the 2030 Agenda. Our comments on these specific sections follow.

Comments on Accelerator Discussion Paper 4, “Determinants of Health” and Accelerator Discussion Paper 1, “Sustainable Financing”:

Multistakeholder partnerships are critical to achieving the transformative change called for in the 2030 Agenda, yet Accelerator Discussion Paper 4 currently employs language that is inconsistent with Sustainable Development Goal 17 around partnerships for the goals (“SDG 17”) and the UN HLM Political Declaration on NCDs.

While we appreciate the added reference to public-private partnerships and their importance to SDG 17 in this draft, the discussion paper generally takes a narrow and negative approach toward the private sector which is at odds with directives from the signatory agencies’ leadership. The Director General of WHO, to take one of the 12 signatory agencies, has repeatedly affirmed the importance of partnerships in achieving the SDGs, yet the paper arbitrarily labels certain industries as “health-harming” and targets “pervasive industry interference” rather than recognizing the private sector as a legitimate stakeholder. The paper also refers to the food industry’s advertising budget as evidence of “pervasive industry interference” in policymaking to “win” public opinion. Language inspiring the final GAP should reflect that the private sector is an important stakeholder, and that marketing of products does not equate to any kind of contribution to policymaking.

Collaboration with industry, as was recently demonstrated when IFBA announced its support for the WHO package on industrial trans-fat elimination, can deliver public health benefits. Failing to include public-private partnerships as a key component of a whole-of-society approach is a missed opportunity, and language chosen from this discussion paper for inclusion in the GAP should align with the multistakeholder partnership vision of the 2030 Agenda.

Accelerator Discussion Papers 1 and 4 include policy recommendations generated with minimal consultation from Member States, which feature language considered and rejected during Member State negotiations for the High-level Meeting on Non-communicable Diseases, such as:

- Accelerator 4 and Accelerator 1 explicitly encourage Member States to adopt taxes on sugar sweetened beverages, which remains a controversial topic among Member States and was accordingly rejected during Member State negotiations over the Political Declaration on NCDs.
- There is no Member State consensus for the term “commercial determinants of health,” (found in Accelerator 4), which has been specifically excluded from Member State negotiated texts due to its ill-defined, negative connotations towards the private sector.

Accelerator 4 also includes new policy suggestions and recommendations that have not been considered by the signatory agencies’ governing bodies, such as determinants of health related to climate change, enforcing regulations related to reducing carbon emissions, fossil fuel use, and agriculture generally. These and other raised policy issues would benefit from Member State input before their final adoption. The GAP purpose of streamlining collaboration among health-related International Organisations should not be disrupted by also introducing policy recommendations for Member States.

Thank you for the opportunity to submit these comments. We recognize the responsibility business has to contribute to global health, and we are committed to working in partnership with the signatory agencies and a wide range of stakeholders to seek collaborative solutions. We hope you will consider our comments and ensure that the Global Action Plan aligns with the multistakeholder partnership vision of the 2030 Agenda and effectively streamlines partnership to best achieve health and well-being for all.

Sincerely,

Rocco Renaldi, IFBA Secretary General

**J&J Global Public Health Input on
WHO Global Action Plan for Healthy Lives and Well-being**

Accelerator Discussion Paper 1: Sustainable Financing

- Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?
 - In the paragraph on p. 3 entitled “A lack of investment in public goods,” please consider adding “antimicrobial resistance” and “global health security” to the list of “common goods” for which “donors and governments of LICs and MICs need more incentives to invest in”
- Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?
 - While UHC is an important, unifying goal, there is no one-size-fits-all approach to how UHC is financed and delivered through government, non-profit or private-sector channels. Rather, each country must tailor strategies that align to local needs, resources, market conditions and societal values. UHC can be established through a variety of models and systems, but all require sustainable financing for both providers and patients. Financing considerations should account for the full complexity of the healthcare system, rather than addressing specific issues in isolation. We support investments in value-based care that ensure patients and health systems are spending their money on effective solutions.
 - Page 9 says “Parallel and pooled funding, such as multi-donor funds, will be expanded to guarantee a critical mass of financial support to key country priorities.” The Global Fund replenishment is a key example here.
- Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?
 - Page 4 says “Discussions between external partners must be at the country level and should facilitate engagement with civil society, along with relevant stakeholders from the private sector.” – The Access Accelerated initiative, of which J&J is a member, is one initiative supporting this type of multi-stakeholder coordination at the country level.

Accelerator Discussion Paper 5: Research & Development (R&D), Innovation, and Access

- Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?
 - In the country-led forums described on pages 5 and 6, please consider including the private sector, for its expertise and contributions on R&D, innovation, and access.
 - Regarding Action 3 on page 7, consider embracing horizon scanning so we can plan – well in advance – for the entry of innovative and disruptive technologies, such as long-acting injectable medicines, including by partnering early on care pathway redesign to minimize delays.
 - Regarding Table A on pages 10-11, consider adding for SDG 3.3., scaling up access to recommended, evidence-based treatments for AIDS; TB, including DR-TB; malaria; and neglected tropical diseases.

- Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?
 - The proposed actions do not appear to focus on operational research. Unique challenges in resource-limited settings require that we embrace operational research in real-world settings to generate the meaningful evidence, data and insights needed to inform guidelines and best practice adoption as early as possible.
 - Goal 5 references pull mechanisms in R&D pipelines. The global pipeline for new global health products is not sufficient, notably in antimicrobial resistance (AMR), including TB. In some cases, this may be due to scientific barriers that can be broken down with additional investments in basic research, though the range of resistant pathogens is very large and constantly changing, which requires a diverse body of research. In most areas though, incentive models do not align with the unique AMR marketplace, where product use must be carefully stewarded and targeted to the right patients to prevent the development of further resistance. As there is no one-size-fits-all approach to this challenge, we support a basket of incentive programs designed to spur additional at-risk investment in AMR development. With few exceptions, the lack of such investment to date has directly contributed to the AMR crisis we see today. We applaud the various “push” mechanisms, such as Biomedical Advanced Research and Development Authority’s CARB-X, set up to encourage innovation in this area. We see opportunity for further use of “pull” and market-based incentives such as priority review vouchers, transferable exclusivity vouchers, market entry rewards, and pre-proposals for special procurement mechanisms or health technology assessments that address the complexity and unique nature of the AMR marketplace. Regardless of the additional incentive models that may be pursued, it is important to maintain existing regulatory exclusivities and intellectual property protections for companies that bring innovations to the market. As we have experienced with SIRTURO, these protections are a key element of any comprehensive strategy to stimulate innovation and access to new treatments.
- Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?
 - Johnson & Johnson Global Public Health collaborates with global, public and private sector organizations to expand access to care and services to improve global health.
 - As one example, following the 2014 Ebola outbreak, the global community developed an R&D blueprint and established the Coalition for Epidemic Preparedness Innovations (CEPI), which is now advancing the development of new platforms and technologies to tackle the most imminent pandemic threats. There is incredible emerging science, for example in tuberculosis, but we need a coordinated action plan to incentivize and catalyze R&D to develop the tools needed to accelerate progress. And we need to match that innovation in science with innovation in delivery so that new tools begin reaching patients as soon as they are available.



**International Alliance for Responsible Drinking (IARD)
Public Comment on Global Action Plan for Healthy Lives and Well-being**

24 June 2019

Via email to SDG3_Secretariat@who.int

Subject: Global Action Plan for Healthy Lives and Well-being: General Comments on the Draft Outline and Accelerators 1 & 4

Dear Sir / Madam,

The [International Alliance for Responsible Drinking \(IARD\)](#) welcomes the opportunity to submit more substantive comments on the draft outline of the Global Action Plan for Healthy Lives and Well-being (Global Action Plan), including Accelerator 4; *Determinants of Health*. These comments build on those submitted by IARD on 16 May on the Consultation with Non-State Actors.

About IARD:

IARD is a not-for-profit organization, supported by the leading beer, wine, and spirits producers¹. IARD is dedicated to addressing harmful drinking worldwide and promoting responsible drinking among those who choose to drink. IARD is the only convener of the CEOs of these leading global companies, for the sole purpose and shared objective of reducing the harmful use of alcohol. IARD acknowledges the role of harmful drinking as a risk factor for some non-communicable diseases (NCDs), and, in line with the UN and WHO's 'whole of society' approach, we believe that our sector has an important role to play in improving health.

General Comments:

- Overall, we welcome the initiative by the Governments of Germany, Norway and Ghana and support the aim of the Global Action Plan and its Accelerators to further progress towards the health-related SDGs. We believe that gaining broad multi-stakeholder input through this consultation is essential for building a realistic, cohesive and deliverable approach to tackling NCDs and improving health.
- We value existing UN and WHO policies that are Member State approved and emphasize a 'whole of society' approach to improving health, recognizing the contribution of the private sector and not excluding it from its important role in improving health, and we urge the Global Action Plan to be aligned accordingly.
- However, we maintain some concerns raised in our previous comments, primarily around the process by which the Global Action Plan is being developed and specific language not being consistent with official WHO / UN policy previously approved by Member States, included in the current draft outline. In our view, these issues risk undermining both the credibility, effectiveness and stakeholder buy-in to the Action Plan as UN agencies and MS look to implement its recommendations in the future.

¹ A full list of IARD members is available here: <http://www.iard.org/welcome-to-iard/members-affiliations/>



Specific Comments Regarding Accelerator 1:

1. **We urge that any emphasis placed on taxation of alcohol to raise revenue (Accelerator 1) appropriately recognizes previous Member State approved policies that emphasize the importance of national context when implementing fiscal measures.** Furthermore, we suggest that the Global Action Plan recognize that reducing *harmful use* of alcohol is the Member-State mandated focus, consistent with WHO's Global Alcohol Strategy, the Global Action Plan on NCDs, and the recently adopted UN PD on NCDs, and not reducing consumption per se. Whilst taxation of alcohol beverages should be part of a comprehensive fiscal and regulatory framework, proportionate, appropriate for each local context, and consistent with World Trade Organization principles, it should also neither create market distortions nor exacerbate issues of harmful consumption. High levels of taxation may lead to unintended consequences, including growth in the unrecorded and illegal markets. Other potential outcomes may include tax evasion and corruption, illicit trade, and a resulting loss, rather than an increase, in government revenue.²

Specific Comments Regarding Accelerator 4:

1. **In addition to alignment with the UN PD on NCDs, we would urge that the development of the Global Action Plan complement, and not contradict, SDG 17 on strengthening partnerships and the 'whole of society' approach adopted by UN and WHO Member States, that includes the private sector.** These constructive Member State approved policies recognize the important and positive role the private sector has to play in improving health. We strongly agree that the private sector can and should do more to contribute, through its unique expertise, innovation and resources, to tackle NCDs, improve health and further sustainable development objectives.
2. **Therefore, we urge the removal of language in the current draft outline of the Global Action Plan (notably in Accelerator 4) that goes against the spirit of the inclusive approach of the above mentioned UN/WHO policies around inclusion of the private sector.** This language is not in line with official UN policy previously approved by Member States and risks undermining the intergovernmental nature of some of the agencies concerned and multi-stakeholder solutions to improve health as called for by UN MS . Specifically, Accelerator 4 on the '*commercial determinants of health*' goes much beyond MS approved language in previous WHO action plans, the SDGs, or the 2018 UN PD on NCDs. Furthermore, phrases that broadly characterize private sector practices as "health harming", or make non-specific references to "pervasive industry interference" in policymaking, are divisive and counterproductive as the UN, WHO and Member States seek to build holistic whole of society approaches to improve health.
3. **We share the important concerns raised by some Member States at the World Health Assembly (WHA) about the lack of Member State consultation on the Global Action Plan and resulting risk to its credibility, and questions about transparency.** Asking Member States to implement actions or policies they have not previously reviewed and approved may raise serious questions regarding

² IARD, Statement on Taxation as a Policy Lever to Reduce Harmful Drinking (fully referenced)
<http://www.iard.org/wp-content/uploads/2017/12/IARD-taxation-statement.pdf>



governance precedence around the development of the Action Plan. Further, we believe it may undermine its credibility, adoption and implementation in the future. To this end, **we agree with the suggestions made by some Member States at the 2019 WHA that if the Global Action Plan is not submitted to a full and rigorous Member State review then it should be re-named to indicate that it is a document that has neither been requested nor formally approved by UN / WHO governing bodies.**

4. **Finally, we propose further meaningful consultation with private sector stakeholders in the development of the Global Action Plan.** Whilst we welcome this opportunity to comment in more detail, we note that stakeholders have only a 'draft outline' and set of 'discussion papers' to comment on, rather than any clear sense of the likely direction of the final Global Action Plan. We are convinced that a more meaningful opportunity for private sector input at a later stage of the Global Action Plan's development, would be invaluable for highlighting the value the private sector can bring to SDG achievement, and generate inter-sectoral trust needed to make progress on the goals we all share.

Thank you for the opportunity to share our views, and we encourage broad, transparent stakeholder engagement throughout this process and similar endeavors going forward.

Respectfully,

IARD

IFPMA feedback in response to: [Invitation for public comment: Global Action Plan for Healthy Lives and Well-being](#)

The International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), representing the global biopharmaceutical industry, welcomes and appreciates the opportunity to provide input on the Global Action Plan for Healthy Lives and Well-being and the associated Accelerator Discussion Papers. We support the overall proposed vision of accelerating progress towards the attainment of SDG3 targets by 2030, and the need for multi-stakeholder collaboration in order to succeed. We support the GAP signatory agencies in their efforts and look forward to future consultations.

We believe the biopharmaceutical industry has a significant role to play in advancing the SDG3 GAP and in working towards UHC. Noting this, we are encouraged by, and appreciative of, the inclusive mention of the private sector in the Accelerator Discussion Paper 2 on Primary Health Care as a stakeholder in national and sub-national coordination platforms, while also noting the acknowledgement of the heterogeneity of the broader private sector as put forward by Accelerator Discussion Paper 4. Noting the crucial role the biopharmaceutical industry plays in innovation, we also strongly advocate for its inclusion as a stakeholder in the country-led forums to accelerate research and scaling of innovation, which are noted in Accelerator Discussion Paper 5, and in any other GAP platforms and mechanisms which will require a concerted, multi-stakeholder approach in order to be successful.

Comments on the Papers**Accelerator Discussion Paper 1: Sustainable Financing**

- With respect to the sustainable financing paper, it is encouraging that the paper acknowledges the need for a holistic, multi-stakeholder approach to achieve SDG3 targets and notes the need to increase government spending on health.
- In addition to increased spending, the need to drive further efficiencies in spending is noted (with reference to strategic purchasing reforms as well as institutionalizing HTA). There will likely be the need to monitor how efforts related to HTA and value assessment develop and are prioritized amongst countries. The focus on efficiencies could provide an opportunity to not only explore expanding the role of insurance, but also opportunities to create further efficiencies in the health system as a whole (e.g., greater focus on prevention, primary care, etc.).
- While UHC is an important, unifying goal, there is no one-size-fits-all approach to how UHC is financed and delivered through government, non-profit or private-sector channels. Rather, each country must tailor strategies that align to local needs, resources, market conditions and societal values. UHC can be established through a variety of models and systems, but all require sustainable financing for both providers and patients. Financing considerations should account for the full complexity of the healthcare system, rather than addressing specific issues in isolation. We support investments in value-based care that ensure patients and health systems are spending their money on effective solutions.

- The need to expand policy dialogue beyond Ministries of Health—e.g., to include Ministries of Finance is explicitly noted, which will be important in advancing dialogue with governments beyond historically siloed approaches.

Accelerator Discussion Paper 4: Determinants of Health

- We welcome the Accelerator Discussion Paper 4 on determinants of health, and agree that while determinants is not a new agenda, it is clear that they are both wide-ranging and have received a disproportionately low level of attention to date. This is concerning given the interaction of social, commercial, environmental and structural determinants with health and well-being, and vice versa.
- We are encouraged to see that the section on commercial determinants acknowledges that the private sector is highly heterogeneous and that there are many private sector actors which are significantly supporting efforts to positively enhance health and well-being.
 - At the same time, the focus on the role of the “health-harming” private sector is understood and would appear to be the main crux of what we consider to be “commercial determinants”. In this context, the inclusion of “strengthening legal, policy and regulatory frameworks for increasing access to affordable medicines, services and health technologies” in Table 1 on the “potential areas of joint action by GHOs” seems somewhat incongruent, given that the rest of the joint actions are understandably related to addressing the negative externalities brought about by various determinants of health.
 - The other joint actions within the section on commercial determinants are designed to address determinants such as climate change and “health-harming” products such as tobacco and alcohol, and so the joint action point on access to medicines could be perceived as wrongly portraying sectors which produce health-enhancing products and services as being problematic.

Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access

- The proposed actions do not appear to focus on operational research. Unique challenges in resource-limited settings require that we embrace operational research in real-world settings to generate the meaningful evidence, data and insights needed to inform guidelines and best practice adoption as early as possible.
- In relation to *Action 2 (page 5)* and the reference to the *creation of new country-led forums (or supporting existing ones) to accelerate research, access and the scaling of innovations in support of the health-related SDGs*, we strongly advocate for the inclusion of the private sector in any mechanism/forum that relates to discussions and consultations on research, access, and the scaling of innovations.
 - The private sector is responsible for the majority of global innovation, and delivers significant expertise and contributions in R&D, innovation, and access. As such, sustainable solutions to support the attainment of health-related SDGs will not be possible without the involvement of private sector in these discussions.

- In relation to *Action 3 (page 7)*, horizon scanning could be a valuable tool in ensuring the entry of innovative health-related technologies and products onto the market can be reflected in the timely design of care pathways.

Accelerator Discussion Paper 6: Data and Digital Health

- **Comment on Joint Action 1: Commit to principles for data and digital health**
 - **Open standards, open source and open innovation:** The biopharmaceutical industry, in contrast to many others, requires detailed mechanisms in order to apply the open source and open innovation principles. However, the paper does not address: (i) what kind of “data” will be considered as open data, (ii) which stakeholders are interested in investing in open source initiatives and (iii) the possible ways the aforementioned mechanisms can be implemented. These aspects are crucial to consider for further discussions in this field.
 - **Open data with confidentiality safeguards – de-identified health data:** The paper does not specify the “de-identified” data definition. Thus, it is important to clarify whether the “de-identified” data refer to pseudonymized, and not anonymized data. In contrast to anonymized, pseudonymized information, as aggregated and non-identifiable, can be leveraged for medical product development and thus the needs of patients. Moreover, the paper does not state which stakeholders (private, public or both) would be required to make the de-identified data publicly available.
- **Comment on Joint Action 3: Assess gaps in data and health information systems and digital health maturity**
 - It is important to analyze the digital initiatives that the EMA and the FDA are currently working and leading on; especially in order to align in the multilateral fora with best practices and develop a unified approach in this highly heterogeneous digital field. Certain core principles, maturity criteria and focus of digital health mechanisms could be, for instance:
 - Privacy rules, harmonized and research-friendly approach of data use: secondary use of research data, pseudonymization as a safeguard for re-use, cross-border data transfer;
 - Digital data use, such as clinical trial data collection by electronic means;
 - Harmonized health data use: national standards for data capture and exchange, access to electronic health records;
 - RWE: work on acceptance of RWE, standards and guidelines

I. Executive Summary: Our Requests

For the reasons set forth below, USCIB makes the following requests:

- The WHO GAP Secretariat pause work to ensure that all appropriate governance mechanisms are in place, including robust consultation and engagement with Member States. Process mechanisms should not be rushed or ignored simply to meet a self-imposed deadline of September/UNGA rollout.
- The WHO GAP Secretariat should ensure that all language contained in the GAP and the Accelerators is aligned with the 2018 Political Declaration on NCDs and SDG 17. Currently that is not the case with Accelerator 4 and parts of Accelerator 1.
- The WHO GAP Secretariat should ensure that the GAP does not stray into areas of policymaking, as that is the prerogative of Member States. The GAP should not promote policy recommendations that have not been approved by Member States, or that have not been considered by Member States.

We note that these governance concerns have arisen due to the published content of the work to date, which indicates that this GAP is far more of a vehicle for controversial policy recommendations, particularly as it relates to the private sector, than had been described at the outset. If this GAP had truly remained as an “internal alignment exercise” among UN agencies, then we would withdraw our process concerns. However, the content developed to date goes far beyond an alignment exercise, and accordingly enters the space where Member State review is warranted.

II. This GAP Requires More Robust Governance and Stakeholder Engagement

A. USCIB Requests that the Secretariat Elevate the GAP to the Relevant Governing Bodies

USCIB requests that this GAP be elevated to WHO’s governing bodies for appropriately broad and thorough review in keeping with WHO governance procedures. USCIB appreciates that the WHO Secretariat has opened a short consultation period on the GAP. Nonetheless, we believe that this exercise – which is the first online consultation on the GAP-- is best viewed as a starting point for stakeholder engagement. The WHO GAP Secretariat has reiterated its intent to launch the Final Plan at UNGA this September. Yet we are more than halfway through June, and we have only been provided with the sparsely written outline of a global action plan. This suggests that the process is being rushed at the expense of an artificial deadline. We accordingly request that the WHO Secretariat pause work on the GAP until it undertakes a review of process and procedures to ensure fulsome stakeholder engagement on all elements of the GAP, not just an outline, is planned for the near future.

Furthermore, as is explained further below in Sections III-V, we believe that the work product developed to date contains policy recommendations that go beyond what Member States have considered, and in some cases resurrects policy recommendations that Member States have explicitly rejected. We note that in response to the question “how and when will governing bodies be involved?,” WHO’s FAQ website states that

"In case recommended actions should require a change of policies, these suggested changes would be brought to the attention of the relevant governing bodies and discussion can occur where relevant and according to the procedures of the different governing bodies involved."¹

While we understand that this GAP was intended to be an internal alignment exercise for UN agencies and other global health organizations, the work published in Accelerator 4 and Accelerator 1, as detailed in Sections III, IV and V below reflects an effort to use the GAP as a vehicle for new policy recommendations intended for implementation by Member States. Therefore in accordance with the process described in WHO's FAQ website above, we believe that discussion should occur with WHO's governing bodies through the appropriate process, including placement on the 2020 Executive Board and 2020 World Health Assembly agendas until and if such time it can be adopted by a Member State resolution. We would encourage the WHO GAP Secretariat to continue to find opportunities for stakeholder engagement, including potential side events at the UN General Assembly in order to further dialogue on draft Plans. However, the notion that a Final Plan should be presented at the UN General Assembly without having undergone broad, thorough and significant Member State review is from our perspective an unfortunate short-circuiting of good governance and process on a critical issue.

B. The Communication to Date on the Global Action Plan Has Been Insufficient And Is Not In Keeping With Past Practices for Global Action Plans.

The communication with all stakeholders, including civil society, private sector and Member States to date has not been extensive:

- A one-day civil society consultation, during which questions about purpose and process were raised by participants. Notably a draft of the GAP itself had not been released at this time.
- A two-hour technical briefing offered by WHO on Member States, with very limited time for floor interventions and participant questions. Notably a draft of the GAP itself had not been released at this time.
- This less than two-week consultation exercise, which is being held only three months before the planned launch of the Global Action Plan at the UN General Assembly in September 2019. Notably, a draft of the GAP itself still has not been released, only an outline.

Furthermore, this GAP has been absent from the agenda during key WHO meetings including the 2019 Executive Board and World Health Assembly. There is no indication that WHO or any of the global health organizations listed as joining the GAP plan to conduct regional consultations on the contents of the GAP prior to the UNGA launch, hold separate consultations for Member States, share drafts with Members of their executive boards, or seek to have the GAP formally adopted via resolution at the World Health Assembly (or like meetings). This stands in significant contrast to the consultation process for the 2013-2020 Global Action Plan on NCDs, which held by our count 15 consultations, published multiple draft plans, and was included by WHO on both the WHA and WHO Executive Committee agendas, and ultimately formally adopted by Member State resolution.

¹ See WHO's FAQ on the Global Action Plan: <https://www.who.int/sdg/global-action-plan/frequently-asked-questions#question9>

The consultative process for the NCD Global Action Plan was so extensive and viewed as so important that it has been preserved in detail on WHO's website.²

The WHO GAP Secretariat has taken the position that this Global Action Plan differs from previous Global Action Plans because it is simply an "internal alignment exercise" among UN agencies. If that were the case—and this GAP stayed strictly within the realm of internal alignment exercise—then USCIB would withdraw its objections to the process. However, the purpose and intent of this GAP is at this point not clearly defined, and the materials published to date move solidly into the realm of policymaking. Which ultimately means it is most appropriate to treat this GAP as any other Global Action Plan – serious and deserving of Member State review and approval.

C. WHO's Governing Bodies are Best Placed to Lead Member State Engagement on This Global Action Plan.

We believe that it at a minimum, it must be WHO's governing bodies who are engaged with this process:

- The April 2018 letter from the Heads of State of Germany, Ghana and Norway was directed to the Director General of WHO and requested that WHO lead the development of this GAP.
- WHO serves as the Secretariat of the GAP. In this function it hosts all information related to the GAP on its website, it operates this consultation period, is presumably using funds from WHO's budget to oversee and develop the GAP, and most importantly has oversight and coordination responsibility related to the GAP.

Therefore, we believe that given the leadership role that WHO is fulfilling regarding this GAP, it must be WHO's governing bodies with whom the agency should appropriately consult – not just inform – as it proceeds with the development. To the extent other UN agencies would have a governing interest in the GAP, USCIB would have no objection to their inclusion in the process as well, as we believe robust consultation can drive forward meaningful consensus. We would, however, object to any assertions that the governance process should be short-circuited simply because the number of UN agencies involved makes it challenging to do so. When a GAP moves into the realm of policymaking, it should not be able to circumvent Member State governance in doing so – such an action would set a troubling precedent. Again, we would note that this governance challenge arises because the GAP has shifted its focus from simply being an internal alignment exercise to one that seeks to drive new or unproven or even previously Member State rejected policies intended for implementation by Member States.

III. Comment on Accelerator 4 and Accelerator 1: Certain Content Is Inconsistent with the UN High-Level Meeting on NCDs Political Declaration, Adopted by the UN General Assembly.

The Accelerators are ultimately intended for implementation by Member States in order to drive progress on Sustainable Development Goal 3. While this is a laudable goal, we question why they are proceeding without acknowledgment of or reliance on the UN High-Level Meeting on NCDs ("HLM") and its accompanying Political Declaration. This HLM, which was held less than one year ago and was the culmination of months, if not years, of work, resulted in a roadmap for accelerating progress on NCDs – the Political Declaration – wherein Heads of State committed to thirteen new steps to tackle NCDs. The Director-General of WHO applauded world leaders for taking "a set of landmark steps to beat NCDs....

² https://www.who.int/nmh/events/2013/consultation_process/en/

These add up to a historic opportunity to promote health, save lives, and grow economies.”³ It is therefore unclear why the WHO and related UN agencies have undertaken a separate, independent effort to develop guidance for UN agencies and Member States on how to accelerate progress on NCDs. Nor is it clear why the WHO has deemed it appropriate to launch this independent effort at the UN General Assembly only one year after the HLM.

Specifically, we would note that both Accelerator 4 (Determinants of Health) and Accelerator 1 (Sustainable Financing) include policy recommendations that were considered and rejected during Member State negotiations for the HLM:

- The phrase “commercial determinants of health” (found in Accelerator 4) has been specifically excluded from Member State negotiated texts and has never been officially debated within a WHO or UN context, and as a result there is no Member State consensus on that term. It is a matter of concern that UN agencies should be asked to address something that is unspecified and undefined by Member States.
- Moreover, both Accelerator 1 and Accelerator 4 explicitly encourage Member States to adopt sugar taxation, which is a significantly controversial idea among Member States and was accordingly considered and explicitly rejected during Member State negotiations over the Political Declaration. Of note, sugar-sweetened beverage taxation was also purposefully excluded from the WHO Independent High-Level Commission on NCDs landmark report “Time to Deliver,” it is not a WHO “Best Buy” NCD intervention, and by WHO’s own CHOICE analysis it did not yield positive health outcomes.

IV. Comment on Accelerator 4: The Overall Tone is Inconsistent with Sustainable Development Goal 17, “Partnership for the Goals.”

We find the tone of Accelerator 4 toward the private sector to be discouraging and not aligned with the UN Sustainable Development Goal 17 around partnerships for the goals (“SDG 17”). While we appreciate that some language has been added to reference public-private partnerships as important to SDG17, the overall approach toward the private sector remains overwhelmingly negative. This Accelerator refers to the private sector as “health harming” and references “pervasive industry interference” in policymaking, rather than recognizing that the private sector is a legitimate stakeholder. As an example of “pervasive industry interference” in policymaking, Accelerator 4 makes the case that the food industry’s advertising budget is evidence of “industry interference” in policymaking to “win” public opinion. In other words, there is no reflection that 1) the private sector is an appropriate stakeholder in policymaking; and 2) marketing of products is not *prima facie* a bad act. One is left with the sense that the only way to interact with the private sector in order to achieve SDG is through a mantra of “enforce, restrict, regulate.”

This is a discouraging mantra considering the UN’s call to action from the private sector. SDG 17 is founded upon that notion that “[a] successful sustainable development agenda requires partnerships between governments, the private sector and civil society.” This language – inclusive and encouraging – is in distinct contrast to the tone of Accelerator 4.

³ See WHO Media Statement on HLM: <https://www.who.int/news-room/detail/27-09-2018-heads-of-state-commit-to-lead-response-to-beat-noncommunicable-diseases-promote-mental-health>

V. Comment on Accelerator 4: It Raises New Policy Issues that Have Not Been Considered by the Appropriate Governing Bodies.

Some of the content in Accelerator 4 moves into the area of new policies that have not yet had an opportunity for consideration by WHO's governing bodies, focusing on determinants of health related to climate change, enforcing regulations related to reducing carbon emissions, fossil fuel use and agriculture generally. While Accelerator 4 restrains from offering specific policy recommendations in these areas, it is raising new policy issues that would benefit from Member State input prior to final adoption. Member States can help assess prioritization and provide critical perspective from national context.

VI. Comment on Accelerator 5: It Fails to Adequately Address Innovation Incentives and IPR.

While USCIB appreciates the mention of private sector researchers and innovators in the first paragraph, we are concerned that neither the subsequent roadmap elements or themes contain any reference to existing and proven innovation incentive models, such as research and experimentation (R&E) tax credits and public-private cooperative research programs. We also note that protection of intellectual property rights (IPR) is another proven way to incentivize R&D and innovation, and that is also not mentioned anywhere in this paper.

VII. USCIB Supports Efforts to Meaningfully Address SDG 3.

USCIB firmly believes that the private sector has an important opportunity to contribute meaningfully to SDG 3, and that the GAP should more fully represent this dimension of private sector engagement. These efforts, which have included many important public-private partnerships, have delivered meaningful results. We offer just a few examples of the many pledges around the globe:

- In conjunction with Singapore's Ministry of Health, seven major beverage companies, including The Coca-Cola Company and PepsiCo, signed an industry pledge to remove by 2020 drinks that contain more than 12 percent sugar from their portfolios of sugar-sweetened beverages.
- In partnership with the Conference Board of Canada, the Canadian Beverage Association and its membership have committed to reducing beverage calories consumed per person by 20 percent by 2025. A report prepared by The Conference Board of Canada shows that in the first two years, calories have been reduced by an unprecedented 10.2 percent. That means that since 2004 there has been almost a 30 percent reduction in calories. ⁴
- In 2014, in partnership with the Alliance for a Healthier Generation, the American Beverage Association and leading beverage companies set a goal to reduce beverage calories consumed per person nationally by 20 percent by 2025. In the first three years of implementation (2015-

⁴ The Conference Board of Canada, "Counting the Calories, Canadian's Consumption of High-Calorie Beverages Continues to Decline" (August 2018), available at <https://www.conferenceboard.ca/press/newsrelease/2018/08/09/counting-the-calories-canadians-consumption-of-high-calorie-beverages-continues-to-decline?AspxAutoDetectCookieSupport=1> (last accessed May 29, 2019).

2017), about 60 percent of all new brands and flavors introduced were no-, low- and mid-calorie choice.

- Through the auspices of UNESDA, the European soft drink association, the leading beverage companies have committed to reducing the average added sugar content of their still and carbonated soft drinks by 10 percent between 2015 and 2020. This commitment was introduced at the EU Platform for Action on Diet, Physical Activity and Health. This commitment comes on top of the 12 percent sugar and calorie reduction already achieved from 2000 and 2015, and represents an effective tripling of the sugar reduction pace.

USCIB and its members welcome the opportunity to discuss public-private partnerships with any of the global health organizations in pursuit of SDG 3.

VIII. Conclusion

We thank you for the opportunity to submit these comments and hope that you will keep in mind our request to ensure that any Global Action Plan is developed with robust stakeholder engagement and strong governance practices. We believe that with the appropriate processes in place, we can work collaboratively to develop a Global Action Plan which is meaningful, actionable, and achievable.

Ariana Childs-Graham
Director, Primary Health Care Initiative
Representing the Primary Health Care Strategy Group:

General Feedback

- The engagement and dialogue process at country level still seems unclear. More concrete action and timeline information here would be beneficial.
- The draft states ‘the global action plan will seek to avoid creating new platforms. Instead the signatory agencies are committed to more effective leveraging of and alignment with existing country-led planning and assessment processes’. What will be done to address duplicative and fragmented country level coordinating mechanisms? Countries often have different coordinating mechanisms and therefore different timelines and commitments to the signatory agencies. Will any of the existing mechanisms be consolidated. If so, by when?

Accelerator Discussion Paper 2: Primary Health Care (PHC)

- There should be explicit calls for a PHC-first approach given that it is the most equitable form of health care. Suggest adding in the following language for Save the Children’s PHC report: “The World Bank estimates that 90% of all health needs can be met at the primary health care level.”¹
- Prioritize focus on quality of care in PHC, which includes interpersonal dynamics between providers and patients. Poor quality care is now recognized to be a bigger barrier to improved survival than lack of access to care with nearly two-thirds of global deaths due to poor quality of care and the rest due to non-utilization.² This is further reinforced by global findings from WRA’s year-long *What Women Want* campaign. *What Women Want* asked nearly 1.2 million women and girls from 114 countries an open-ended question about their top request for quality reproductive and maternal health. Respectful and dignified care (rather than a specific health service or intervention) rose to the top demand with more than 100,000 responses. Too many women are having negative and demeaning experiences when they seek care, and this issue must be addressed if PHC is to be effective.
- Expand on how the accelerator will support shift from “poorly integrated hospital-centric” services to delivering primary health care at all levels particularly at local facilities and at the community level via integrated community based primary health care teams including community health workers and clinical supervisor cadres.
- The ‘Reframing support for country programs’ comprehensively outlines the different health systems investments that multilaterals offer at the country level. However, there is not much

¹ Doherty G and Govender R, ‘The cost effectiveness of primary care services in developing countries: A review of international literature’, Working Paper No. 37, Disease Control Priorities Project, World Bank, WHO and Fogarty International Centre of the US National institutes of Health, 2004, https://www.researchgate.net/publication/242783643_The_Cost-Effectiveness_of_Primary_Care_Services_in_Developing_Countries_A_Review_of_the_International_Literature Henceforth ‘World Bank Report’.

² M. Kruk, et al. High-quality health systems-time for a revolution. Report of the Lancet Global Health Commission on High Quality Health Systems in the SDG Era. 2018. Embargoed, unpublished report.

mention of how these efforts will be linked more closely to move away from fragmentation and duplication. Are there concrete partnerships being developed to consolidate these efforts or coordinate more closely? Any additional detail here would be beneficial.

- Include people and citizens, especially those belonging to marginalized and vulnerable groups, in coordination platforms and health systems assessments. While it is encouraging to see civil society participation prioritized for national and sub-national coordination platforms, too often civil society participation is made of 'elite' health and development professionals largely based in capital cities. To really accelerate progress on PHC, signatory agencies must deliberately make space at the table for community members and leaders, as they know their local challenges and solutions best.
- Under 'Exploring a key role for UHC2030 with links to a new G7 initiative for a knowledge portal for PHC: UHC2030 could be a suitable vehicle for global-level discourse on PHC,' This Mechanism should also provide a link between global and national level discourse on PHC instead of global level alone.
- Under 'PHC ACCELERATOR STRUCTURE AND PARTNERS' Community and civil society missing as key partners.

Metrics

- The WHO Guidelines for Community Health Workers and complementary metrics underdevelopment should be included in the progress monitoring for PHC to ensure that progress for health access for most vulnerable (often those remote and rural populations served by CHWs) is being adequately tracked. Community health is essential for ensuring PHC reaches historically underserved and neglected populations first.
- Ensure that people-generated evidence is used to inform PHC policy and implementation at all levels. In addition to leveraging more 'traditional' forms of health and demographic data, peoples' demands and perspectives should be collected, analyzed, and used to inform PHC decision-making to help ensure that policies and programs are truly responsive to people's self-expressed needs, including marginalized and vulnerable groups. The *What Women Want* campaign is one large-scale example; others include information generated through community dialogues, citizen hearings, complaint/suggestion boxes, and score cards.
- Under 'Global guidance on health systems assessment for PHC' It might be worth emphasizing that this should be led by national priorities and assessments of their own needs and gaps.
- Point 'ii. Global guidance on the operationalization of PHC' It is important to ensure that any indicators for the operational framework are linked to what else is being asked of countries to report on for the SDGs and not create parallel structures. This should also include the aspirational monitoring framework and associated metrics to be established.

Financing

- Financing (both adequate resourcing and accountability/tracking for budget allocations) should be added to the explanation sections. Communities and civil society often do not have access to the financial means required to participate in and inform policy and program discussions in a meaningful way. Further, there needs to be increased transparency around actual spend of budget allocations that are labeled for PHC.

Key inputs/contributions from interested signatory agencies

- **‘Willingness to engage in mapping the funding mechanisms and modalities available to communities and civil society working on health and engage in discussions towards harmonizing funding approaches at country / sub-national level.’**
 - Valuable if GAP partners pool funds to fund national civil society to work on UHC and reduce the fragmentation of civil society. The CSEM of UHC2030 is keen to do this but getting money is very difficult. Global Health Initiatives direct significant resources going to support national civil society platforms and in some instances are also contributing to fragmentation. This is partly represented in outcome of the CSO consultation in April (ref annex 1): “Participants urged GAP signatories to increase resources to support engagement of communities and civil society in country, regional and global bodies and processes, and to align separate funding streams for civil society engagement for more efficient and rational allocation of funding and to move support out of thematic silos” This needs to be even better reflected in the accelerator paper.
- **Objectives : ‘Adopt specific measures to increase opportunities for engagement in activities of global health organizations where such engagement is demonstrated to add value in delivering better policy and/or programmatic outcomes.’** It needs to be underlined that this should also be the case at national level.

SDG3_Secretariat

From: Catherine Cook <Catherine.Cook@hri.global>
Sent: Tuesday, July 2, 2019 3:58 PM
To: SDG3_Secretariat
Cc: Olga Szubert; Naomi Burke-Shyne
Subject: GAP consultation feedback

Dear colleagues,

Many thanks for the opportunity to provide feedback on the Global Action Plan for Healthy Lives and Well-being accelerator discussion papers.

Please find below some feedback on behalf of Harm Reduction International, which focuses on the **Accelerator Paper 1: Sustainable Financing**:

Page 1: 'The participating agencies are committed to:.... ensuring no-one is left behind.' It is important that this paper aligns closely with the community and civil society engagement paper. Health care is often delivered by community and civil society organisations and this paper should clearly articulate the need for governments to ensure the necessary mechanisms are in place (e.g. social contracting) for this to continue in countries undergoing transition from ODA. This is particularly crucial for services reaching key and marginalised populations (i.e. those left furthest behind).

The role of community and civil society in design, delivery and monitoring of services to ensure that they are of high-quality is crucial and warrants mention in this paper. The paper necessarily emphasises allocative efficiency in health spending, but this needs a clear proviso throughout that these efficiencies will not come to the detriment of quality in service provision.

Page 4: 'Discussions between external partners must be at the country level and should facilitate engagement with civil society, along with relevant stakeholders from the private sector'. It is crucial that civil society are meaningfully engaged in this process, as they are a key part of the health system in most countries and closest to those left furthest behind. Coordinating agencies should do more than 'facilitate engagement'. Civil society should be invited and funded to join these discussions and have an equal seat at the table. Strong efforts must be made to ensure representation from those communities most left behind. Particularly in the countries undergoing transition from DAH, these dialogues provide a crucial opportunity for community and civil society dialogue with government on sustainable financing for health.

Page 6: 'taxes on products and processes harmful to health' often have a greater impact on poor people, and those most left behind. This may be a short-sighted strategy given UHC's aim to reduce the number of people pushed into extreme poverty as a result of spending on their own healthcare. Other progressive domestic revenue mobilisation efforts should be emphasised in the document.

Page 7: Spotlight on OECD: it would be useful to know more about the regional networks that have been established and how civil society can engage with them.

Driver 3: Enhanced support for countries to increase the efficiency and effectiveness of health spending. While there are efficiency gains to be found within national health budgets, it would also be useful to encourage governments to look across at different areas of government spending. The European Monitoring Centre on Drugs and Drug Addiction, for example, encourages countries to critically evaluate their spending on drug policy, including health interventions and drug law enforcement spending. UNAIDS recommend that governments 'undertake a rebalancing of investments in drug control to ensure sufficient funding for human rights programmes and health services, including the comprehensive package of harm reduction and HIV services, community-led responses and social enablers'. ([UNAIDS, 2019, Health, Rights and Drugs, p7](#)). Harm Reduction International's research shows that [shifting just a small percentage of ineffective drug law enforcement spending over to health and harm reduction could end](#)

[AIDS by 2030 among people who inject drugs](#), who are among those most left behind in terms of health care provision in all countries around the world.

Page 8: 'Domestic budget advocacy is a critical enabler by providing greater accountability for health spending.' This is crucial work but much of this will be undertaken by community and civil society organisations. This advocacy work will require DAH funding in most countries, since it is usually not prioritised by national governments. The paper should include a commitment that the coordinating agencies will make funding available for this work.

Thank you again for the opportunity to contribute.

Best wishes,
Catherine

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*please note I am part time and my hours may vary



SDG3_Secretariat

From: Liudmyla Maistat <Imaistat@medicinespatentpool.org>
Sent: Friday, June 28, 2019 10:49 AM
To: SDG3_Secretariat
Subject: MPP comments on Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access

Categories: Blue Category

Dear SDG3 Secretariat,

Please find below comments of the Medicines Patent Pool (MPP) on Accelerator Discussion Paper 5: R&D and Access.

General comments on Accelerator 5:

1. **Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations**
 - would be good if the GAP, in particular the Accelerator 5, is more aligned with the WHO Road Map on Access to Medicines and Vaccines in terms of identifying and addressing critical access barriers.
 - In order to provide more support to countries to accelerate progress towards achieving the health-related SDGs, in particular, to address lack of affordability of new medicines and formulations, as one of the critical access barrier, it might be helpful to include other organizations which work directly with governments and other key stakeholders on facilitating and accelerating access to medicines in the group working on Accelerator 5. Previous and current collaborations, models and mechanisms which resulted in improved access to treatments should be considered to be further involved and applied.
2. **Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?**

It might be helpful:

- to link the proposed actions more to the WHO Road Map on Access to Medicines and Vaccines, in particular, to the activities within the two strategic areas, actions, measuring progress (targets and indicators), deliverables and milestones;
- if the proposed actions are based on the previous and existing good practices and recommended for scale up;
- to include more concrete examples of good and innovative practices and the most successful experiences in accelerating and expanding access to a new treatment at affordable prices in LMICs:

e.g. due to MPP access-oriented licensing and collaboration of many stakeholders, access to many medicines and formulations for treating HIV and HCV was significantly improved in LMICs.

The example of DTG (dolutegravir) and the new combination TLD is quite unique and ground-breaking:

- new treatment with favourable clinical profile was made accessible in record time in dozens of countries;
- it became available in a new fixed dose combination first developed by the generic manufacturers;
- multiple manufacturers came to market very rapidly enabling the product to be made available at a price that was even cheaper than preceding standard of care;
- multiple agencies/organizations became involved in this and coordinated successfully to make it possible, including WHO, Unitaid, Global Fund, MPP, Gates, CHAI, etc.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

MPP is closely involved and will continue providing support to countries in accelerating progress toward the health-related SDG targets aligned with accelerator 5, in particular, helping countries to get faster access to new quality assured essential medicines and formulations through access-oriented licensing and patent pooling.

In terms of **Annex A Products**, we suggest to focus attention on medicines that are newly added to the WHO EML, at every biannual revision. For a start, any new drugs that make when the new list is announced in the coming weeks, should definitely be a priority as those are ones that have proven to meet all the WHO criteria for being considered essential. And it would seem desirable for the international community to place particular attention on essential medicines (in line with the SDG 3.8).

Best regards,

Mila Maistat

Policy and Advocacy Manager

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Subject: Invitation for public comment: Global Action Plan for Healthy Lives and Well-being - SDG Accelerators

<https://www.who.int/sdg/global-action-plan/consultations/invitation-for-public-comment-global-action-plan-for-healthy-lives-and-well-being>

*Invitation for public comment: Global Action Plan for Healthy Lives and Well-being - SDG Accelerators **Strengthening collaboration among multilateral health organizations to accelerate country progress on the health-related Sustainable Development Goals*

*Discussion period: *17-30 June 2019

*Submissions: *Please submit your responses to SDG3_Secretariat@who.int by Sunday, 30 June 2019. Please include the title of either (a) the accelerator discussion paper(s) on which you are submitting comments, and/or (b) general comments, in the subject line of your email response. All submissions will be published online.

*Engage on Twitter: *Invite others to join the public discussion, using hashtag *#ActionSDG3* (Please note comments made on Twitter will not be considered in the preparation of the final Plan).

Background

Twelve multilateral global health and development organizations have united under a joint vision and commitment to align efforts and more effectively support countries in achieving the health-related targets of the 2030 Agenda for Sustainable Development. The 12 signatory agencies are Gavi, the Vaccine Alliance (Gavi) <<https://www.gavi.org/>>, the Global Financing Facility (GFF), <<https://www.globalfinancingfacility.org/>> the Global Fund <<https://www.theglobalfund.org/en/>> to Fight AIDS, TB and Malaria, <<https://www.unaids.org/en>>UNAIDS <<https://www.unaids.org/en>>, UNDP <<https://www.undp.org/content/undp/en/home.html>>, UNFPA <<https://www.unfpa.org/>>, UNICEF <<https://www.unicef.org/>>, Unitaid <<https://unitaid.org/#en>>, UN Women <<http://www.unwomen.org/en>>, World Bank Group <<https://www.worldbank.org/>>, WFP <<https://www1.wfp.org/zero-hunger>> and WHO <<https://www.who.int/en/>>.

These agencies signed a commitment <<https://apps.who.int/iris/bitstream/handle/10665/311667/WHO-DCO-2018.3-eng.pdf>> in October 2018 to develop a “Global Action Plan for Healthy Lives and Well-being for All” to align their efforts to more effectively support countries to achieve the health-related SDG targets. Read a draft outline for the Global Action Plan <https://www.who.int/docs/default-source/global-action-plan/sdg-gap-outline.pdf?sfvrsn=ac41053b_2>, which will be launched in September 2019.

Country priorities and needs will be the key driver for the collective actions undertaken by the 12 agencies. Over the past months, several country consultations were held to identify key priorities and needs at the country level. Country consultation is the focus of chapter 3 in the Global Action Plan.

Chapter 4 in the draft outline relates to “accelerator” areas. Working groups developed discussion papers in seven “accelerator” areas in which joint action by the signatory agencies could support countries to accelerate progress towards the health-related SDGs. Each paper includes suggested concrete actions to be undertaken by the signatory agencies, primarily at the national level, to support countries.

Feedback on the discussion papers

The Global Action Plan signatory agencies are inviting stakeholder feedback on the discussion papers, through a public process from 17-30 June 2019. All stakeholders, including governments and non-State actors, are encouraged to make written submissions. Signatory agencies are committed to ensuring an inclusive process in developing the Global Action Plan. Several multi-stakeholder consultations have been conducted on seven thematic or “accelerator” areas.

Submissions will be published online and will inform the final draft of the Global Action Plan, which will be presented during the United Nations General Assembly in September 2019.

*Note:** These documents are working papers and subject to change. They do not necessarily reflect the views of the 12 Global Action Plan signatory agencies. **Key elements of the accelerator discussion papers will be used

as inputs to the Global Action Plan. *

Questions

The following questions are proposed as a guide to respondents.

General comments on the Global Action Plan:

1. What do you see as the key opportunities offered by *The Global Action Plan for Healthy Lives and Well-being for All?*
2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

Comments on the accelerator discussion papers:

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?
2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?
3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

Please note the following guidelines when providing feedback:

- Please provide your feedback in writing, either in the body of an email, or in a separate document sent as an email attachment. Comments inserted directly into the PDFs of the outline or accelerator papers will not be accepted.
- Include the full name, title and affiliation (e.g. representing a Member State, or an organization, or in an individual capacity) of the person providing feedback.
- Include the title of either (a) the accelerator discussion paper(s) on which you are submitting comments and/or (b) general comments in the subject line of your email response.
- Please ensure that your feedback is high level, action-orientated, precise, feasible and related to the specific issues raised in the accelerator papers. Feedback should not exceed one page per accelerator paper/outline.
- The Global Action Plan Secretariat is not able to consider feedback that does not contribute directly to the Global Action Plan and its goals of greater alignment across the 12 signatory organizations in support of the achievement of the health-related SDGs by countries, e.g. feedback focused on an individual agency or its mandate.
- The Global Action Plan Secretariat will not respond to individual comments directly. However, all comments will be taken into consideration during the drafting of the final Global Action Plan.

***Please note: *All comments received will be published online.**

Papers for public comment

- Outline of the Global Action Plan

<https://www.who.int/docs/default-source/global-action-plan/sdg-gap-outline.pdf?sfvrsn=ac41053b_2>

Accelerator discussion papers:

1. Sustainable Financing

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-1-sustainable-financing-17june19-1.pdf?sfvrsn=1a6dfc60_2>

2. Primary Health Care

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-2-primary-health-care--phc-17062019-rev.pdf?sfvrsn=4b9499d1_2>

3. Community and civil society engagement

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-3-community-civil-society-engagement-17062019-1.pdf?sfvrsn=aea20165_2>

4. Determinants of Health

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-4-determinants-of-health-170619-1.pdf?sfvrsn=b9c5b594_2>

5. Research and development, innovation and access

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-5.pdf?sfvrsn=edc2788e_2>

6. Data and digital health

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-6.pdf?sfvrsn=50880bf1_2>

7. Innovative programming in fragile and vulnerable states and for disease outbreak responses

<https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-7.pdf?sfvrsn=30405e53_4>

Submissions:

Please submit your response by *23:59 CET, Sunday, 30 June 2019 *to
SDG3_Secretariat@who.int

In the subject line of your email response, include the title of either (a) the accelerator discussion paper(s) on which you are submitting comments, and/or (b) general comments.

Thank you in advance for your time and valuable feedback.



INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE
Advancing Hospice & Palliative Care Worldwide

General comments on the Global Action Plan Primary Health Care Accelerator

A coordinated global palliative care response submitted by The International Association for Hospice and Palliative Care, Dr. Katherine Pettus, PhD, Advocacy Officer, kpettus@lahpc.com

1. What do you see as the key opportunities offered by *Global Action Plan for Healthy Lives and Well-being for All*?

One of the major opportunities for the Global Action Plan for Healthy Lives and Well-Being for all is to address the major neglect of the development of health systems that should be there for people ***throughout their lives*** and to ensure that the most vulnerable and those with the highest health needs are not left behind. The focus on primary health care is crucial but progress will not be made without ensuring that primary health care covers the spectrum from promotion, prevention, treatment, rehabilitation and palliation as outlined in the Astana Declaration and within the UHC definition. Addressing the health system and community response to the latter part of the spectrum cuts across work by all signatory agencies, yet with the exception of WHO is rarely mentioned, leaving millions of the most vulnerable behind.

There is currently no specific recognition in the primary health care acceleration paper or the Global Action Plan itself of the need for healthcare throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation and palliative care. From years of working in palliative care, we know that if the full spectrum is not explicitly referenced, the latter part of the spectrum will be neglected, will not be financed, and the 61.5 million people who need it will continue to live and die in serious pain and distress. Women and girls will continue to be left to care for people in their homes and communities unsupported and ill-equipped creating a knock-on effect on mental and physical well-being, gender equality and household poverty.

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Palliative care must be integrated into the primary health care system response. Access to palliative care is something that the majority of us will need at some point, however much financing is dedicated to prevention and promotion. By failing to recognise a response that ensures health systems and primary health care throughout people's lives, we are failing the most vulnerable in our societies.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

There is little effective response to date by the signatories on accelerating impact in countries on access to palliative care as part of health systems. Much can be learned however from UNAIDs collaborative work on access to ART treatment and care and the Global Fund coordinating and financing mechanisms. WHO's technical assistance needs to be coupled with effective financing.

Comments on the accelerator discussion papers:

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

- 1a. Utilise language that explicitly discusses primary health care systems throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation and palliative care.
- 1b. Remain constantly mindful of the most vulnerable and marginalised in societies including those facing multiple conditions, stigma and societal fears of death and dying and include people with palliative care needs in all consultations and planning exercises.
- 1c. We would like to UN Women included in this accelerator as the impact of inadequately resourced primary health care services is likely to fall on women and girls due to caregiving responsibilities.

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2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

2a Ensure that the in country needs assessments and the subsequent plans, financial analysis and monitoring include the need for primary health care **throughout people's lives**, including palliative care, and women and girls who are often their caregivers, so that the most vulnerable do not continue to be left behind. Also focus on:
1. Community health workers. 2. Access to medicines and equipment. 3. Leaving no one behind.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

Yes, our organisation works with organisations globally to advocate for, and access financing to support, initiatives to ensure palliative care is integrated into primary health care, particularly in low and middle-income countries.

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Global Action Plans for Healthy Lives and Wellbeing:

World Naturopathic Federation (WNF) response

Prepared by Dr. Iva Lloyd, ND President of the WNF

The World Naturopathic Federation (WNF) represents seventy national naturopathic organizations and naturopathic educational institutions spanning all world regions. The mission of the WNF is to represent the global naturopathic profession and to support regulation and enhanced educational standards for the naturopathic profession.

The Astana Declaration included reference to Traditional knowledge and Traditional medicines and according to *WHO Global Report on Traditional and Complementary Medicine 2019*, 88% of Member States acknowledge the use of Traditional and Complementary Medicine (T&CM) in their country. The report also stated that the following T&CM professions are practiced in about 100 countries: Acupuncture, Herbal Medicine, Indigenous Medicine, Homeopathy, Traditional Chinese Medicine, Naturopathy, Chiropractic, Osteopathy and Ayurveda.

The WNF continues to work with member organizations to support integration of naturopathy into the existing healthcare structure of each country. We are prepared to support the initiatives of the WHO and the United Nations, as well as the signatory agencies in all activities involving the inclusion of T&CM in healthcare initiatives.

General Comments on the Global Action Plans

1. What do you see as the key opportunities offered by *The Global Action Plan for Healthy Lives and Well-being for All*?

In the opening paragraph of the Foreword of the *WHO Global Report on Traditional and Complementary Medicine 2019*, WHO Director General Tedros Adhanom Ghebreyesus stated, "Traditional and complementary medicine (T&CM) is an important and often underestimated health resource with many applications, especially in the prevention and management of lifestyle-related chronic diseases, and in meeting the health needs of ageing populations. Many countries are seeking to expand coverage of essential health services at a time when consumer expectations for care are rising, costs are soaring, and most budgets are either stagnant or being reduced. Given the unique health challenges of the 21st century, interest in T&CM is undergoing a revival."

- The WNF would like to echo the Director General's comments and would like to encourage the United Nations and the signatory agencies to include naturopathy and other systems of T&CM in their plans.

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<https://www.facebook.com/worldnaturopathicfederation>

Accelerator Discussion Paper 2: Primary Health Care

- We estimate that there are over 100,000 naturopathic practitioners around the world. Naturopathy / naturopathic medicine is practiced in about 100 countries, spanning all world regions.
- Naturopathic practitioners are trained as Primary Health Care (PHC) providers. In a number of countries (for example: South Africa, India, Brazil, Canada, United States, Australia, Switzerland, DR Congo) the naturopathic training is over 4,000 hours. Here is a link to the Global Report on Naturopathic Regulation: http://worldnaturopathicfederation.org/wp-content/uploads/2018/10/Global-Naturopathic-Regulation_finalb.pdf
- There are currently about 100 naturopathic community clinics focused on provided naturopathic care to the underprivileged. An aim of the WNF is to seek funding to expand the number of community clinics and to increase their presence throughout the world.
- The WNF community has established a website to educate practitioners and the public on the role of natural medicine and AMR: <https://www.wnf-amr.org/>
- Naturopathic practitioners are well positioned to assist in addressing the PHC crises that we face.

Accelerator Discussion Paper 4: Determinants of Health

- Naturopathic practitioners take a wholistic approach to patient care. They address a broad range of determinants of health (DOH) including lifestyle, environmental determinants and social factors. The Naturopathic approach to healthcare is consistent and supportive of the direction outlined in the Astana Declaration and the Accelerator Discussion Papers.
- Naturopathic practitioners are known for their focus on patient education, for working with patients on lifestyle changes, understanding the link between DOH and symptoms, conditions and diseases.
- To learn more about naturopathy and the DOH please check out the *WNF White Paper on Naturopathic Philosophy, Principles and Theories*: http://worldnaturopathicfederation.org/wp-content/uploads/2015/12/White-Paper_FINAL.pdf

Accelerator Discussion Paper 5: Research & Development (R&D), Innovation and Access

- Consolidating the research in the field of Naturopathy has been a focus of the WNF. Earlier this year the WNF published a report highlighting 2500 index research articles written by naturopaths / naturopathic doctors: http://worldnaturopathicfederation.org/wp-content/uploads/2019/04/WNF_Research-Written-by-Naturopaths-Naturopathic-Doctors.pdf
- There are over 20 naturopathic research centers spanning seven countries: <http://worldnaturopathicfederation.org/naturopathic-research-institutes/>.
- The practice of naturopathy / naturopathic medicine is strongly supported by research and the WNF is working to consolidate those findings in a way that is more accessible to governments and agencies.
- The WNF is in the process of completing a Health Technology Assessment on naturopathy which will provide a clear framework for the practice, safety, cost effective and research supporting the naturopathic profession.

UHC2030 Contribution to SDG3 Global Action Plan Public Comment

We welcome this opportunity to respond to the invitation to public comment on the GAP. Although it was not possible to gather consolidated inputs from all the UHC2030 membership in the time available, this submission has been agreed by the UHC2030 Co-Chairs as reflecting discussions at the recent (June 2019) UHC2030 Steering Committee. We understand that the Civil Society Engagement Mechanism (CSEM) GAP Advisory Group will also submit feedback.

We have three overarching comments:

- 1) We strongly agree with the guiding principles that the '7 Behaviours' for effective health cooperation underpin the GAP (especially its work on Alignment), and that the GAP makes use of existing mechanisms rather than creating new ones (especially at country level). The Steering Committee requested that UHC2030 continues to collaborate with the GAP on these issues.
- 2) The GAP could bring out a stronger narrative about the key global health moments this year (including the UHC High-Level Meeting and the SDG Summit), how these will bring together a common focus on health goals, and how the GAP can be the 12 agencies' "offer" in support of countries translating commitment into accelerated impact.
- 3) Linked to this, we feel there are opportunities for the GAP to make reference to, and reinforce where appropriate, the '[Key Asks from the UHC Movement](#)' (UHC Key Asks) and action agenda. These asks were prepared through an extensive multi-stakeholder process to inform and set expectations of the UHC High-Level Meeting, and are set out in more detail below. The GAP could indicate how agencies will support a positive response, and guide collective support for ambitious reforms and implementation in partner countries.

Detailed feedback

GLOBAL ACTION PLAN OUTLINE

1.2 Sustaining and accelerating country progress across the health-related SDGs

- This could also refer to the UN High-level Meeting on UHC in 2019 – a major opportunity to mobilise the highest political support for UHC as the cornerstone to achieving SDG3, uniting health agendas under a common theme.
- Linked to this, the GAP could indicate how agencies will support a positive response to the Key Asks from the UHC Movement, and how the GAP will guide collective advocacy efforts (where appropriate) and support for ambitious reforms in partner countries. The top line message of the UHC Key Asks is that *Everyone, everywhere should have access to quality and affordable health services. We call on Political Leaders to legislate, invest and collaborate with all of society to make UHC a reality.*

1.3 Challenges and opportunities for collective action

- This section could acknowledge that many of the challenges identified are consistent with the UHC Key Asks and action agenda – there is a positive convergence of priority issues and actions needed. The GAP is welcome to draw on the asks to reinforce its messaging. The

attached annex suggests links also between key asks and individual accelerators. For reference the asks are:

- **1. Ensure Political Leadership Beyond Health** - Commit to achieve UHC for healthy lives and well-being for all at all stages, as a social contract.
 - **2. Leave No One Behind** - Pursue equity in access to quality health services with financial protection.
 - **3. Regulate and Legislate** - Create a strong, enabling regulatory and legal environment responsive to people's needs.
 - **4. Uphold Quality of Care** - Build quality health systems that people and communities trust.
 - **5. Invest More, Invest Better** - Sustain public financing and harmonise health investments.
 - **6. Move Together** - Establish multi-stakeholder mechanisms for engaging the whole of society for a healthier world.
- Linking to the **High Level Political Forum**, another existing mechanism the GAP could connect with (e.g. to share experience of the GAP as working in partnership in support of SDG3) is the [Sustainable Development Partnership Platform/ Partnership Exchange](#) for SDG 3.

4.2 Accelerator proposals

- **Financing.**
 - The proposed 'code of conduct' could be elevated to apply to the GAP agencies overall, not just this accelerator.
 - Discussion of sustainability and transition from external finance could make reference to the consensus [Statement on Transition and Sustainability](#), and how GAP agencies will apply these principles.
- **PHC.**
 - The GAP narrative could bring out more strongly how this accelerator is at the heart of all the accelerators.
 - We welcome the ongoing discussions on UHC2030's potential role in global coordination and lesson-sharing, and look forward to confirming specific actions/activities.
- **Civil society and community engagement.** We understand that GAP discussions explored harmonised funding approaches for civil society – but these are not reflected in latest accelerator actions. Could this be revisited?

5.1 2023 SDG mid-point milestones:

- The Key Asks have an associated set of milestones. Where relevant, the GAP may wish to reference or adopt some of these:

- **Key Ask 1 milestone:** Governments incorporate aspirational health-related SDG targets into national planning processes, policies and strategies to ensure everyone can access quality health services without financial hardship.
- **Key Ask 2 milestone:** Governments report disaggregated data to SDG official statistics to capture the full spectrum of the equity dimensions of UHC monitoring progress (SDG 3.8.1 and 3.8.2).
- **Key Ask 3 milestone:** Governments introduce legal and regulatory measures that accelerate progress toward UHC.
- **Key Ask 4 milestone:** The coverage of quality essential health services has been delivered to one billion additional people (SDG 3.8.1).
- **Key Ask 5 milestone:** Governments adopt ambitious investment goals for UHC, make progress in mobilising domestic pooled funding and reduce catastrophic health expenditure (SDG 3.8.2).
- **Key Ask 6 milestone:** All UN Member States endorse the UHC2030 Global Compact and establish multistakeholder platforms to ensure the involvement of civil society, communities and the private sector, in regular policy dialogue and review of progress with all government.

5.2 Tracking joint actions:

- The GAP could make reference to opportunities to embed (or cross-reference) GAP accountability in existing mechanisms, for example the **HLPF** follow-up mechanisms (e.g. Goal 3 and Goal 17 Thematic Reviews).
- We understand also that the GAP is exploring a scorecard mechanism to track agencies' commitments and behaviour and consolidate feedback from countries. We could jointly explore a role for UHC2030 in supporting coordination of a related multistakeholder reporting/accountability function (linking especially to 'Align' and the 7 behaviours).

Annex: links between accelerators and key asks

1. Sustainable Financing – refer key asks 1 and 5 and their action agenda, such as:

- **Key Asks 1 Action Agenda:** Support international and national regulation and fight tax evasion and corruption through cooperation with finance ministries, national treasuries and national anti-corruption agencies to ensure more powerful people and entities pay their fair share.
- **Key Asks 5 Action Agenda:** Foster strong alignment among global health actors and development partners to support progress, including coordination of financing mechanisms. Countries need to adapt to transition from external funding that aim to increase effective coverage of priority interventions toward achieving and sustaining UHC.
- **Key Asks 5 Action Agenda:** Prioritise debt restructuring to address the debt sustainability challenges faced by many countries and decrease competition in the fiscal space between debt servicing and health spending.

2. Primary Health Care – refer key asks 2 and 6 and their action agenda, such as:

- **Key Asks 2 Action Agenda:** Establish resilient, responsive and inclusive health systems that are accessible to all, irrespective of socio-economic or legal status, health condition or any other factors. Such systems should prioritise an essential health package based on PHC principles.
- **Key Asks 2 Action Agenda:** Incorporate the health needs of vulnerable populations, in particular in fragile settings, in national and local health care policies and plans, with increased focus on PHC, including disease prevention, immunisation services and health promotion activities.
- **Key Asks 6 Action Agenda:** Empower communities through a PHC approach. This applies, among other issues, to promoting good health, managing disease and mitigating health crises at the community level, while also strengthening community participation of all populations.
- **Key Asks 6 Action Agenda:** Enhance international coordination and enabling environments at all levels to strengthen national health systems and share knowledge and experience to strengthen the sustainability of UHC.

3. Community and civil society engagement – refer key asks 2 and 6 and their action agenda, such as:

- **Key Asks 2 Action Agenda:** Establish inclusive social accountability mechanisms for all parts of the health system so that everyone is responsible for progress toward UHC.
- **Key Asks 6 Action Agenda:** Enable and introduce processes for structured and meaningful engagement of all government sectors and actors, the private sector and a broad base of civil society, including youth and academia.
- **Key Asks 6 Action Agenda:** Empower individuals, families, communities, local providers and civil society organisations to be at the centre of UHC, especially by strengthening and enhancing community capacity to get involved in decision-making and accountability processes.
- **Key Asks 6 Action Agenda:** Support financially civil society and community groups as key contributors to health systems development, and critical advocates for vulnerable and marginalised populations.

4. Determinants of Health – refer preambular of the UHC Key Asks, such as:

- **Cross-cutting agenda - gender equity:** UHC2030 recognises the critical importance of gender equality for the achievement of UHC, including protecting, respecting and fulfilling women's and girls' rights, changing harmful gender norms and eliminating political, economic and social gender barriers that prevent all people, however they identify their gender, from enjoying their right to health. Across these Key Asks and Action Agenda from the UHC Movement, we urge political leaders to re-commit to gender equality, redress gender power dynamics and ensure women's and girls' rights as foundational principles for UHC.

5. Research and development, innovation and access – refer key asks 1, 4 and 5 and their action agenda, such as:

- **Key Asks 1 Action Agenda:** Strengthen national policy and institutional coherence between trade and intellectual property for the right to health. This requires establishing inter-ministerial bodies to coordinate laws, policies and practices that impact health technology innovation and access.
- **Key Asks 4 Action Agenda:** Promote innovation and harness a variety of technologies, including digital technologies, to improve equitable access to health services, complement and enhance existing health service delivery models and empower and enable people and communities to play an active role in their own health.
- **Key Asks 4 Action Agenda:** Empower providers to undertake real-time implementation research to identify and scale best practices for achieving quality.
- **Key Asks 5 Action Agenda:** Invest in global and regional public goods including universal access to essential medicines, vaccines, technology and emergency preparedness.

6. Data and digital health - refer key asks 3 and 4 and their action agenda, such as:

- **Key Asks 3 Action Agenda:** Prioritise public oversight, data protection and data ownership by the patient, and resolve data transferability
- **Key Asks 4 Action Agenda:** Ensure the appropriate, safe and affordable use of digital and AI innovation. Digital health and AI provide new opportunities to respond to the unique needs of each person, organise services seamlessly, involve patients in decision-making and collect, connect and disseminate data with smart and autonomous systems.

7. Innovative programming in fragile and vulnerable states and for disease outbreak responses – refer key asks 1 and 2 and their action agenda, such as:

- **Key Asks 1 Action Agenda:** Promote peace and strengthen cooperation between humanitarian and development actors in fragile settings. Develop strong relationships to enhance the health security agenda, including through resilient foresight capabilities.
- **Key Asks 2 Action Agenda:** Incorporate the health needs of vulnerable populations, in particular in fragile settings, in national and local health care policies and plans, with increased focus on PHC, including disease prevention, immunisation services and health promotion activities.

02/07/2019

General comments on the Global Action Plan Primary Health Care Accelerator

A coordinated global palliative care response submitted by: Name: Dr. Zipporah Ali

Title: Executive Director

Organization: Kenya Hospices and Palliative Care Association (KEHPCA)

1. What do you see as the key opportunities offered by *Global Action Plan for Healthy Lives and Well-being for All*?

One of the major opportunities for the Global Action Plan for Healthy Lives and Well-Being for all is to address the major neglect of the development of health systems that are there for people *throughout their lives* and to ensure that the most vulnerable and those with the highest health needs are not left behind. The focus on primary health care is crucial but progress will not be made without ensuring that primary health care covers the spectrum from promotion, prevention, treatment, rehabilitation, and palliation as outlined in the Astana Declaration and within the UHC definition. Addressing the health system and community response to the latter part of the spectrum cuts across work by all signatory agencies, yet with the exception of WHO is rarely mentioned, leaving millions of the most vulnerable behind.

There is currently no specific recognition in the primary health care acceleration paper or the Global Action Plan itself of the need for healthcare throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation, and palliative care. From years of working in palliative care, we know that if the full spectrum is not explicitly referenced, the latter part of the spectrum will be neglected, will not be financed, and the 61.5 million adults and children who need it, will continue to live and die in serious pain and distress. Women and girls will continue to be left to care for people in their homes and communities unsupported and ill-equipped creating a knock-on effect on mental and physical well-being, gender inequality and household poverty. Palliative care must be integrated into the primary health care system response. Access to palliative care is something that the majority of us will need at some point, however much financing is dedicated to prevention and promotion. By failing to recognise a response that ensures health systems and primary health care throughout people's lives, we are failing the most vulnerable in our societies.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

There is little effective response to date by the signatories on accelerating impact in countries on access to palliative care as part of health systems. Much can be learned however from UNAIDS collaborative work on access to ART treatment and care and the Global Fund coordinating and financing mechanisms. WHO's technical assistance needs to be coupled with effective financing.

Comments on the accelerator discussion papers:

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

1a. Utilise language that explicitly discusses primary health care systems throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation, and palliative care.

1b. Remain constantly mindful of the most vulnerable and marginalized in societies including those facing multiple conditions, stigma and societal fears of death and dying and include people with palliative care needs in all consultations and planning exercises.

~~Our Vision: To promote and support accessible, affordable and sustainable palliative care for individuals and families by creating networks of information, expertise and resources in Africa.~~
Registration No. 20478

Directors: Dr. John Weru, MBCHB, MPC, PGD (BE) (Chair), Dr. Meshack Liru (Vice Chair), Mrs. Ruth N. Were (Hon. Secretary)

Mr. Faustin Mgendi (Hon. Treasurer), Dr. Zipporah Ali MD, MPH, HonDUniv (Executive Director)


1c. We would like to UN Women included in this accelerator as the impact of inadequately resourced primary health care services is likely to fall on women and girls due to caregiving responsibilities.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

2a. Ensure that the in country needs assessments and the subsequent plans, financial analysis and monitoring include the need for primary health care **throughout people's lives**, including palliative care, and include women and girls who are often their caregivers, so that the most vulnerable do not continue to be left behind. Also focus on: 1. Community health workers. 2. Access to medicines and equipment. 3. Leaving no one behind.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

Yes, our organisation works with organisations globally to advocate for, and access financing to support, initiatives to ensure palliative care is integrated into primary health care, particularly in low and middle-income countries.



Dr. Zipporah Ali
Executive Director
Kenya Hospices and Palliative Care Association

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General comments on the Global Action Plan Primary Health Care Accelerator

A coordinated global palliative care response submitted by: Name: Eunice Garanganga Title: Director

Organisation: Hospice and Palliative Care Association of Zimbabwe (HOSPAZ)

1. What do you see as the key opportunities offered by *Global Action Plan for Healthy Lives and Well-being for All*?

One of the major opportunities for the Global Action Plan for Healthy Lives and Well-Being for all is to address the major neglect of the development of health systems that are there for people *throughout their lives* and to ensure that the most vulnerable and those with the highest health needs are not left behind. The focus on primary health care is crucial but progress will not be made without ensuring that primary health care covers the spectrum from promotion, prevention, treatment, rehabilitation and palliation as outlined in the Astana Declaration and within the UHC definition. Addressing the health system and community response to the latter part of the spectrum cuts across work by all signatory agencies, yet with the exception of WHO is rarely mentioned, leaving millions of the most vulnerable behind.

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Comment on
Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access
Incentives for Global Health

The Health Impact Fund (HIF) proposal is for an international fund that would reward innovative medicines in proportion to their impact on global health, while requiring them to be supplied in participating and low-income countries at the cost of production.

Goal 1: The HIF builds access into the R&D pathway by design, since supply either generically or at a pre-specified access-friendly price is the requirement for obtaining payments from the HIF. Moreover, it also encourages supply to underserved populations since they become profitable if they can benefit from HIF-registered drugs.

Goal 2: By design, the HIF encourages alignment with SDG priorities, since companies are incentivized to achieve health impact. The direct connection between payments and health benefits ensures targeting of health benefits.

Goal 3: The HIF creates an incentive for drug manufacturers to connect and collaborate with governments, distributors, clinicians, since they are rewarded for health impact, which can only be achieved through such collaborations. That is, throughout the lifecycle of drug development, approvals, supply and distribution, there is an incentive to have proper integration with local and national health sectors in target countries. The HIF system also encourages countries to fund the HIF in proportion to income, so as to spread the burden of drug development expenditures fairly across countries.

Goal 4: The HIF ensures and optimized innovation system because it takes advantage of the private information of innovative firms about their specific costs of drug development and the opportunities they perceive. When priorities are set only on the basis of demand, this ignores important information about the costs and opportunities for drug development.

The HIF is, essentially, an international form of existing drug insurance schemes such as the UK's NHS, which sets prices on the basis of expected health impact. This kind of system has had considerable demonstrated success in incentivizing new drug development and providing access to insured patients. Indeed, the existing system of private drug development incentivized by profits, while imperfect, is the system for which we have the strongest evidence. However, drug development in our current system is focused on profitable opportunities, and insurance is limited to each country, resulting in (a) little innovation targeting the needs of the poor and (b) poor access to resulting products. The HIF would rely on and correct this model, for specific drugs, extending effective insurance to patients in low-income (and other participating) countries, fully aligning the private profit incentive with the social goal of improving health.

For more information, please see www.healthimpactfund.org or contact us at aidan@healthimpactfund.org

Comments on the Global Action Plan Primary Health Care Accelerator

A coordinated global palliative care response submitted by:

Name: Claire Morris **Title:** Global Advocacy Director
Alliance

Organisation: Worldwide Hospice Palliative Care

1. What do you see as the key opportunities offered by *Global Action Plan for Healthy Lives and Well-being for All*?

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Yes, our organisation works with organisations globally to advocate for, and access financing to support, initiatives to ensure palliative care is integrated into primary health care, particularly in low and middle-income countries.



IOGT International submission

02.07.2019

Public Comment: Global Action Plan for Healthy Lives and Well-being for All

IOGT International welcomes the opportunity to contribute our expertise to the process of developing the Global Action Plan for Healthy Lives and Well-being for All.

General comments on the Global Action Plan:

1. What do you see as the key opportunities offered by The Global Action Plan for Healthy Lives and Well-being for All?

There are four key opportunities offered by The Global Action Plan for Healthy Lives and Well-being for All:

- Protect and promote the Human Right to Health and Wellbeing for all

Promoting and protecting health is essential to human welfare and sustained economic and social development. Health for All is essential to achieve better quality of life, global peace and security and sustainable development. This is not new and was first recognized by the Alma-Ata Declaration signatories. Nevertheless, the absolutely low level of investments in health promotion and care in many low- and middle-income countries remains a significant obstacle to achieving SDG3 and all other SDGs. In high-income countries most healthcare spending is for treatment, not health promotion and prevention.

- Foster momentum for and coherent approaches to SDG 3

The Global Action Plan for Healthy Lives and Well-being for All has the potential to help establish the understanding of health spending as investments, not as expenditures.



Spending on health promotion, prevention and care is investment in human capital and potential, in community resilience and thriving economies. Consider the potential of addressing alcohol harm as obstacle to health and development. Alcohol adversely affects 13 of 17 SDGs. Alcohol use is the number one risk factor for death and DALYs in the age group 15 to 49 years – typically the most productive years of our lives. This can be modified and prevented – and the policy solutions are well-proven, cost-effective and high-impact, reaping major benefits across most targets of SDG3 and multiple other SDGs.

- Facilitate the long-overdue pivot to prevention and health promotion

In the era of sustainable development, the Global Action Plan for Healthy Lives and Well-being for All should engender a paradigm shift to achieve health and well-being for all and help reach the other SDGs.

The paradigm shift starts with a pivot to prevention of health risk factors, such as tobacco and alcohol, as well as systematic and comprehensive approaches to tackling health determinants, such as the commercial determinants of health.

Preventing health problems from occurring or expanding represents by far the best approach to reaching health for all – especially considering the ever-increasing burden of health risk factors. In the era of sustainable development a pivot to evidence-based prevention and health promotion holds four major benefits:

- Cost-effectiveness
 - Sustainability
 - People and community empowerment, and
 - Human Rights protection and promotion.
- Effectively mainstreaming health risk factors into other SDGs and offer a toolbox to tackle them to help achieve multiple other SDGs



The example of alcohol as obstacle to development and the importance of just alcohol taxation for helping reach multiple other SDGs shows how critical it is that the Global Action Plan for Healthy Lives and Well-being for All effectively mainstreams assessments of health risk factors into all other relevant SDGs – and that the best buy measures are effectively offered to policy makers in other SDGs as tools to help achieve more comprehensive and long-term sustainable outcomes.

For example, a \$1 investment in the alcohol policy best buy measures generates a return of \$9 dollars. This illustrates the potential that addressing health risk factors holds for SDG3, resource mobilization and other SDGs.

Such approaches also help building multi-stakeholder, cross-sectorial actions to reach health for all and leave no one behind.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

IOGT International strongly recommends the WHO-UNDP Joint Program on “Strengthening and integrating national policies and programmes addressing gender-based violence, harmful use of alcohol and infectious diseases.”

UNDP, WHO and civil society partners FORUT (Norwegian IOGT movement’s development branch) and IOGT International are implementing a Joint Programme to strengthen and align national policy frameworks for the harmful use of alcohol, gender-based violence, and infectious diseases.

The Joint Programme has been undertaken in 12 countries in Africa and Eastern Europe, with multi-stakeholder delegations being trained on the issues, then designing and implementing country road maps that aim to ensure that the policy frameworks for each of the three issues take account of the risks and impacts of each other. Each country delegation comprises government, civil society and UN agencies to address the issues in an integrated manner.



The Joint Programme hypothesized that taking an integrated approach to all three issues – and strengthening national alcohol policies in particular – would result in significantly improved outcomes for health and development.

By convening a diverse range of stakeholders who can influence policies – ministries of health, ministries of finance, law enforcement, UN organizations, civil society and academics – to sensitize them to the multiple interactions of gender-based violence, the harmful use of alcohol and HIV and TB, and then having them implement at country level an agreed road map, the participating countries can achieve the dual goals of strengthening their health policies and integrating programmes addressing the three issues.

Programme experience to date has demonstrated that all 12 participating countries consider the alignment of these policy frameworks to be a matter of priority. Nine of the countries have established multi-stakeholder working groups to endorse and implement their country road maps. UNDP, WHO and other partners are providing technical assistance as they work towards fuller integration.

Of the three issues, national policies on alcohol are the least developed. Of the nine countries participating in Africa, only one had in place a national policy on alcohol. And that one policy did not take into account the linkages between alcohol and GBV or HIV. In most of the other countries a national alcohol plan was stuck in draft form, often after intervention by non-health sectors or the alcohol industry. The Joint Programme plans to support implementation in the 12 existing countries while expanding to another 18 countries in 2015-2016.

The new WHO-led SAFER initiative and technical package, in collaboration with UNDP and the UN Interagency Task Force on NCDs, supported by civil society partners is also a collaborative effort that is a great example of how the Global Action Plan for Healthy Lives and Well-being for All can be brought to live and concretely be filled with action.



Comments on the accelerator discussion papers:

Financing

- 1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?**

In 2010, almost a decade ago, the World Health Report presented the following evidence:

"Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation].

"Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries. "

Alcohol taxation, like other health promotion taxes, holds massive potential for achieving SDG3, UHC, and multiple other SDGs. Alcohol taxation is a triple win measure:

- It helps reduce and prevent alcohol-related harm.
- It helps promote health and sustainable development for all.
- And it helps raise domestic resources for health and development.

Health promotion taxation, like alcohol taxes, is pro-poor, pro-health and pro-sustainable development.

Therefore, fiscal policy measures like alcohol taxation should be fundamental elements of efforts to tackle SDG3 and beyond and foster wide-ranging partnerships.

The paper should more clearly highlight the demand for and urgent need for the provision of technical advice and assistance on alcohol taxation to developing countries.



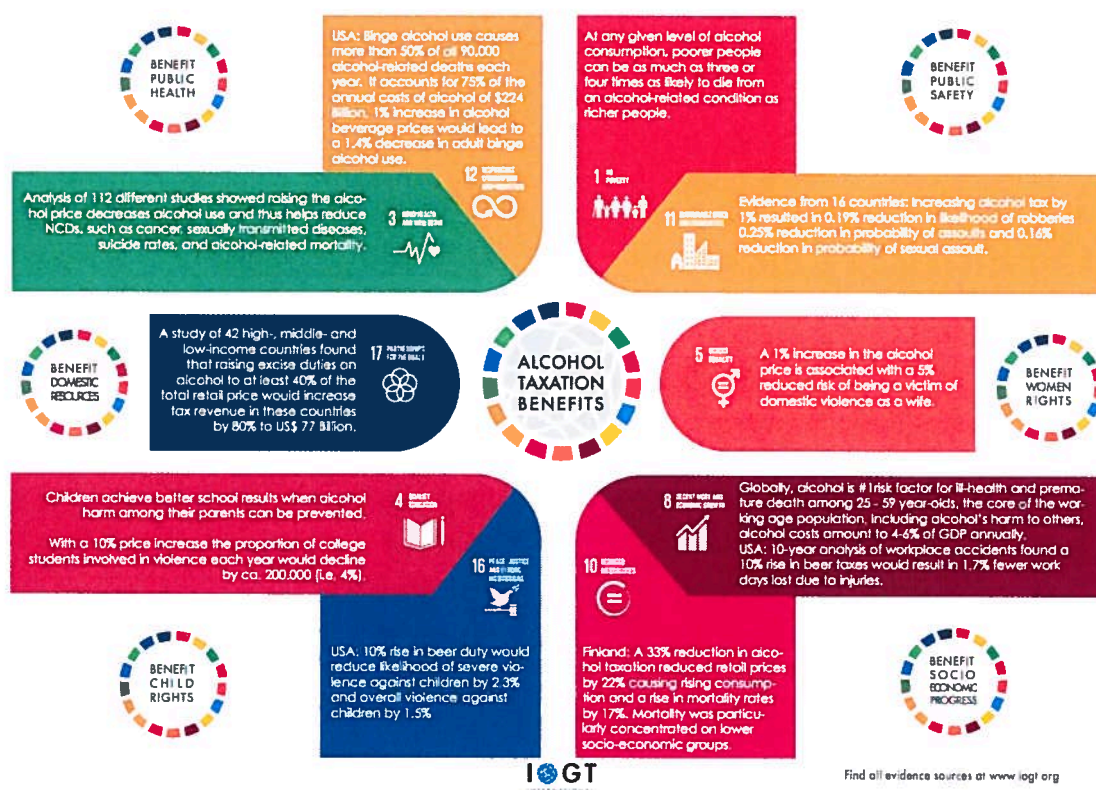
Secondly, the paper should clearly outline the importance of removing subsidies for alcohol and other health and development harmful commodity industries.

Thirdly, the paper should also more clearly highlight the significance of divesting from such industries, especially in developed countries, should be priorities.

Fourthly, the paper should outline the importance of the investment case for health promotion taxation.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

An action that is critical to foster progress towards the SDGs, especially SDG3, is to support member states with investment cases for the health promotion taxation. The UN Interagency Task Force on NCDs already does this well for the NCDs best buys and we therefore recommend that this dimension is included in the SDG3 GAP.



We propose a "Global joint initiative for alcohol taxation" (and/ or STAX as a whole). The country-demand for more technical capacity-building support in this area is high and unmet. Furthermore, there are clear benefits across the targets of SDG3 and multiple other SDGs from such an innovative joint initiative.

In Uganda, [alcohol taxation is being used to support services for people affected by HIV/ AIDS](#). In Kenya, [alcohol harm poses an obstacle to President Kenyatta's "Big 4 Agenda"](#) – and [alcohol taxation is a significant tool](#). Thailand and the Philippines are other examples of how alcohol taxation helps achieve other SDG targets. Therefore, such a joint global initiative has substantial potential to put countries better on track to achieve SDG3.



3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

IOGT International is leading the work to form the joint global initiative mentioned above. We are a key partner of the SAFER initiative mentioned above.

Comments on the accelerator discussion papers:

Determinants of health

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

IOGT International lacks even clearer mention of conflicts of interest, their nature and the critical need to safeguard against such conflicts of interest and to protect policy coherence across the involved agencies to achieve SDG3.

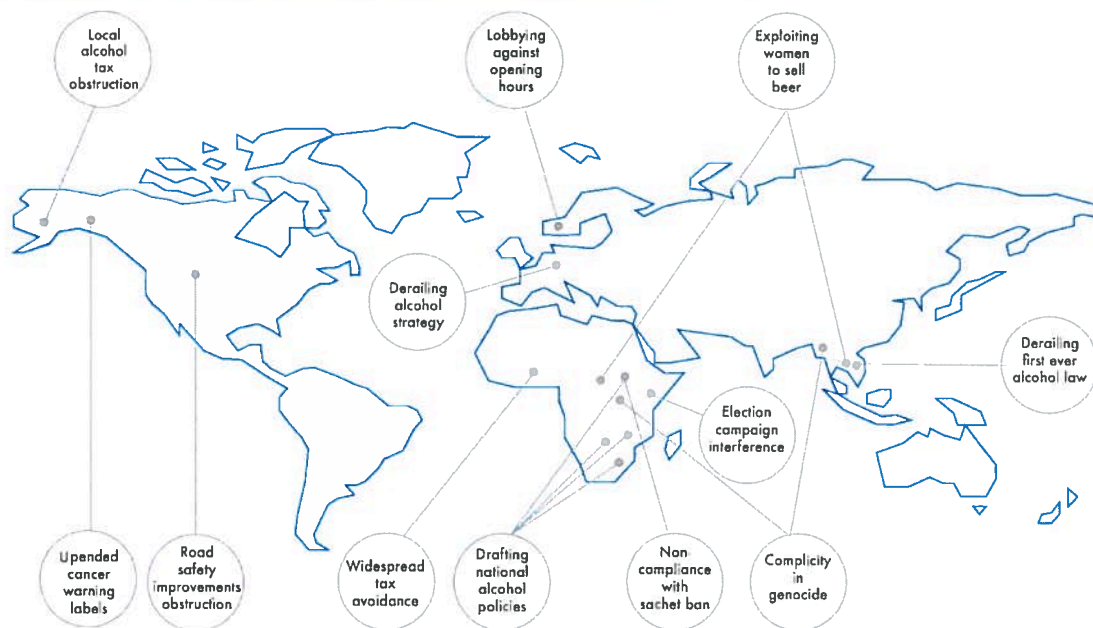
Consider for example the fundamental conflict of interest at work regarding the alcohol industry: While increased alcohol consumption leads to increased adverse health and development impacts, it also leads to increased sales for the alcohol industry, causing a fundamental and direct conflict between the public interest and the profit interests of the alcohol industry. The alcohol industry receives significant profits from the harmful use of alcohol, with 65% of sales in high-income countries and 76% of sales in middle-income countries resulting from Heavy Episodic Alcohol Consumption.

For example, in the United Kingdom alone, alcohol sales would drop by 38%, or 13 billion GBP, if alcohol users would not drink in excess of recommendations.

[A mapping of alcohol industry political activity also clearly shows that the industry and their front groups are actively and aggressively working to derail obstruct and undermine WHO-recommended alcohol policy solutions.](#)



BIG ALCOHOL LOBBYING: WORLDWIDE FOOTPRINT OF INTERFERENCE



IOGT
INTERNATIONAL

If the alcohol industry really had an interest in promoting health, they would not contest science and undermine public awareness of the fact that alcohol causes cancer and heart disease.

We urge all agencies of the Global Action Plan for Healthy Lives and Well-being for All to adopt WHO and UNDP on conflict of interest, including the Global Fund, that still has not terminated their partnership with beer giant Heineken.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?



Action should be taken to harmonize and find a uniform approach to health harmful industries across all agencies involved. The Global Fund should terminate its ill-advised partnership with beer giant Heineken, and the high standards of WHO and UNDP should be adopted by all other agencies involved.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

IOGT International is partnering with countries to help protect alcohol policy formulation and implementation processes from alcohol industry interference. We are also working with leading scientists to develop an interactive tool to inform about that tactics of the alcohol industry and the perils of engaging with the alcohol industry in so-called CSR partnerships. Thirdly, we are running a campaign called Big Alcohol Exposed in order to immunize decision-makers, communities and the broader public against the myths and tactics of the alcohol industry by revealing the unethical business practices.

SDG3_Secretariat

From: Billi McCarthy-Price <billi@globalvoices.org.au>
Sent: Tuesday, July 2, 2019 8:02 AM
To: SDG3_Secretariat
Subject: General Comments

Hi there,

I hope this email finds you well.

Thank you for providing us all with the opportunity to provide feedback on the Global Action Plan for Healthy Lives and Well-being for All and accelerator discussion papers.

Please find my comments outlined below:

Global Action Plan for Healthy Lives and Well-being for All

Overall, this document does not provide enough detail to support its proclamation of being an 'action plan'.

This document should better explain how the organisations will work in a bottom-up approach, together with their communities on the ground, to ensure that they can sustain and accelerate progress across the health-related SDGs. This document should better outline how together the 12 stakeholders plan on incorporating experience-based co-design into their decision-making and investment approach, to support meaningful collective action. This should include articulating how the Action Plan will work together with those population groups that it identifies as being particularly vulnerable, including children and young people.

Accelerator Discussion Paper 3: Community and Civil Society Engagement

I appreciate the inclusion of the objectives:

1. Adopt specific measures to increase opportunities for engagement in activities of global health organizations where such engagement is demonstrated to add value in delivering better policy and/or programmatic outcomes.
2. Support more meaningful, diverse engagement, especially of under-represented communities.

However, I feel that the outlined key inputs/contribution provided do not adequately address these objectives. There needs to be greater details provided as to what this collaboration will look like, including an outline of the estimated resources required to ensure that it is meaningful.

For many civil-society organisations led and engaging on behalf of under-represented communities, it can be difficult to dedicate time to collaboration, especially if it is not deemed as valuable to stakeholders. This is especially true for many youth organisations, who are additionally limited by reduced capacity to engage, most commonly as a result of not being able to secure sustainable funding.

Nevertheless, young people are keen to be a part of the decision-making process, contribute their knowledge and ways of knowing, and provide ideas and solutions that are appropriate for their population group. This is especially important in the health sector, where youth-led co-design activities have proven to result in better treatment outcomes, particularly in mental health service design and provision.

Thank you once again for the opportunity to contribute and I wish you all the best in the development of the final version of the Action Plan.

Kind regards,

Billi McCarthy-Price

Chief Executive Officer | Global Voices
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Submission on

GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL

Accelerator Discussion Paper 4: Determinants of health

Global Alcohol Policy Alliance

The authors and contributors of this accelerator discussion paper are to be congratulated. It is a valuable overview with important recommendations.

This submission is made on behalf of the Global Alcohol Policy Alliance, an international NGO with a focus on the promotion of evidence based alcohol policy free from industry influence.

GAPA strongly supports the section in the accelerator paper on commercial determinants. This highlights pervasive lobbying and industry interference in policymaking and significant expenditure on advertising to win the contest for public opinion and points out that these stand in the way of policy coherence. These have been widely observed in relation to alcohol policy and is particularly apparent in those middle income countries with growing economies, the primary targets of the alcohol industry. The growth and consolidation of the transnational alcohol corporations have produced very powerful actors in national and global health environments. Their actions have resulted in delays and outright subversion of effective alcohol policy.

Trade and investment agreements are part of the environment in which the industry works to prevent effective policy being enacted and are used to create a chilling effect as countries are concerned not only that they might be sued but also about the resources which would be required to respond to such actions.

The accelerator paper points out that taking multi-sectoral action to make visible and address commercial determinants will also assist the achievement of SDG 16: to develop transparent and accountable institutions. The experience in the alcohol policy field suggests this is something urgently needed to ensure commercial determinants do not prevent the achievement of SDG 3.5 on substance abuse including harmful use of alcohol. The commercial determinants in the alcohol space also have relevance for a number of other health related targets such as 3.4 on NCDs, 3.3 on HIV/AIDS and tuberculosis and 3.6 on road traffic accidents.

There is an urgent need, as the accelerator paper suggests, for GHOs to review their code of conduct policies regarding private sector engagement in order to avoid conflicts of interest with private sector actors developing, selling or marketing health-harming products. The conflict of interest with alcohol industry is considerable. The industry relies on very heavy drinking occasions for significant parts of their sales and profits and interferes with the uptake of effective policy to prevent any loss of sales. Strengthening the regulatory framework for alcohol is urgently needed and, as with tobacco, the protection needs to be global in order to assist national governments to protect public policy from vested commercial interests.



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Comments on the Global Action Plan

- Important to make the difference between physical and mental health and the interconnections between the two.
- Mental health is a development issue and there is a clear correlation between facilitating people's access to social benefits and the improvement in their mental health status.

Comments on Accelerator Discussion Paper 3: Community and Civil Society Engagement

- 1) Action 2: Improving alignment of community and civil society funding and capacity strengthening at the country level:
 - Suggest to explicitly state that a community led mental health model can help supplement existing public health models and reduce burden on health systems. Community volunteers can be trained to provide primary support for common mental health disorders and make referrals to the public health system to address severe mental health disorders¹
 - Caregiver networks should be encouraged and strengthened
 - Investments should be made to build capacities of primary healthcare workers
 - Community mental health model is the most effective way to build resilience and ensure 'prevention' sustainably within a community
 - Workplaces in urban centres can be encouraged to take up mental health policies further expanding the definition of 'community' and strengthening interpersonal ties in urban contexts²
 - Building peer support groups is another way to build and strengthen community engagement

¹ As evident in models supported by the WHO Quality Rights Programme
https://www.who.int/mental_health/policy/quality_rights/en/

² https://www.who.int/occupational_health/publications/healthy_workplaces_model.pdf?ua=1 and
http://www.euro.who.int/data/assets/pdf_file/0018/124047/e94345.pdf?ua=1

- Persons with disabilities should be given representation on bodies working in conflict and vulnerable settings

2) Emergency Preparedness:

- Emergency personnel should be trained in working with persons with disabilities and in primary mental health care to be able to address mental distress in the aftermath of a crisis situation/ disaster or disease outbreak
- Emergency personnel should also be trained in working with women and adolescent girls to avert risks to their sexual and reproductive health in a conflict situation/ aftermath of a disaster

2 July 2019

**Comments from the International College of Person Centered Medicine
on the Global Action Plan for Healthy Lives and Well-being for All**

We are honoured to provide comments on behalf of the International College of Person Centered Medicine (ICPCM) on the **Global Action Plan for Healthy Lives and Well-being for All** aimed at supporting countries to achieve the health-related SDG targets.

The ICPCM welcomes the inclusive and participatory process adopted in the developing and refining the Action Plan. We are convinced that the SDG3 – to ensure “healthy lives and well-being for all at all ages” is a noble goal that deserves support by all stakeholders.

ICPCM particularly welcomes the linkages of this goal to poverty eradication, reducing inequality, food security, education, gender equality, climate action and peace. We are heartened by the integration of health into the 14 goals and 50 targets in a multisectoral collaboration, as we believe that healthy lives and well-being cannot be achieved by the health sector alone. The determinants of health, that are outside the health sector, are the bedrock of achieving healthy lives and well-being and the Action plan does well in this regard.

The ICPCM welcomes the Action Plan's departure from vertical and competing approaches, into collaboration, synergy and multisectoral interventions. Universal health coverage, along with interventions that address the determinants of health, is a sound entry point for healthy lives and well-being. ICPCM fully supports the “health in all sectors” approach as there cannot be development without healthy and productive populations.

From the vantage point of the ICPCM - which works to advance person- and persons- centered care - we reaffirm our commitment to the principles of the International Conference on Primary Health Care held in Alma-Ata in 1978 promoting that health should be recognized as a fundamental right and also a duty of all individuals and communities. Therefore, it must be formally incorporated into the greater legal structures of nations.

We also propose the recognition of the value of the conceptualization of Primary Health Care as Persons-centered Integral Health Care, in which persons are posited as the center of the concept of integral health and as the goal of health actions. Such conceptualization of Primary Health Care may contribute to the strengthening of its philosophical base, clarify its fundamental purpose, highlight quality of care and social commitment, and facilitate its implementation, measurement and evaluation. For these reasons, it should constitute a guiding axis for country's policies and actions to improve health and well-being.

Likewise, we strongly urge that the “persons” including families and communities be fully engaged in all phases of the Action Plan including assessing, implementing and evaluation of the interventions. To this end we propose a ‘bottom-up’ and grass roots approach, rather than a top-down and conventional models driven by experts. Implementation of the Action Plan should take into consideration that health is “produced” by individuals, families and communities within the context of their lives. A person-centered approach will ensure that individuals, families and

communities are considered agencies of their healthy lives and well-being, not just passive recipients of care.

Finally, in the next phase of the Action Plan, a road map needs to be developed to guide the inputs and actions of the partner agencies. This should take note of the comparative advantage of each agency, avoid duplication or even competition between the agencies, and set out how each can add value to achieving the targets set out in SDG3.

INVITATION FOR PUBLIC COMMENT GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL

(General comments on the Global Action Plan)

Gefra Fulane (1), Cristina Bernardo (1) & Ricardo Baptista Leite (1)

(1) UNITE, *the Global Parliamentarians Network to End HIV/AIDS, Viral Hepatitis and other Infectious Diseases* (<http://unitenetwork.org/>)

For UNITE, *the Global Parliamentarians Network to End HIV/AIDS, Viral Hepatitis and other Infectious Diseases*, the Global Action Plan for Healthy Lives and Well-being (herein GAP) offers opportunities to achieve the health-related Sustainable Development Goals (SDGs) that go beyond the Goal 3. To respond to challenges related to maternal, new born and child health, communicable and non-communicable diseases, substance abuse and injuries, universal health coverage and sustainable financingⁱ, *sil*o-based efforts are no longer accepted. Integrated initiatives rooted on comprehensive and cross-sectoral responses are needed to improve overall performance across all health-related SDGs and ensure healthy lives and well-being for all at all ages.

Innovative partnerships across institutions working on attaining the SDG3 have to be rooted on real-world assessment of needs, be driven on the best scientific and community evidence, and be embedded into policymaking. Embedding the GAP into policymaking should go far from *ad hoc* sharing “*the formal written documents, rules, and guidelines that present policy makers’ decisions about what actions are deemed legitimate*”ⁱⁱ and target investments on affective engagement from the onset of the planning and implementation of the GAP’s accelerators locally and globally. However, embedding policymakers is not an easy task. It requires the ability to convene partners, to engage with decision-makers for them to support innovations, methods and monitoring approaches of the GAP. This task is even more complex in low- and middle-income countries where evidence and policymaking are mostly on opposite sidesⁱⁱⁱ.

As a network of parliamentarians, current and former legislators from all over the world, at UNITE we promote political responses to end infectious diseases through activities to increase political awareness, political will, political advocacy, political leadership, and political accountability. Mostly left behind, policymakers and legislators can have countless contributions to make to change the trajectory of their countries in the co-creation and implementation of a GAP that stands on good policies to save lives.

Two general recommendations we make on the GAP:

1. To embed the GAP into local policymaking

To increase the will to uptake, adapt and implement the GAP accelerators' actions, ongoing interest of local political representatives must exist. The 12 signatories of the GAP work differently within specific countries. Some have robust establishment in country, and a trust and impact-based relationship is endured. But others are not. Embedding the GAP into local policymaking processes implies to engage government bodies and decision-making entities, but also the parliamentarians who have a key role in approving budgets, changing laws, influencing policies, and keeping governments accountable. This implies that the 7 GAP's accelerators need to be translated to fit into policymakers' backgrounds, interests, and what they value the most. This way, policymakers and legislators can have the opportunity to increase access to resources, suggest changes of laws toward an effective implementation of the accelerators, boost the emergence of community and peer-led initiatives, increase domestic support and funding.

2. A global political platform to boost the GAP

Shared goals for the GAP should imply shared responsibility in both the implementation and the assessment of the actions. A global platform that is composed of current and future policymakers and legislators that will ensure the global acceleration and accountability of the actions on the GAP, position the objectives within the global decision-making arenas and forums, and influence the accurate development of value-based guidelines and actions plans, is mandatory. This does not require the creation of new platforms. Existing institutions, network of parliamentarians like UNITE and others, can be leveraged in joint actions to advocate for- and build global consensus on- the GAP.

About UNITE

UNITE was found in 2017 by Dr Ricardo Baptista Leite, Medical Doctor, Member of the Portuguese National Parliament and is Vice President of the Parliamentary Network on the World Bank and International Monetary Fund. UNITE works on promoting political responses to end the threat of infectious diseases in line with the 2030 United Nations Sustainable Development Goals. A non-partisan and non-profit organization UNITE was created with auspicious of the UNAIDS, and currently accounts with 92 members of parliament from 49 countries across 5 continents. Please find more about UNITE at <http://unitenetwork.org/>.

ⁱ WHO (2019) <https://www.who.int/sdg/targets/en/>

ⁱⁱ Sheikh K, Gilson L, Agyepong IA, Hanson K, Ssengooba F, et al. (2011) Building the Field of Health Policy and Systems Research: Framing the Questions. *PLoS Med* 8(8): e1001073. doi:10.1371/journal.pmed.1001073. Page 2.

ⁱⁱⁱ Hyder, A.A., Bloom, G., Leach, M., Syed, S.B. and Peters, D.H., 2007. Exploring health systems research and its influence on policy processes in low income countries. *BMC public health*, 7(1), p.309.



INVITATION FOR PUBLIC COMMENT

GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL

(Accelerator Discussion Paper 1: Sustainable Financing)

Amish Laxmidas (1), Cristina Bernardo (1) & Ricardo Baptista Leite (1)

(1) UNITE, the Global Parliamentarians Network to End HIV/AIDS, Viral Hepatitis and other Infectious Diseases (<http://unitenetwork.org/>)

On 'A fragmented approach in how development partners invest and align with national health priorities' (PAGE 2)

- Institutions like UNITE can engage with Foreign Affairs Committees and Development Committees for larger support and funding on DAH and monitor which countries are missing their pledges. Through bilateral pressure (from Parliaments to Parliaments), leading countries can impact more effectively
- Institutions like UNITE could be a link to provide numbers and data regarding DAH and share it to the Health, Foreign Affairs and Development Committees of the donor countries to LMICs

On 'Inefficient and inequitable health spending' (PAGE 3)

- UNITE is partnering with the Parliamentary Network (PN) on the World Bank and IMF and has a track-record in engaging parliamentarians in a) more spending on health and b) with the PN assuring that the anti-corrupt, more transparent and fairer contributions are being taken and that parliamentarians can easily monitor how money given by World Bank was implemented by countries and monitor the efficiency.

ON What principles govern the approach of Sustainable Financing Accelerator for SDG 3 (PAGE 3)

- UNITE salutes the approach in which countries take the 'driving seat' in leading the change and this allows to facilitate the message of why international development aid is important and why UN institutions are helpful and useful today
- This country-led demand and support can include a financial amount to be exclusively given to national political parties which must give to MPs to spend on health in their constituencies – this will create a country-led demand and a local-led impact as well

About UNITE

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INVITATION FOR PUBLIC COMMENT
GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL
(Accelerator Discussion Paper 3: Community and Civil Society Engagement)

Victoria Grandsoult (1), Cristina Bernardo (1) & Ricardo Baptista Leite (1)

(1) UNITE, *the Global Parliamentarians Network to End HIV/AIDS, Viral Hepatitis and other Infectious Diseases*
(<http://unitenetwork.org/>)

Action 2: Improving alignment of community and civil society funding and capacity strengthening at the country level (Comments on Objectives 1 & 2)

- UNITE's global network offers a key, but often missing, response to the global response to fulfilling SDG 3: engaging parliamentarians. Members of parliament approve health budgets, change laws and influence policies, and their participation is a crucial component in allocating funding, growing the capacity of community and civil coalitions, and strengthening health policy dialogue and awareness.
- UNITE connects MP's with community leaders, who provide specific details on the disease burden in their community and how they are responding. Engaging MP's to harmonize financing initiatives offers a more sustainable response for community and civil society funding and capacity strengthening at the country level.

Action 4: Building/Strengthening a Virtual Platform (Comments on Objectives 1-4)

- Building and strengthening a virtual platform would be an immensely productive initiative that the UNITE Secretariat and global network could simultaneously benefit from and support. A virtual platform to join all relevant, international stakeholders would greatly increase the opportunities to share best practices and streamline political engagement with the community and civil society.
- This online space could provide accessibility to policy initiatives and calls to actions implemented by UNITE and its parliamentarian members to empower civil society and community partners to better advocate for their needs, while promoting participation from other governments to execute similar initiatives in their communities.

About UNITE

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INVITATION FOR PUBLIC COMMENT

GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL (Accelerator Discussion Paper 4: Determinants of Health)

Cristina Bernardo (1) & Ricardo Baptista Leite (1)

(1) UNITE, the Global Parliamentarians Network to End HIV/AIDS, Viral Hepatitis and other Infectious Diseases (<http://unitenetwork.org/>)

Accelerating progress on SDG3, related SDGs and the pledge to leave no one behind requires unified efforts to address the determinants of health inequities or disparities (Introduction)

- UNITE network empower parliamentarians to be the leading actors in fulfilling the 2030 SDG agenda. To do so successfully, the parliamentarians engage in a multi-stakeholder approach grounded in human rights. The multi-stakeholder responses can contribute for the determinants of health.

There are critical gaps and challenges [...] One challenge is that policies, regulations and actions are typically compartmentalized or siloed across sectors, and institutions give insufficient attention to interactions, contradictions and connections. (Scope).

- UNITE is a collaborative network, between parliamentarians and all relevant stakeholders. The continued growth of UNITE's international representation can also address the determinants of health in a way that would accelerate and sustain progress on health and wellbeing. Members of Parliament approve health budgets, change laws and influence policies, keep governments and multilateral organizations accountable and are at an interface between decision makers, civil society and community-based organizations. The UNITE collaborative efforts can contribute for the priority aspects of three key determinants: environmental determinants, commercial determinants and social determinants.

Laws and policies matter. The continued existence of discriminatory laws, such as [...] drug use, can significantly affect access to health care (Structural determinants).

- UNITE network parliamentarians Advocate for the elimination of laws, policies and practices that perpetuate discrimination, harmful criminalization and stigma that can impact negatively the achievement of the SDG's goals mainly among key populations and vulnerable groups. UNITE network parliamentarians contribute for the review of laws and policies that stigmatise or discriminate against marginalized groups.

Action area 3: Integrating strategies and approaches, and monitoring and evaluating progress (Annex1).

- UNITE supports parliamentarians with information on integrated health approaches towards ending ID's as a global health threat. Building parliamentarians accountability to enable their proactive assessment of the progress the human rights approaches.

About UNITE

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Response to Global Action Plan and Accelerator 5

Feedback from the RBM Partnership to End Malaria, June 2019

General comments on the Global Action Plan

1. *What do you see as the key opportunities offered by The Global Action Plan for Healthy Lives and Well-being for All?*

There is a clear rationale for the Global Action Plan (GAP), and for alignment of the 12 leading global health and development agencies to accelerate progress towards the health-related targets of the 2030 Agenda for Sustainable Development. The proposed accelerators could bring about sweeping transformations to the global health infrastructure and create important forces for generating country-led demand for health innovations. Enacting the proposed accelerator recommendations will provide an opportunity for health actors to exchange key information, build on past successes, and eliminate cross-cutting bottlenecks that delay or limit access to health innovations by the populations that need them. The GAP could therefore be a momentous step to expanding quality health coverage and realizing the fundamental human right to the highest attainable standard of health.

2. *Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?*

Under the RBM Partnership to End Malaria, a collaboration founded by four signatory agencies (UNDP, UNICEF, WB, and WHO), a global scale-up of core malaria interventions – especially artemisinin combination therapies (ACTs), long-lasting insecticide treated nets (LLINs), and malaria rapid diagnostic tests (mRDTs) – together with key health system investments – especially in community health workers (CHWs), health management information systems (HMIS), and procurement supply management (PSM) – have led to reductions in malaria burden, which have themselves decongested primary health clinics and freed up resources to address other health needs. Likewise, history has shown that failure to explicitly allocate resources to addressing malaria can lead to resurgences, which can overwhelm health systems and cripple their capacity for providing a full range of health services during peak malaria transmission seasons. This partnership has been most effective when malaria endemic country and regional leadership engage with donor countries and agencies, implementing partners, civil society, and the private sector to agree on shared objectives and follow one, well-coordinated strategic plan.

Comments on the Accelerator discussion paper 5 on R&D, Innovation & Access:

1. *Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?*

Given the importance and scale of the proposed changes for R&D, innovation and access, the almost total silence on the role of the private sector is deeply troubling. The London Declaration on neglected tropical diseases (NTDs), one of the most successful multi-stakeholder interventions for health, has the private sector right at its heart – not as a secondary add on. The private sector role – including through multi-stakeholder partnerships, product development partnerships (PDPs) and bilaterally with countries – is only fleetingly touched in the proposed revisions. This is the principal omission in the GAP report.



With a 20-year record of remarkable achievement in reducing the malaria burden, the RBM Partnership to End Malaria has successfully collaborated with the private sector from its inception. We have learned how to leverage private sector participation as an active constituency, managing Conflict of Interest concerns and collaborating for impact against malaria. As a case in point, the Innovation 2 Impact (I2I) Initiative provided the impetus for changes to the innovation and policy processes adopted by the WHO GMP – these changes presage the current WHO reforms and are indicated as directions in the GAP.

In addition, malaria-specific PDPs such as IVCC, MMV and FIND have developed a wealth of experience and expertise about how to work effectively with the private sector to bring new effective products to market and into the hands of affected populations. The example of MenAfriVac, a vaccine developed to use against meningococcal bacterium *Neisseria meningitidis* group A at less than US \$0.50/dose is a case in point. There exist many other such examples (positive and negative) across the PDP community. The UN Secretary General has emphasized that the Sustainable Development Goals (SDGs) depend on the achievement of SDG 17 – the commitment to stronger partnerships. The RBM Partnership more broadly and PDPs more specifically are among the necessary partnerships which will improve the alignment and effectiveness of the agencies in the GAP report.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

The private sector is not listed as a constituency expected to participate in the new “Annual Global Forum” to align national R&D/innovation agendas, an oversight given the important role of business in developing and delivering malaria innovations. Over the next months, as the 12 GAP signatory agencies start translating the GAP commitments into practice at global, regional and country level, broader partner engagement beyond the GAP agencies will be essential. Mechanisms for meaningful engagement of all innovator constituencies, directly including global health partnerships and a defined mechanism for coordinating engagement of the private sector, must be effectively leveraged.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

The RBM Partnership to End Malaria works actively to eliminate malaria as defined by the World Health Assembly (WHA) adopted resolution, and in line with targets set by the WHO Global Technical Strategy (GTS) for Malaria. In addition to reaching the GTS targets, achieving Universal Health Coverage (UHC) will require adopting a ‘last mile first’ approach which ensures that vulnerable and most-at-risk populations are prioritized. In particular, this means ensuring that quality community-based interventions for prevention, including vector control, diagnosis, and treatment are available for hard to reach populations. For the highest malaria burden countries which increasingly represent a disproportionately large share of the global malaria burden – the top 11 burden countries represent 71% of malaria cases globally – the RBM Partnership and WHO are supporting countries with a High Burden to High Impact (HBHI) approach. This approach is grounded in a multisectoral development response and effective health system and includes the response elements of Political Will; Strategic Information; Improved Guidance; and Unified National Coordination. This approach is designed to accelerate progress to achieve malaria targets in line with SDG 3 and provide also a multisectoral framework for malaria to which the accelerator actions could align.



Background on the RBM Partnership

Comprised of more than 500 partners, including malaria endemic countries, bilateral and multilateral development partners, the private sector, nongovernmental and community-based organizations, foundations, research and academic institutions, the RBM Partnership to End Malaria mobilises partners and builds consensus in order to coordinate specific initiatives for political advocacy and resource mobilisation, mission-critical country and regional support, and strategic communications to amplify collective efforts to end the disease for good. Launched in 1998 by WHO, UNICEF, UNDP and the World Bank, and currently hosted by the United Nations Office for Project Services (UNOPS) in Geneva, Switzerland, the RBM Partnership convenes partners, builds consensus, and coordinates an integrated response to malaria at national, regional, and global levels. Guided by the Action and Investment to defeat Malaria (AIM) 2016-2030 and RBM Partnership Strategic Plan 2018-2020, the RBM Partnership positions the fight against malaria in the context of the broader development agenda, indicating how reducing and eliminating malaria creates healthier, more equitable and prosperous societies, and promotes a broadly inclusive and multi-sectoral response to achieving those ends.

SDG3_Secretariat

From: Lindsay Denny <ldenny@globalwater2020.org>
Sent: Tuesday, July 2, 2019 10:27 PM
To: SDG3_Secretariat
Subject: Accelerator 2 & 7

To Whom It May Concern:

Regarding Accelerator 2 and Accelerator 7: We support the inclusion of WASH in healthcare facilities throughout the document as it relates to the need for robust infrastructure for safe, quality care.

More than [80 commitments](#) have been gathered to drive momentum towards ensuring sustainable basic WASH in healthcare facilities will available in all healthcare facilities by 2030. To facilitate coordination, it would be important for signatories (such as WHO, UNICEF, WBG and GFF) as well as other stakeholders to participate in the global discussion around improving WASH in healthcare facilities, including where work in fragile and vulnerable settings is (or should be) underway. WASH should be considered as foundational, supporting both the broader system strengthening and emergency preparedness activities underway and therefore WASH activities should be integrated into these approaches. Signatories should be encouraging sustainable financing which includes not only funding of treatment but also prevention, whereby increasing the effectiveness of the limited funds.

Best,
Lindsay Denny, MPH
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Invitation for public comment: Global Action Plan for Healthy Lives and Well-being – EFA comment on the Global Action Plan outline

EFA is the European voice for over 200 million people living with allergies and airways diseases. We bring together national associations from 25 countries and channel their knowledge and demands to European institutions.

EFA welcomes the joint vision expressed by the 12 global health and development organisations to strengthen their collaboration and advance collective action towards the achievement of the '*Sustainable Development Goal 3 – Ensure healthy lives and promote well-being for all at all ages*'. EFA is glad to see that the draft Global Action Plan for Healthy Lives and Well-being for All acknowledges the cross-cutting nature of health challenges and the subsequent need for multi-sectoral action to accelerate progress on the SDG3.

Despite benefiting from public health action and healthcare systems based on solidarity, 200 million Europeans living with allergy, asthma and COPD still suffer daily from these chronic diseases. Even if preventable, many end up dying from them. In particular, our comments are meant to weight the actions Europe should apply to achieve health in our continent. Below we offer our insights on how EFA understands the opportunities presented by the draft Global Action Plan, and ways to enrich the current text to support progress towards the SDG3 and related health and development goals:

- In line with its multi-sectoral approach, the Global Action Plan presents an opportunity to further link **SDG3 with other international thematic initiatives on addressing human health**, such as the 2015 Paris Agreement, the WHO Framework Convention on Tobacco Control, the WHO work on Ambient and Indoor air pollution, and the joint FAO/WHO Codex Alimentarius Commission. The Plan should ensure efficient connection with and between the different initiatives, focusing especially on risk factors and emerging health threats.
- By supporting actions of health-related inequalities, the Plan should become **the vehicle to promote awareness on the challenges facing vulnerable groups of the society**, including the poor, the chronic patients, the women/children/elders, the stigmatised, and the discriminated. These challenges need to be further studied, measured, and anchored in real-world evidence.
- Building on the intersectoral perspective of the current initiative, EFA believes that a future Plan needs to **embed, enable and emphasize on vertical aspects of governance**. That would entail the further engagement of international, regional, national and local actors in addressing health challenges and contributing to the SDG3. Having a better grasp of what each level can offer and how actions at one level translate and diffuse to the others can lead to better results, replicable all along the policy chain. Finally, such an approach would result in a comprehensive action plan that enables collaborative schemes and participation, taking full advantage of civil society experiences and resources in the area of health and well-being.
- When it comes to multilateral initiatives in the area of health and particularly the health-related goals of SDG3, it is **important to have all relevant UN agencies and programs on board**. For example, the UN Environmental Programme should be part of the discussions on challenges as persistent as air pollution.

Submitted on 2 July 2019 by Panagiotis Chaslaridis, Policy Officer at the European Federation of Allergy and Airways Diseases Patients' Associations.

**Global Action Plan for Healthy Lives and Well-being – EFA comments on Accelerator Discussion Paper 4
'Determinants of Health'**

Environmental determinants (p. 2)

- **Generate more knowledge on the impact air pollution has on human health** (including in-vitro health), to put public health in the driving seat of sustainable development in Europe. While the 1st WHO Global Conference on Air Pollution and Health has been an important milestone, UN agencies should be vocal in streamlining urgent action towards the national air pollution levels. EFA suggests:
 - **accelerate the ongoing WHO Air Quality Guidelines revision**, to set irrefutable science-based air quality levels beyond industry and traffic emissions, and to guide policy-makers and the public on actions to prevent, reduce and tackle air pollution
 - **reinforce the European Environment and Health process**, by monitoring the progress on the Parma and Ostrava declarations to improve indoor and outdoor air quality at national level
- In its considerations on healthy food and environment-friendly diets, EFA recommends to make an **explicit reference to the reduction of unhealthy food production technologies**, because of its suspicion of harmful effects on health. Pesticide and biocide use, highly processed food, chemical based packaging and the sudden introduction of (natural or created) novel foods, seem to be at the origin of an alarming increase in the prevalence of **food allergies** in Europe.

Commercial determinants (p. 3)

- EFA calls WHO and other agencies to underpin and strengthen the **human rights approach on health-harming products such as tobacco** to facilitate the protection of the most vulnerable (e.g. children) from accessing tobacco and from exposure to second-hand smoke. Whether patients or consumers there should be a specific **access to justice for people victims of the industry whitewashing of tobacco and its derivatives**. This could be realized in partnership with UNICEF, OHCHR and in line with the WHO Framework Convention on Tobacco Control and the Convention of the Rights of the Child.

Structural determinants (p. 4)

- Foster the discussion for the definition of a long-term strategy on chronic diseases, especially those that are non-communicable. Such a strategy should be underpinned by **ambitious national percentage targets for the reduction of deaths from chronic diseases**, especially those developing due to preventable risk factors.
- Target actions towards vulnerable societal groups, as being a patient translates into stigmatisation, discrimination, and social isolation. **Concerted action towards disease management based on a multi-disciplinary care approach** can offer better health outcomes and the collateral benefit of better social inclusion for the people living with the disease.

Annex 1

- Promote the reporting on human rights related to health **within the Universal Periodic Review process**.

Submitted on 2 July 2019 by Panagiotis Chaslaridis, Policy Officer at the European Federation of Allergy and Airways Diseases Patients' Associations.



Comments on the draft of the Global Action Plan for Healthy Lives and Well-Being for All Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access

The Business Alliance Against Malaria (BAAM) welcomes this opportunity to provide input into the Global Action Plan for Healthy Lives and Wellbeing (GAP) and the related accelerator discussion papers. Our comments are centered on the Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access.

We are an alliance committed to leveraging our leadership and innovative business strategies toward the elimination of malaria within our lifetime. United for a malaria-free world, we work together to inspire action and rally the business community at both local and international levels. As a coalition, our objectives are to catalyze action, promote innovations supporting treatment and prevention, and providing an engagement platform for our members.

BAAM believes that improving coordination of stakeholders in global research and innovation for health requires a collaborative and integrative approach that involves all relevant stakeholders within the healthcare value chain, including the private sector. In our view, the paper lacks references to the roles and contributions that the private sector provides in the delivery of innovative solutions to address pressing health challenges. The private sector sits at the heart of innovative processes at all levels of the value chain, from research and development of new health technologies to delivering and implementing solutions in communities.

The private sector has been involved in the fight against malaria for decades, providing innovative solutions for malaria prevention and treatment programs as core contribution, and facilitating access and capacity building initiatives as part of corporate social responsibility and/or workplace health efforts. While we here underscore commitments toward malaria elimination, the private sector has been committed for the long haul to addressing several other disease areas and challenging systemic issues.

The private sector holds significant experience in research, management, capacity building, and related activities, helping drive efficient, effective, and quality interventions. Partnerships between the public and the private sector are an essential conduit to health system strengthening, helping reduce duplication and maximize resources, building on the engagement and expertise of contributors at local, regional, and international levels. We believe that long-term solutions to systemic issues in innovation and access for health need to include dialogue with the private sector on how innovation is generated, governed, and delivered.

To fully realize the vision of GAP, and of the SDGs overall, we need a bold, ambitious, and clear policy framework that enables public-private collaboration and implementation. These issues are at the core of current discussions in global health, from malaria elimination, the fight against tuberculosis, the management of non-communicable diseases, to addressing dementia.



Breaking silos and creating trust, favoring integration and curbing inefficiencies are key approaches that enable the private sector to meaningfully contribute their core mission of delivering innovation. Dialogue and inclusion are vital to achieve effective system changes and mainstream private sector commitments into healthcare strategies.

Therefore, the Business Alliance Against Malaria encourages the authors of the Discussion Paper 5 to:

- Include references about the role private sector plays in innovation and access and the need for strong partnerships between the public and the private sectors. This is consistent to the spirit in which the Sustainable Development Goals were brought to life, including SDG17.
- Encourage private sector participation in the forums described in Action 2 and – especially – in Action 3. While we appreciate the challenges and the barriers related to private sector participation, we believe, nonetheless, that appropriate mechanisms for engagement can be developed, for instance through alliances and coalitions, modeled on systems currently in place at the WHO, Global Fund, and other GAP agencies.
- Define the criteria for developing the evidence-based list of existing innovations that could be scaled mentioned in Action 5. Also, we would encourage developing a mechanism to help private sector submitting examples for WHO's consideration.



Submission to the Global Action Plan consultation

The Global Financing Facility (GFF) civil society coordinating group (CSCG), hosted by the Partnership for Maternal, Newborn & Child Health (PMNCH),¹ is a network of civil society organizations engaging in the GFF process across 36 countries, at regional and global levels. The CSCG welcomes the GFF's innovative approach to enhancing financing for women's, children's and adolescents' health and well-being, particularly the focus on effective partnership and alignment of development partners. The CSCG also welcomes the Global Action Plan's objective of aligning major development partners' efforts to increase efficiencies and improve health outcomes.

The GFF's goals include the realization of universal access to high-quality and integrated sexual, reproductive, maternal, newborn and child and adolescent health and nutrition services, and the prioritization of services delivered at primary health-care level, ensuring that they reach the most marginalized. As outlined in the advocacy brief included as part of our submission, these services should form the basis for countries' efforts to achieve universal health coverage (UHC).

The global financing gap for achieving universal coverage of essential interventions to improve women's, children's and adolescents' health has been estimated at US\$ 33.3 billion per year.²

ACCELERATOR PAPER 1 – SUSTAINABLE FINANCING

The CSCG welcomes the Global Action Plan's [Accelerator Paper 1 on Sustainable Financing](#) and notes the following points.

More money for health: While the paper recognizes the continued reliance by some countries on development assistance for health (DAH),³ the drivers under this theme are centred on increasing domestic resources, which is crucial. However, it will be many years before some low- and lower-middle-income countries are able to fund health services fully from their national budgets. Therefore sustained efforts by key development partners are needed to ensure that bilateral donors meet their commitments to allocate 0.7% of their gross national income to official development assistance (ODA). This should be reflected as an important driver in Paper 1, emphasizing that ODA/DAH should be transformative, and support countries' domestic resource mobilization efforts (for example, ensuring better alignment of country development plans with national resource mobilization activities).

We welcome *driver 1 - Supporting people's and communities' voices for appropriate domestic allocations to health*, and the paper's recognition of the important role of civil society and communities in advocating for appropriate domestic resources for health, as well as the call for

¹ PMNCH is an alliance of over 1,000 member organization across 192 countries and 10 constituencies.
<https://www.who.int/pmnch/en/>

² Global Financing Facility: business plan. Washington DC: World Bank, 2015. <http://www.worldbank.org/en/topic/health/brief/global-financing-facility-business-plan>

³ Total DAH to countries in 2016 was US\$ 14.4 billion, representing less than 0.2% of spending on health worldwide. Although only a fraction of total spending on health globally, DAH provides about 30% of spending in low-income countries



increased resources (financial, human and technical) to enable them to play this role. We endorse the call for joint support to platforms (i.e. national coalitions/networks) of community and civil society organizations to structure their dialogue with and engagement in national health planning and related accountability processes. We urge that such platforms help to align resources from partners around support for communities and civil society, as called for in [Accelerator Paper 3 on Community and Civil Society Engagement](#). In addition to investing in these platforms, signatories to the Global Action Plan should encourage governments to institutionalize social accountability in health planning, in order to ensure feedback and redress. Governments must also enable community and civil society organizations to access financial information, and enhance the transparency of these data to enable them to engage effectively and support accountability. Signatories should support efforts to ensure that data from governments and donors are made available and that community and civil society organizations are financially supported in this important accountability role.

On driver 2 - Evidence-based dialogues between budget and health officials to accelerate fiscal reforms and mobilize more money for health, we note that very few low- and middle-income countries have finalized their health financing strategies/policies, and that where the development of these policies has started it has not been aligned with the UHC agenda. That lack of alignment has resulted in some policies stalling, and among others implementation has stagnated. Signatories should collaborate to fast-track support for the development of health financing strategies through inclusive processes.

More health for the money: A key benefit of the GFF for countries has been its ability to align partner financing behind national priorities by facilitating resource mapping, multi-stakeholder planning, aligned implementation and resource tracking. Driver 3 must identify disparate partner investments as a key cause of inefficiencies and call explicitly for increased efforts by signatories to support nationally defined financing priorities and strategies for public health and nutrition.

Joint programming and innovative financing: Countries have also identified the burden associated with managing different programmes that have different reporting structures. They have called for funds to be aligned as far as possible. We welcome driver 6 and call for the most ambitious realization of this aim, including for example aligned reporting structures and joint planning and audit arrangements.

Despite the private sector's significant role in health service delivery, little literature is available on how to successfully engage this sector. Signatories should develop a plan to document lessons learned from any successful innovative approaches involving the private sector, especially the for-profit private sector.

ACCELERATOR PAPER 3 – COMMUNITY AND CIVIL SOCIETY ENGAGEMENT

Recognizing their critical role in planning, implementation, resource mobilization, monitoring and accountability, we call for more and better investment by signatories in communities and civil society. We welcome the Global Action Plan's [Accelerator Paper 3 on Community and Civil Society Engagement](#) and note the following points.



Action 1 - Joint advocacy and enabling actions to expand civic space for health and investments in communities and civil society: While Action 1 includes outcomes concerning advocacy and capacity building for the inclusion of communities and civil society organizations in all processes, including country processes, it does not reflect outputs linked to monitoring processes for ensuring inclusiveness. We suggest that outputs linked to ensuring that guiding policies, strategies and documents be revised should be included, to ensure the prioritization of community and civil society engagement, and that monitoring of this engagement should form part of these partners' accountability efforts.

Outputs should include a review of how the various health spaces integrate communities and civil society, and how these can be aligned. As well as creating a virtual forum under action 4, live fora should be created or improved to foster participation by health community and civil society organizations. Both platforms should include civil society organizations working on social determinants of health.

Action 2 - Improving alignment of community and civil society funding and capacity strengthening at country level: We suggest changing this title to "improving alignment of community and civil society funding for improved engagement, coordination and capacity strengthening". Funding for community and civil society organizations should be aligned with a view to ensuring that limited development resources are used to create structures that enable the most effective community and civil society participation in policy-making and planning processes, and to support the alignment of community and civil society efforts and their capacity building. The current title does not reflect this nuance.

Analyses of current support mechanisms for civil society organizations, by various global health initiatives, are available and can be used to develop recommendations for improved alignment (see the summary of one such analysis included as part of this submission). We suggest that outputs should focus on modalities for alignment and implementation, rather than further analysis of existing mechanisms. The following should be key outputs, and the CSCG commits to undertake further assessment and consultation to inform a phased approach for increasing alignment of support to community and civil society organizations:

- institutional strategies for phased alignment of support to communities and civil society;
- financing of communities and civil society (focused on mobilization and engagement, coordination, advocacy, monitoring and accountability) harmonized and aligned through partially pooled funding, reducing duplication and gaps, including through existing initiatives that extend beyond the Global Action Plan, such as UHC2030; and
- increased coordination among signatories to increase efficiencies in governance structures related to communities and civil society, including alignment of principles and identification of synergies in work planning (particularly for capacity building), research and monitoring.

Action 3 - Strengthening the mechanisms and capacity of global health organizations for meaningful community and civil society engagement: We endorse this area of action and request that strategies focus on reaching the under-represented, hard-to-reach, locally headquartered organizations that are



Global Civil Society
Coordinating
Group for the GFF

more difficult to engage. A metric should be included when monitoring the engagement strategies, to assess who was reached.

Action 4 - Building/strengthening a virtual platform: In line with comments above on Action 3, efforts concerning the virtual platform should be assessed to determine whether they enable information exchange and engagement by communities and civil society organizations that have not been engaged before.

SDG3_Secretariat

From: Thomas Feeny <tfeeny@r4d.org>
Sent: Tuesday, July 2, 2019 6:48 PM
To: SDG3_Secretariat
Cc: Karlee Silver (GCC)
Subject: Comments on Accelerator Paper #5 R&D, Innovation & Access

To whom it may concern,

I am writing in my capacity as Director of the Secretariat for the [International Development Innovation Alliance](#) (IDIA), a collaboration platform bringing together the leaders of innovation from 14 global development agencies. Due to the majority of IDIA members being away on summer vacation, it has not been possible on this occasion to assemble an official submission or set of comments from IDIA on Paper 5. However, the IDIA members have asked me to share with you a range of documents they have produced reflecting consensus areas of good practice in this space that may be helpful with regard to the different issues discussed in the paper.

To this end, please find links below to the following resources:

1. [IDIA Insight Guide on Scaling Innovation](#)
2. [IDIA Insight Guide on Good Practices for Scaling Innovation](#)
3. [IDIA Insight Guide on Gender & Innovation](#)
4. [IDIA Principles to Facilitate Innovation in International Development](#)

As you will see, Karlee Silver (CEO Grand Challenges Canada and one of our IDIA representatives, copied) has submitted separate, more detailed comments on Accelerator Paper #5 and also kindly offered to act as an interlocutor should the WHO be interested in further engaging with the IDIA members on this important work.

Kind regards

Thomas Feeny
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SDG3_Secretariat

From: Jenny Vaughan <Jenny@stopaids.org.uk>
Sent: Tuesday, July 2, 2019 7:00 PM
To: SDG3_Secretariat
Subject: STOPAIDS General comments on the GAP consultation with comments on Sustainable Financing, Community and Civil Society Engagement, Determinants of Health and R&D, Innovation and Access

To whomever it may concern,

Please find below feedback from STOPAIDS on the GAP consultation.

Very best wishes,

Jenny

General comments:

The Global Action Plan should be clear in its intentions and literature to be a plan for collaboration and coalition between Global Health Multilaterals rather than an introduction of a new parallel set out outcomes or goals to accompany the SDGs - the misconception around the purpose of the GAP seems to be widespread but is much clearer in the outline document.

More detailed is required about how the signatory agencies plan to support agency collaboration and coordination at country level.

On Sustainable Financing:

The GAP should set out support for/commitments to achievement to achieve:

- A rethinking by bilateral and multilateral donors around how they decide to work and support countries, with eligibility and allocation criteria underpinning ODA becoming more nuanced to allow it to better target support to the poor and marginalised first, wherever they are.
- Successful transitions that are fundamentally grounded in and driven by sustainability of development outcomes.
- Better collaboration between donors to ensure shared clear transition plans, tools and approaches which work together with national stakeholders, including civil society, to ensure shared ownership. Increased efforts to improve donor coordination, harmonisation and alignment in providing technical and financial support for countries to increase domestic resource mobilisation to fill funding gaps.
- Prioritisation of an appropriate general taxbased financing system to strengthen the public health system, and urgent international action to end tax avoidance and evasion and to restructure low- and lower-middle income countries' debts.

On Community and Civil Society Engagement:

The GAP should set out support for/commitments to achievement to achieve:

- Efforts towards SDG 3 which includes significant investment in and support for community-based and community-led health services, advocacy and mobilisation.
- Meaningful participation of civil society and communities in decision-making, and the creation of governance and accountability mechanisms that actively encourage, resource and ensure an equal and representative civil society voice at all levels.
- The restructuring of global health multilateral governance structures to include voting seats for civil society and affected communities at all levels of decision making where this is not currently in place.

On Determinants of Health:

The GAP should set out support for/commitments to achievement to achieve:

- A person-centered approach to achieving SDG 3 that focuses on the health and well-being of all individuals throughout their lives.
- A human rights-based approach to achieving SDG 3 that enables equitable access to health services for all. Legally and socially enabling environments for all people to access health care without stigma and discrimination.
- The prioritisation of the most vulnerable and marginalised so that they are reached first in all efforts to achieve SDG 3.

On R&D, Innovation and Access:

The GAP should set out support for/commitments to achievement to achieve:

- A R&D system which is geared towards public health outcomes.
- System-wide change to the entire R&D process and the expansion of delinked R&D efforts for new medicines, vaccines and diagnostics which should be needs-driven, evidence-based and guided by the principles of affordability, effectiveness, efficiency and equity.
- The promotion and uptake of the use of all TRIPS flexibilities.

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Establishing sustainable health financing as accelerator number 1 gives this theme its due priority. However, the definition of the strategies and actions requires a sound analysis of the real trends and perspectives of the decisive determinants, in particular, economic capacity, public revenue and health shares of public expenditure. Unfortunately, the present version of this document fails to recognize the abysmal differences regarding economic capacities between and within countries. This combines with a complete avoidance to address the necessity of global solidarity and redistribution of resources in order to achieve SDG 3 and other goals of human development enshrined in the 2030 agenda. Since the economically most disadvantaged countries, especially LICs, are far from being in a position to raise the necessary resources as defined by comprehensive research.¹

According to the most recent IMF data on economic growth the weighted average of GDP per capita in low-income countries will rise from less than 700 US\$ in 2017 to approximately 940 US\$ in 2030.² If at the same time all LICs will realize highly ambitious efforts to generate additional domestic revenue, the proportion of GDP would increase from roughly 17% to more than 24%.³ This would raise government revenue per capita from 100 US\$ to approximately 230 US\$. In order to reach SDG 3 health targets this country group would have to spend at least 100 US\$ per capita and year in the period 2026-2030. Evidently, even very high prioritization of health would not suffice to cover this amount. For instance, reaching the Abuja target of 15% of general government budget would result in a mean value of less than 32 US\$ in this five-year period.

While it is necessary to promote and support countries in developing adequate fiscal policies to increase domestic resources and allocate them to priority areas of human development such as health, the remaining funding gap would reach extreme dimensions representing approximately two-thirds of the total financing needs. Additionally, OOPS needs to be minimized because it impedes access and effectiveness of health services and leads to extreme financial hardship. Therefore, the increased transfer of public resources from economically privileged to disadvantaged countries constitutes a duty and precondition, if we sincerely intend to accomplish SDG 3 in the most impoverished countries by 2030. At present, ODA grants for health only represent less than half of the 0.1% target. Whereas few donor countries reach this target, the majority lags far behind. At the same time, LICs merely receive about 50% of ODA grants for health. If all DAC members and other high-income countries would raise ODA grants for health to the level of 0.1% of GNI by 2027 and would allocate 90% of these resources to LICs, the average value per capita would amount to 56 US\$.

Evidently, relying only on domestic efforts for health financing entails the danger to leave hundreds of million human beings behind with regard to health outcomes and survival chances. Dealing with this severe threat should be regarded as a fundamental task by international organizations engaged in global health. This requires the advocacy for and the collaboration in the development of a global plan for financing SDG 3 that brings together the common efforts of rich and poor countries, establishes needs-oriented targets, defines clear responsibilities and funding sources, and contains concrete time-bound steps.

¹ Estimations of the costs to accomplish SDG 3 and its targets were developed by a team within the WHO Department of Health Systems Governance and Financing and published in The Lancet in July 2017 ([https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30263-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext))

² World Economic Outlook, April 2019; All amounts are stated in constant 2017 US\$; the original estimates of resource needs indicated in the WHO study in 2014 US\$ were converted accordingly using IMF world inflation rates

³ This is in line with the conclusions of the IMF staff discussion note cited in the document, which states that "increasing the tax to GDP ratio by 5 percentage points of GDP within the next decade is an ambitious but reasonable target in many countries"; see: Gaspar et al: Fiscal Policy and Development: Human, Social, and Physical Investment for the SDGs, page 5

General Comment on the Global Action Plan
submitted by Medical Mission Institute Würzburg, Germany

While it is clear that the collaboration of international organizations engaged in global health is not able to develop a roadmap in terms of achieving SDG 3 without the cooperation of UN member states, the global action plan should be understood as a first fundamental step of this process. The original proposal submitted to World Health Organization by the governments of Ghana, Germany and Norway regarding one joint plan to “Ensure healthy lives and promote well-being for all” points to the same direction. This perspective should be reflected in the general approach and the defined actions of the present global plan.

Likewise, the participating organizations should not restrict their perspective and scope of action on country-level efforts, but formulate concise measures to consequently use their potential for convening all stakeholders under the auspices of shared responsibility and international solidarity. A cornerstone should represent the promotion of appropriate commitments and measures taken by economically privileged nations to support and enable better health services and outcomes in the more disadvantaged countries and populations. This cooperative approach comprehends both providing financial contributions to bridge the remaining huge resource gaps especially in LICs and taking all necessary measures to eliminate global or regional detrimental health impacts resulting from their own economic and political practices. Consequently, we need to transition to a novel and audacious way of thinking and acting in the SDG era that establishes clear policies with respect to the required redistribution of resources and capabilities as well as standards to reverse the destructive effects of the dominating economic system, which range from climate change and loss of biodiversity to social polarization and political authoritarianism. With their intensified collaboration the specialized organizations should initiate systematic efforts to produce the scientific analysis and political advocacy that lay the basis for this endeavor. Only then, we will be able to create the necessary conditions to overcome the myriad of severe health risks and forces of exclusion from life-saving services, thus achieving that the gaps of survival chances will narrow instead of widen again, which would make a mockery of the principle to leave no one behind.

Furthermore, there are many distinct and important tasks that the partnering organizations should perceive as elements of their genuine mandate and address through this global approach. First, systematic and objective progress reviews of the implementation of international agreements help to create the incentives or, in a considerable number of cases, the pressure that spur more adequate actions by politically responsible decision-makers, government officials and other players. Second, the independent collection and comparative assessment of health-relevant data, based on sound scientific criteria and rooted in human rights, contribute to identify the most urgent health needs and understand the causes of health threats, instead of simply relying on stated priorities, as well as to allocate technical and financial resources in a more purposeful and effective manner. Third, joint actions beyond the health field are necessary in order to promote and enable government efforts to increase public revenue and invest the additional resources in essential measures of human development, especially by avoiding destructive competition and resisting influential economic powers that intend to impose low-taxation policies. Fourth, so-called intellectual property rights enacted increasingly in trade agreements, in particular patent provisions and data exclusivity, exacerbate the orientation of the research done by private companies towards lucrative demand and lead to further monopolization of its results, which calls not only for thorough scientific evaluation and consequent political debate of these highly problematic tendencies, but also evidences the necessity to promote coordinated efforts aiming to strengthen research and development of health technologies that are publicly funded and primarily directed towards the needs of economically disadvantaged countries with high disease burdens as well as vulnerable populations.



Public Services International
Internationale des Services Publics
Internacional de Servicios Públicos
Internationale der Öffentlichen Dienste
International Facklig Organisation for Offentliga Tjänster
國際公務勞連

Public Services International (PSI) welcomes the efforts at formulating a Global Action Plan for Healthy Lives and Well-being, aimed at strengthening collaboration among multilateral health organizations to accelerate progress towards achieving the health-related SDGs. PSI is a global trade union federation which brings together over 30 million women and men delivering public services in 168 countries and territories. About half of these work in the health and social sector.

Thus, as a stakeholder in the sector, we are happy to make general comments on the Global Action, and on the accelerator discussion paper 1 i.e. sustainable financing.

General comments on the Global Action Plan:

Non-inclusion of Human Resources for Health

PSI is strongly of the view that there is a major gap in the Global Action Plan (GAP). This is the non-inclusion of Human Resources for Health as an accelerator. The health workforce is the backbone of healthcare delivery. Accelerating improvement of employment and working conditions in the health services should be one of the key elements of the GAP.

PSI represented health workers' unions on the United Nations Secretary General's High-Level Commission on Health Employment and Economic Growth (UN CommHEEG) in 2016. Grounded on data from the *WHO Global Strategy on Human Resources for Health: Workforce 2030*, the CommHEEG raised global attention to the alarming projection of a shortfall of 18 million health and social workers by 2030, if decisive actions are not taken at both country-level and internationally.

The CommHEEG and subsequently the Working for Health: Five-Year Action Plan for Health Employment and Inclusive Economic Growth (2017-2022) adopted by the 70th World Health Assembly based on the CommHEEG's recommendations also witnessed a novel inter-agency collaboration between the World Health Organization, International Labour Organisation and OECD which could be provide invaluable lessons for carrying the Global Action Plan forward.

We thus advocate for the inclusion of Human Resource for Health as an accelerator.

On the process of formulating the Global Action Plan

While we welcome the idea of the GAP, we do believe the process could have been formulated in a way that left nobody behind at the different level of its development. For example, the issue raised above about the non-inclusion of HRH is one which might have been addressed if stakeholders, including health workers had been engaged in consultation, at a much earlier stage.

It is also worrisome that the GAP draft outline states that the accelerator papers "do not necessarily reflect the views of the 12 Global Action Plan signatory agencies". Shared commitment of views is essential for concerted action.

We thus call for the inclusion of room for feedback from stakeholders, subsequent to this consultation process and consensus among the 12 GAP signatory agencies.

Accelerator 1: Sustainable Financing

We share the commitment of the participating agencies to “support countries to implement pro-poor and pro-health fiscal policies” (page 1, last paragraph). It is however important to point out that this cannot be fully realised without addressing the constricted *fiscal policy space* they face, due to loan conditionalities of international financial institutions.

Thus, fostering “an open and inclusive dialogue at the country, regional and international level” as discussed on page 3 has to include explicit appreciation of how *quantitative performance criteria* (QPCs) and Structural Benchmarks (SBs) of International Monetary Fund loan facilities undermine sustainable financing in low and middle income countries, with the intent of expanding fiscal policy space that would thus enhance governments’ funding for public health.

We support the document’s call for “more coordinated global advocacy/action” on public health-related taxes and tax avoidance. This is an issue which PSI takes seriously. We will be very happy to collaborate (along with the Centre for International Corporate Tax Accountability and Research (CICTAR) which is closely related to us) with the participating agencies on this.

We are however of the view that there should be deeper inclusion of the role of progressive taxation for efficient and equitable resource mobilisation. For this purpose, we propose reformulation of the section on “inefficient and inequitable health spending” (page 3) to read “improve the efficiency and equity of health spending *and resource mobilisation*”.

Further, this section should point out the importance of progressive tax systems for public funding of health as a fundamental human right. In the light of the Global Fund’s Technical Review Panel’s report released in October 2018, the section should equally point out “the need to shift to compulsory pre-paid financing arrangements for health services, which is critical for achieving health coverage and for equity”.

Another means to drive home the importance of taxes for sustainable funding of health would be the inclusion of progressive taxation and compulsory pre-paid financing arrangements in driver 1, rather than its current emphasis strictly on taxation of products harmful to health.

An aspect of the section on “inefficient and inequitable health spending” as it presently reads is the way it engages with human resources. But what “appropriate use of skilled health personnel”, “in driving efficiency” has meant in practice has been freeze or cuts in wages, and increasing precarious working conditions of health workers, as part of the turn of most governments to financial consolidation, in the wake of the global economic crisis.

Safe and effective staffing for health is an investment and not a cost. This is particularly important with the huge shortfall in human resources for health globally and especially in low- and middle-income countries. We thus call for “tripartite social dialogue” to be enshrined as the primary vehicle for determining “appropriate” deployment of health workers.

Babatunde AIYELABOLA

Health and Social Sector Officer

Public Services International

Consultation: Global Action Plan for Healthy Lives and Well-being
NCD Alliance Feedback
June 2019

The NCD Alliance welcomes the opportunity to provide feedback to the twelve signatory agencies of the Global Action Plan (GAP) and commends the agencies for conducting several multi-stakeholder consultations on the accelerators thus far. The seven accelerators appropriately identify areas in which the agencies can better work together to achieve the health-related SDGs and targets. In particular, the NCD Alliance wishes to provide general comments on Accelerators (1) Sustainable Financing; (2) Primary Health Care; (3) Community and Civil Society Engagement; and (4) Determinants of Health.

We welcome the GAP process and the willingness of the agencies to strike a new balance between human and financial resources accorded to different challenges in global public health in order to better reflect the global burden of disease and threats to health and development. The added value of the GAP will be to move beyond a siloed and disease-specific approach to a way of working which recognises all challenges and determinants of population health in all resource contexts. The GAP also provides an opportunity for the agencies to respond to the growing burden of co- and multi-morbidities. It is increasingly recognised that people very rarely live with only one health condition and is estimated that up to 95 per cent of people living with chronic conditions have to contend with more than one disease. This new, coordinated approach must therefore reflect the day-to-day reality of people living with health conditions and move beyond disease siloes.

We highlight the work of the UN Inter-Agency Taskforce on NCDs as a model of good practice, particularly the development of investment cases, requested by governments, to support their decision-making. The work of the Taskforce has been regrettably limited by lack of resources and merits scaling up to meet demand from Member States for technical assistance. The Taskforce would also benefit from increased interaction across all agencies, notably UNAIDS, GAVI, the Global Fund and the GFF.

Across all levels of the GAP and its accelerators, we urge the signatory agencies to ensure that:

- People living with health conditions, specifically including NCDs, and their carers are at the centre of the development, implementation, and evaluation of all health programmes;
- Primary health care remains the cornerstone of universal health coverage and that primary health care systems are linked to strong referral networks for secondary and tertiary care;
- Programmes and financing models are restructured to better integrate and respond to the growing burden of co- and multi-morbidities;
- Due attention is given to avoiding conflicts of interest and undue influence from industries with vested interests. In particular, partnerships across all supporting agencies must not undermine progress towards any of the SDG3 sub-targets;
- More comprehensive and transparent accountability mechanisms are developed to monitor and evaluate progress.

We strongly support the alignment along the environmental, commercial, and structural determinants of health and well-being, and encourage the agencies to lead the way in assisting governments to implement policies and programmes that reduce exposure to these determinants for all.

The NCD Alliance remains ready to continue working with the agencies to deliver the global goal of better health and well-being for all at all ages.

SDG3_Secretariat

From: Vince Blaser <vblaser@intrahealth.org>
Sent: Tuesday, July 2, 2019 11:55 PM
To: SDG3_Secretariat
Cc: Vince Blaser; Samantha Rick
Subject: Frontline Health Workers Coalition Comments on Draft Global Action Plan for Healthy Lives and Well-Being for All

Dear Global Action Plan for Healthy Lives and Well-being secretariat,

The Frontline Health Workers Coalition (FHCW <https://frontlinehealthworkers.org/>) is an alliance of more than 40 United States-based public and private organizations with a secretariat housed at IntraHealth International in Washington DC. FHCW works together to urge greater and more strategic investment in frontline health workers in low- and middle-income countries as a cost-effective way to save lives and foster a healthier, safer, and more prosperous world. Our member list can be found at <https://www.frontlinehealthworkers.org/our-members>.

FHCW commends the institutions drafting the Global Action Plan for Healthy Lives and Well-Being for All for the opportunity for public comment. We make the following comments for your consideration.

Outline:

FHCW commends the outline of the Global Action Plan for targeting the “several persistent challenges and bottlenecks that cut across all targets.” The degree to which this plan can facilitate concrete means of addressing these bottlenecks -- especially cross-cutting essentials for success like a sustained well-trained and supported health workforce team in all communities -- will be its ultimate measure of success.

While we appreciate the draft outline, the engagement and dialogue process at country level not fully clear. More concrete action and timeline information would be beneficial.

For example, the draft states “the Global Action Plan will seek to avoid creating new platforms. Instead the signatory agencies are committed to more effective leveraging of and alignment with existing country-led planning and assessment processes.”

However, it is unclear how GAP partners will address duplicative and fragmented country- and regional-level coordinating mechanisms. Countries often have different coordinating mechanisms and therefore different timelines and commitments to the signatory agencies. Information about whether the existing mechanisms will be consolidated and, if so, by when, would be helpful for stakeholders.

Sustainable financing:

The FHCW commends the draft plan for pursuing a “more systematic and unified approach in the way agencies organize and operate.” Making this approach a formal part of the organizational structures of the signatories is essential for success.

On page 3 of this paper, it states that human resources for health (HRH) “is the largest component of health spending is one of the most critical factors to driving efficiency.” While we agree that ensuring investments in health workforce have maximum impact for communities of least access to essential health services is essential for the GAP’s success, the implication of this sentence of investments in HRH as a cost are directly contradictory to recent available evidence. The 2016 report of the United Nations High-Level Commission on Health Employment and Economic Growth (<https://www.who.int/hrh/com-heeg/en/>)

reflects the opposite – the commissioners found investments in health employment will provide an estimated 9-1 return. World Bank-supported research also found the return on investments in health employment are significantly greater than the financial sector can achieve. Moreover, the communities of greatest disease burden and preventable death rates are by-in-large the same communities with least access to trained and supported frontline health workers. FHWC strongly recommends this action plan not perpetuate a dated and disproven notions that investments in HRH are a drag, rather than an accelerator, of economic growth.

FHWC recommends the paragraph be amended to state: “the proven massive return on investment potential in human resources for health (HRH) in terms of improved health outcomes and economic growth demand that investments in HRH be focused on communities that currently have least access to quality essential health services so that the triple return on investment in health employment documented by the UN High-Level Commission on Health Employment and Economic Growth can have maximum impact for achieving SDG3 and all the SDGs.”

FHWC recommends an addition to “Driver 3: Enhanced support for countries to increase the efficiency and effectiveness of health spending” to clarify that technical assistance provided by the 12 GAP partners should emphasize the equitable, sustainable and appropriate skill mix of health workers to ensure that unsupported or under-supported frontline health workers (including health workers lacking adequate remuneration) are not overburdened in communities with least access to essential health services. The accelerator should emphasize that utilizing existing tools like WISN and iHRIS can help maximize current investments to ensure the 9 to 1 return on investment that investing in the health workforce brings.

Primary health care:

FHWC commends the focus on ensuring PHC services for all. We understand the imperative to not create new structures but do hope detailed plans are laid out to ensure this plan has implementation and review mechanisms sufficient to ensure PHC does not yet again fall down the priority list in global health policy. We suggest adding in the following language from our member Save the Children’s PHC report: “The World Bank estimates that 90% of all health needs can be met at the primary health care level,” as PHC is the most equitable and comprehensive form of health care.

The inclusion of “The PHC workforce” in the operational framework levels is commended, but at several points, the document references metrics & milestones by which the accelerator partners will measure given countries’ levels of PHC. FHWC implores the accelerator partners to ensure that these metrics include the numbers, density, and distribution of the cadres of health workers most relevant to PHC (frontline health workers including CHWs, nurses, midwives, pharmacists, and community-based physicians), as well as the social care workforce that contributes to health outcomes. Without this data and without meeting, at least, the WHO recommended health worker threshold, countries will be unable to adequately provide primary health care to all communities.

Health workforce communities of practice such as the Global Health Workforce Network also should be included in the PHC communities of practice listed on pages 5 and 6.

FHWC members also would appreciate more information about how the accelerator will support shift from “poorly integrated hospital-centric” services to delivering primary health care at all levels, particularly at local facilities and at the community level via integrated community- based primary health care teams, including community health workers, nurses, midwives and clinical supervisor cadres.

The “Reframing support for country programs” section comprehensively outlines the different health systems investments that multilaterals offer at the country level. However, there is not much mention of how these efforts will be linked more closely to move away from fragmentation and duplication. Are there

concrete partnerships being developed to consolidate these efforts or coordinate more closely? Any additional detail here would be beneficial.

Communities and civil society often do not have access to the financial means required to participate in and inform policy and program discussions in a meaningful way. To better ensure transparency and inclusion of civil society in GAP implementation, financing (both adequate resourcing and accountability/tracking for budget allocations) should be added to the explanations sections. Further, there needs to be increased transparency around actual spend of budget allocations that are labeled for PHC.

The WHO Guidelines for Community Health Workers and complementary metrics underdevelopment should be included in the progress monitoring for PHC to ensure that progress for health access for most vulnerable (often those remote and rural populations served by frontline health workers) is being adequately tracked. Community-based health delivery is essential for ensuring PHC reaches historically underserved and neglected populations first.

Data and Digital Health:

FHWC commends the draft for recognizing health workforce as system users, but there needs to be more capacity building for health workers to use HIS, both general and building data use capacity.

There is also little mention of health workforce data use for HRH. A supported workforce is needed to improve service delivery and health outcomes in addition to service delivery data, and this accelerator needs to add language to reflect this need.

Community and Civil Society Engagement:

We recommend additional prioritization, funding, and action to strengthen civil society participation at county/state and district levels. These levels of the health system often provide the greatest opportunity for consistent participation from communities and civil society and should be prioritized and funded adequately in addition to national mechanisms.

FHWC fully supports the creation of virtual platform, but also acknowledges that the most marginalized communities will be unable to access such a platform. Special actions to accelerate participation and knowledge sharing with remote and isolated (financially, socially, and geographically) populations should be outlined.

Gender equality and the empowerment of women and girls:

A February 2019 Lancet commentary by Richard Horton

([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)30311-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30311-3/fulltext)) states “the entire global health community has abdicated its responsibility for achieving gender justice in health. This situation is strange because a vast quantity of evidence linking gender inequity to poor health exists and the mandate is clear, as set out in Sustainable Development Goal 5. The global health community has not, but must, make SDG 5 an indispensable part of its work to achieve healthy lives for all’

Accelerating action toward SDG 5 must be an indispensable part of this Global Action Plan, and it is not nearly adequately included in the draft. FHWC recommends creating an accelerator specific to SDG 5 and, or at least, adopting a collective coherent approach to pursuing SDG 5 targets in each accelerator of health, aligning across accelerators, as well as in the global action plan; not forgetting the gender-related capacity, research, policy and multi-sectoral governance strategies and platforms necessary to advance health and other SDGs.

If you have any questions or wish to contact us about these comments, please contact FHCW Director Vince Blaser (vblaser@intrahealth.org) and FHCW Deputy Director Samantha Rick (srick@intrahealth.org). Many thanks again for the opportunity to comment.

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Global Health Council welcomes the opportunity to comment on the draft Global Action Plan (GAP) for Healthy Lives and Well-Being for All. As the leading membership organization of NGOs, academia and the private sector, Global Health Council coordinates implementers, advocates, and stakeholders around global health priorities.

Integrated Global Health

We will not be able to achieve SDG 3 without a shift in thinking in how we approach addressing global health challenges. The GAP should recognize not only individual contributions to global health, but opportunities to adopt more holistic approaches, and it should support partners to do the same. The GAP should provide a means to address or leverage multiple focus areas and identify creative collaborations and efficiencies that maximize their impact. Countries need to have the flexibility to utilize investments to address the wide-ranging factors that influence the health of their population, and coordinate and integrate services as needed. A departure from a rigid vertical framework also paves the way for optimal sustainability of our efforts and sets up a path to self-reliance and resilience of countries and communities worldwide.

This also means national plans that not only address health priorities, but can also address other development priorities that are critical to building communities that not only can meet the health needs of their people, but also providing economic and social security.

Civil society role

We echo the acknowledgment of the critical role civil society, including local partners and communities, in achieving the SDGs. The inclusion of civil society must be deliberate, robust, and transparent and must take uniformly place at all stages of planning and implementation. Moreover, civil society representation must be diverse and representative by ensuring the inclusion of women, minorities, young people and other disenfranchised and marginalized people. Specific actions should be included to engage these underrepresented stakeholders and other organizations that have found it challenging or difficult to engage in the past.

Principles of civil society engagement should be incorporated across a number of areas, including financing, health emergencies, and research and data. Civil society has a role across all of the SDGs, and should not be positioned as only a token actor but an active, meaningful contributor to solutions or results. Civil society's role is equally important in holding countries to account and must be included in monitoring and evaluation of how countries are working towards achievement of the SDGs.

Most importantly, as stated in the draft Accelerator Discussion Paper 3, knowledge is power. We support efforts to provide information in one place, allowing for civil society to better access and engage in discussions. We emphasize the importance of ensuring civil society has access to the data and other resources needed for them to effectively engage and advocate on the national level, and not just at the regional or global level. The online

Uniting to Combat Neglected Tropical Diseases Response - Global Action Plan for Healthy Lives and Well-being

Uniting to Combat Neglected Tropical Diseases welcomes the opportunity to feed in to this invitation for comment on the Global Action Plan (GAP). Please see our detailed comments below for your consideration. We would be very happy to discuss and contribute to further additions of this GAP as you see fit.

Scope and timeframe

We welcome this document, the collective action and the commitment to align operational approaches to accelerate progress towards SDG3.

The 12 signatories of this GAP encompass a wide range of partners spanning many health areas; however, we feel this is an initiative of 12 actors advancing their priorities and not the entirety of SDG3 and all its indicators. Diseases of poverty such as Neglected Tropical Diseases are largely absent from the GAP. What are the plans for accelerating diseases not captured by these actors?

As highlighted in the 'Global Action Plan Phase I' document, each of the SDG3 indicators listed, except Neglected Tropical Diseases, has at least two of the signatories working on that indicator as part of their core mandate – and most have more. WHO are the only signatory that notes Neglected Tropical Diseases as part of their core mandate.

A key major challenge noted in the GAP is 'reaching the most vulnerable and leaving no one behind'. This challenge of ensuring that the poorest are prioritised in progress towards the 2030 Agenda is a major issue for many countries, as evidenced in their Voluntary National Reviews.

Yet, Neglected Tropical Diseases, which affect the most vulnerable and hardest to reach in communities and seen as a litmus test for UHC and a marker for equity are absent from this plan. Therefore, in line with the Sustainable Development Goals, it is imperative that these diseases of poverty and neglected people are explicitly in the GAP and given the same attention as Malaria, TB and HIV/AIDS.

Other points to be considered:

The Action Plan document supplied is not complete, with some pertinent areas still '*in development*'. This includes the Theory of Change, as well as the analysis of initial country engagements. Some of the areas still '*in development*' such as the two listed above are instrumental in determining whether the GAP is aligned to country needs and whether it will achieve its goal. When will this document be finalised and will there be further opportunity to engage in its development?

The initial country engagements mentioned above are from a small sample of five countries (names of which are not provided). It would be good to understand how these were chosen to ensure they are representative of the countries targeted under this plan, primarily low- and

middle-income countries.

Finally, the timeframe to submit a response to these documents is too short and does not allow for collective aligned response from our partnership, which works together to achieve SDG 3.3.5. We would welcome further opportunity to engage with the SDG3 secretariat so we can bring together our partnerships collective voice.

Accelerator 1: Sustainable Financing

As stated in the document 'business as usual will not achieve UHC', and therefore we support an emphasis to increase domestic resources for health. We also strongly support the pro-poor approach in health financing.

The GAP should promote the need for all countries to set a minimum target of 5% of GDP for public spending on health, and those that already meeting this should look to increase public spending on health by an additional 1% to 2% of GDP specifically for UHC. This aligns with the latest political declaration on UHC.

The GAP should also explicitly support countries to undertake a transparent cost-effective prioritisation exercise for their essential package of health care, taking into consideration the pro-poor (progressive universalism) approach.

It would be good to undertake a financial resources analysis to determine where the signatories of the GAP align funding as per the SDG3 indicators to see where the gaps are. Finally, where there is new or existing evidence of interactions between health areas, a holistic approach between the relevant partners should be encouraged.

Accelerator 2: PHC

We strongly support the need to focus on the elimination of inequity and that PHC is the backbone in the progressive achievement of UHC. We also echo that progress towards UHC should promote equity and progressive universalism.

It would be good to see the 12 signatories set out concrete plans on how they will strengthen PHC through progressive universalism. Supporting health system strengthening does not give any clear indication on how they do this. Countries will need to determine their health priorities initially which should focus on the poorest first. If some of these priorities are not aligned with any specific signatory, how will the GAP direct resources and support the country in these efforts?

The health workforce is key to a strong primary health system. There is minimal mention in this accelerator of their importance. Within low- and middle-income countries, there is a shortage of quality community health workers. More emphasis should be made on the need for a remunerated trained health workforce at the community level.

Accelerator 3: Community and Civil Society Engagement

Similar to the concerns raised above about the scope of the signatories to the GAP. If it is the signatories doing the engaging then how will you ensure this engagement encapsulates SDG3 in its entirety? Furthermore is it then appropriate to have the signatories monitor this engagement as seems to be the suggestion. Will this not lead to an echo chamber where they talk with their own stakeholders and risk leaving those hardest to reach behind?

Accelerator 4: Determinants of health

Although water, sanitation and hygiene is mentioned as both environmental and structural determinants, more emphasis and importance needs to be placed on WASH – without which we will not achieve multiple SDG3 targets. WHO/UNICEF report that 844m people and 31% of schools still do not have clean water. Lack of clean water is a huge determinant of disease, especially among children. A clear target to increase access to clean water within this document would be welcomed.

General comments on the Global Action Plan Primary Health Care Accelerator

A coordinated global palliative care response submitted by: Prof Julia Downing, Chief Executive, International Children's Palliative Care Network

1. What do you see as the key opportunities offered by *Global Action Plan for Healthy Lives and Well-being for All*?

One of the major opportunities for the Global Action Plan for Healthy Lives and Well-Being for all is to address the major neglect of the development of health systems that are there for people *throughout their lives* and to ensure that the most vulnerable and those with the highest health needs are not left behind. The focus on primary health care is crucial but progress will not be made without ensuring that primary health care covers the spectrum from promotion, prevention, treatment, rehabilitation and palliation as outlined in the Astana Declaration and within the UHC definition. Addressing the health system and community response to the latter part of the spectrum cuts across work by all signatory agencies, yet with the exception of WHO is rarely mentioned, leaving millions of the most vulnerable behind.

There is currently no specific recognition in the primary health care acceleration paper or the Global Action Plan itself of the need for healthcare throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation and palliative care. From years of working in palliative care, we know that if the full spectrum is not explicitly referenced, the latter part of the spectrum will be neglected, will not be financed, and the 61.5 million adults and children, who need it, will continue to live and die in serious pain and distress. Women and girls will continue to be left to care for people in their homes and communities unsupported and ill-equipped creating a knock-on effect on mental and physical well-being, gender equality and household poverty. Palliative care must be integrated into the primary health care system response. Access to palliative care is something that the majority of us will need at some point, however much financing is dedicated to prevention and promotion. By failing to recognise a response that ensures health systems and primary health care throughout people's lives, we are failing the most vulnerable in our societies.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

There is little effective response to date by the signatories on accelerating impact in countries on access to palliative care as part of health systems and that which is available is still to be published. Much can be learned however from UNAIDS collaborative work on access to ART treatment and care and the Global Fund coordinating and financing mechanisms. WHO's technical assistance needs to be coupled with effective financing.

Comments on the accelerator discussion papers:

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

1a. Utilise language that explicitly discusses primary health care systems throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation and palliative care.

1b. Remain constantly mindful of the most vulnerable and marginalised in societies including those facing multiple conditions, stigma and societal fears of death and dying and include people with palliative care needs in all consultations and planning exercises.

1c. We would like the UN Women included in this accelerator as the impact of inadequately resourced primary health care services is likely to fall on women and girls due to caregiving responsibilities.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

2a Ensure that the in country needs assessments and the subsequent plans, financial analysis and monitoring include the need for primary health care *throughout people's lives*, including palliative care, and women and girls who are often their caregivers, so that the most vulnerable do not continue to be left behind. Also focus on: 1. Community health workers. 2. Access to medicines and equipment. 3. Leaving no one behind.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

Yes, our organisation works with organisations globally to advocate for, and access financing to support, initiatives to ensure palliative care is integrated into primary health care, particularly in low and middle-income countries.

Invitation for public comment: Global Action Plan for Healthy Lives and Well-being

Date: 28th June 2019

Submission

Please submit your responses to SDG3_Secretariat@who.int by **Sunday, 30 June 2019**. Please include the title of either (a) the accelerator discussion paper(s) on which you are submitting comments, and/or (b) general comments, in the subject line of your email response. All submissions will be published online.

Comments on the accelerator discussion papers

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?
2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?
3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

1.Sustainable Financing

- **‘Work better to align development assistance for health (DAH) with national priorities, use it to leverage more funds for health, and support maximising the impact of existing domestic resources.’**

Surrounding the commitment of participating agencies: the current statement to ‘work better to align development assistance for health’ does not provide a concrete statement of an outcome orientated intent. Given the size, power and influence of the 12 agencies involved, a more systematic coordination mechanism is needed to ensure development assistance for health does not displace or undermine national priority setting.

- **‘Figure 1: An overview of the four key themes and accelerator drivers’**

On facilitating consensus building and knowledge sharing. Its is important to acknowledge in this section that health financing policies for UHC will be context specific and not widely applicable. To the point above, it is also unclear how this consensus building/ alignment to support government priorities will take place.

- **‘Support country dialogue on scaling up or introducing of taxes on products and processes harmful to health (especially cigarettes, alcohol, sugar) and on broader domestic revenue mobilisation efforts such as global action against tax avoidance.’**

In this section, it is important to also mention income taxation and other progressive taxation strategies. This focus on sin taxes needs to be taken in prospective especially given their revenue generation capacity relative to other taxation methods. It is positive to see a reference to global action against tax avoidance.

- **‘Spotlight on: Convening Ministers of Finance’**

It would be useful to mention the lessons learned from this forum and the potential/appetite for ensuring sustained engagement with ministers of finance throughout the process.

- **‘Re -visiting the current aspirational targets for government spending on health (e.g. spending 15% of general government expenditures) to examine their logic, value, and feasibility, and the value of such targets for increasing health spending’**

In addition to revisiting, there needs to be support for governments to implement strategies and approaches for reaching these targets sustainably.

- **‘Support joint learning/dissemination/capacity building initiatives’**

‘At the country level’: This country selection approach has also been highlighted in the ‘Primary Health Care’ paper. It would be useful to clarify whether there will be alignment across accelerators on which countries are selected and supported and how the different departments will work together.

- **‘Spotlight on: Cote D’Ivoire: The government has made a commitment to increase domestic financing for health by 15% annually until 2024’**

It would be good to know more about how agencies are now supporting the government to realise this commitment and how learning is being documented and shared (to meet other objectives set out in the accelerator).



2.Primary Health Care

➤ 'Figure 2 . SDG3+ GAP partners and additional agencies supporting the PHC Accelerator'

From the list of partners outlined in the schematic, is this list aspirational or existing? Would be interesting to know why civil society is missing?

➤ 'Figure 3. Align, Accelerate, Account through Global Coordination and Country Collaboration'

On the points around country collaboration it would also be valuable to mention the role of other ministries apart from MoH to deliver on a multi-sectoral, and sustainably financed, PHC commitment.

It would also be useful to see more information on how the two pillars of global and country collaboration will align and work together.

➤ 'Exploring a key role for [UHC2030](#) with links to a new G7 initiative for a knowledge portal for PHC: UHC2030 could be a suitable vehicle for global-level discourse on PHC,'

This Mechanism should also provide a link between global and national level discourse on PHC instead of global level alone.

➤ a Global guidance on health systems assessment for PHC

It might be worth emphasizing that this should be led by national priorities and assessments of their own needs and gaps.

➤ ii. Global guidance on the operationalization of PHC

It is important to ensure that any indicators for the operational framework are linked to what else is being asked of countries to report on for the SDGs and not create parallel structures. This should also include the aspirational monitoring framework and associated metrics to be established.

➤ PHC ACCELERATOR STRUCTURE AND PARTNERS

Community and civil society missing as key partners.

3. Community and civil society engagement

➤ PROBLEM AND OPPORTUNITY STATEMENT

Paragraph: ‘Despite clear and proven benefits in engaging communities and civil society, there are a range of barriers that limit their effectiveness and influence, including a lack of resources, capacity and support, and challenging legal, social, and policy environments...’

This paragraph should better reflect the shrinking space for civil society, ref Civicus report <https://monitor.civicus.org/> Shrinking space means less room and opportunity for CSOs to play an active accountability role and advocate for important policy change. The expansion of the Mexico City Policy, now renamed PLGHA, is a case in point

➤ Key inputs/contributions from interested signatory agencies

‘Willingness to engage in mapping the funding mechanisms and modalities available to communities and civil society working on health and engage in discussions towards harmonizing funding approaches at country / sub-national level.’

How can we ensure GAP partners pool funds to fund national civil society to work on UHC and reduce the fragmentation of civil society. The CSEM of UHC2030 is keen to do this but getting money is very difficult. The money is all in the GHIs and they are also causing the fragmentation. This is partly represented in outcome of the CSO consultation in April (ref annex 1):

“Participants urged GAP signatories to increase resources to support engagement of communities and civil society in country, regional and global bodies and processes, and to align separate funding streams for civil society engagement for more efficient and rational allocation of funding and to move support out of thematic silos”

This needs to be even better reflected in the accelerator paper.

➤ Objectives : ‘Adopt specific measures to increase opportunities for engagement in activities of global health organizations where such engagement is demonstrated to add value in delivering better policy and/or programmatic outcomes.’

It needs to be underlined that this should also be the case at national level.



4.Determinants of Health

No comments on this paper.

5.Research and development, innovation and access

➤ Goal 1 - Access should be built into the R&D pathway

Use existing tools and norms to hold R&D development partners to account e.g. the access to medicine foundation expectation for pharmaceutical companies to consider R&D access planning at phase 2 of drug development.

'The resulting 2018 ATMI methodology now incentivises companies to have access provisions in place for R&D projects regardless of whether they are conducted in-house or in partnership. Emphasis will be placed on projects in late stages of development (phase II clinical trials or later) by conducting a deeper analysis into the nature of access plans for product candidates that are closest to approval.' (1)

1. Cole, C., Trolle, S. and Edwards, D. (2018). Developing the latest framework to measure and incentivise pharmaceutical industry contributions to health research and development. Health Research Policy and Systems, 16(1). Accessed via: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6090890/>. [Date Accessed: 27th June 2019]

➤ Action 1 – Develop Global Good Access Practices for Innovation in Health.

As mentioned, most funders have 'access principles'. However, all too often, these principles are vague and non-binding. Operationalisation of these principles will require an accountability mechanism to ensure the access principles are adhered to once the product reaches the 'market'. Once such mechanism can involve the use of civil society as an accountability mechanism. e.g. CEPI's access policy and MSF awareness campaign.

➤ Action 3 – Establish and maintain a new annual global forum to coordinate and accelerate the late stage pipeline of critical medical and health products (including diagnostics, medicines, vaccines and vector control). : 'The WHO would maintain monitoring of a central pipeline, track progress and alert the community to delays in three categories (2-5 years from licensure, <2 years from licensure, filling licensure to access/impact gap).'

Use existing mechanisms that track R&D pipelines to ensure a rich, comprehensive and coordinated database. E.g. Access to medicine Foundation R&D pipeline tracking for drug candidates for global R&D priority products.



- **Goal 3 - National voices should be heard : ‘There are also lessons to be learned in how to build local expertise and demand for research evidence to inform health decision-making.’**

Also research activities need to occur closer to the populations for which the innovations are intended. Therefore, an emphasis on building the local research capacity of LMIC's and the incorporation of data from these populations in global research. This will enrich the diversity of data inputs to ensure innovations capture population differences e.g. precision medicines and pharmacogenomic differences in the global south.

- **Action 5 – WHO to curate an evidence-based list of existing innovations that could be scaled.**

We need to encourage stakeholders to report and share learning of lessons learned when innovation fail to meet expectation. The innovation literature suffers from publication bias in that only success stories are publicised whereby failures are not. This learning of failures is equally if not more valuable to know what did not work.

6.Data and digital health

No comments on this paper.

7.Innovative programming in fragile and vulnerable states and for disease outbreak responses

No comments on this paper.

For any queries regarding the comments outlined in this document. Please get in touch with any of the following:

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July 1, 2019

SDG3 Secretariat
World Health Organization
Rue Appia
Geneva, Switzerland

Dear SDG3 Secretariat,

Partners In Health (PIH) is a social justice organization committed to working alongside the communities it serves to establish meaningful local partnerships and build delivery systems that increase healthcare access, utilization and quality for all. We prioritize programming that tackles the root causes of poverty and disease in rural, underserved populations, and engage in long-term partnerships to strengthen health systems towards the progressive realization of the right to health at sub-national and national levels.

We join with our friends and partners at Wemos, the CSO engagement mechanism of GFF, our fellow members of the Frontline Health Workers Coalition, and others who have also sent responses which we have read and endorse. We seek to add to their commentary by providing our recommendations and general comments regarding the Global Action Plan Accelerator papers.

Accelerator Discussion Paper 1: Bridge the Gap in Financing through increased ODA

- It is great to see Driver 1 is “supporting peoples’ and communities’ voices for appropriate domestic allocations to health (DAH).” To strengthen this plan, we believe that the signatory agencies should be pushing to help the countries which are furthest behind in achieving SDG3 rather than the furthest ahead by equitably distributing support as a principle in external partner engagement.
- The goals outlined in this paper could be realized through a more robust global pooled mechanism with significant increases in ODA from current numbers. This increase would function to close the financing gap that we know clearly exists now and will continue to exist for years to come unless more investments are made and would incentivize increased direct government expenditure on the public health system.
- With the intent of providing more joint support to countries, recommendations for DAH around better coordination of existing resources is important but we need to recognize that coordination will need increased DAH for the poorest countries. Solely increasing domestic resources (if that is possible) is not enough to achieve high quality care delivery driving towards UHC.
- The document needs to include an emphasis on resource mobilization being analyzed or prioritized by how well it effectively reaches the poorest and most vulnerable populations of a country. Data regarding these measurements needs to be disaggregated to understand whether the funding is reaching the poorest communities. Resource allocation needs to be structured to ensure the principle of ‘leaving no one behind’, and proper equitable distribution prioritizing those districts and communities with the most vulnerable first.

Accelerator Discussion Paper 2: UHC can only be achieved through investment at all levels of a health system, not only at the primary care level (PHC).

- Multisectoral action, empowering people and families, and integrated service delivery are essential pillars. However, a PHC only approach will only go so far if these ideals aren't also central to a more comprehensive approach to UHC reflective of the whole health system. Some conditions - and often those with the most severe and catastrophic health & financial consequences for the most vulnerable families - can't be treated at health center level. These conditions include most severe NCDs, cancer, mental illness, surgically-amenable conditions, etc. Reinforcing district hospital based care with strong linkages for referral and mentorship to primary care level services at community & health center level is required to ensure UHC is achieved.
- Direct investments must be made simultaneously at community, primary and secondary levels to ensure one uniform, functioning referral pathway. Far too often well-intentioned donor resources get allocated across different districts that are deemed most vulnerable, but are earmarked specifically to one level of the health system- resulting in a potentially robust community health worker network without a reinforced primary care facility level to refer into nor a fully functioning district hospital, or a great district hospital with few patients because the community and primary care levels are non-existent or poorly invested in. Realigning donor programming to take a whole health system, patient-centered approach aligned to national health plans and strategies, with the governments in the drivers' seats at the sub-national and national levels, could achieve better health outcomes overall.

Accelerator Discussion Paper 3: Implementation goals are required to realize community and civil society engagement

- While it is encouraging to see principles focused on meaningful engagement of communities and civil society as well as an emphasis on gender equality, the paper does not provide a clear roadmap or insight regarding how to realize these goals at the agency level through inclusive manners that consider and prioritize marginalized voices.
- With regards to Action 4, in order to reach those at most risk of being left behind, community platforms need to more thoughtfully develop how they will be taking into account barriers such as use of internet, language barriers, health & medical literacy, power dynamics, stigma, etc. Too often opportunities are only given to those who already speak "the language" (literally in terms of English, but also in terms of those who are more well versed in policy/advocacy structures) - or "meaningful engagement" means being given a seat on a panel but not included in decision-making. The paper does not provide enough information regarding "how" agencies would achieve this. We believe building a virtual platform is great but insufficient.

Accelerator Discussion Paper 4: It is great to see a much more nuanced approach to determinants of health

- It is encouraging to see a much more comprehensive and nuanced approach to determinants of health reflected through these papers than what we usually see from the NCD community where the only focus is on commercial determinants of health. But if the effort is to hold to principles to leave no one behind, it seems logical that the "Structural Determinants" section should be the first category of determinants of health rather than last, as it currently appears.

Accelerator Discussion Paper 5: Engaging with local leaders and industries is required to create a sustainable plan

- Great to see emphasis on building in access & equity to R&D pipelines.
- In addition to "coordination," signatory agencies should prioritize engagement of local academic institutions to lead research, be PIs and be first authors on papers.
- The Paper does not address relationships with industry at all. What are your recommendations in terms of PPPs and relationship with pharma companies, manufacturers, regulatory agencies? We need UN agencies to more actively push for enabling environment to address drug pricing - especially for drugs that have been off patent for nearly 100 years like insulin. Pharma-led global access programs for life-saving treatment for conditions like T1D isn't enough when treatment is prohibitively expensive - many across low-income to high-income countries are being left behind. We need to learn from efforts around HIV and replicate some of the successes and best practices moving forward.

Accelerator Discussion Paper 6: Disaggregation of data by equity measures

- It is great to see strong emphasis on disaggregation of data by equity measures.

Accelerator Discussion Paper 7: Need for emphasis on integrating non-communicable disease management-acute on chronic manifestations in UHC planning

- It is great to see emphasis on protecting health workers' rights.
- To truly achieve SDG3 and UHC, we all must acknowledge and plan for the need to incorporate NCDs into the essential package of care. We would like to see stronger link between acute-on-chronic, i.e. impact of acute infection on manifestation of chronic diseases and how to manage chronic diseases in acute settings. Managing severe NCDs like sickle cell and T1D is incredibly neglected in current emergency response efforts.
- The paper should comment even more significantly on mental health (MH), both in terms of MH challenges among victims of humanitarian crises but also in support to addressing the psychosocial trauma of being a care provider in humanitarian settings, as well as stronger investments in integrating mental health into the existing health system at community, primary and secondary levels.

We sincerely hope that you will find these comments helpful in your ongoing efforts to revise the papers and build out more concrete plans for the signatory agencies, and look forward to the opportunity to continue to serve as a thought partner and key informant in these efforts moving forward, given our collective years of direct implementation experience.

Sincerely,

The Partners In Health UHC core strategy team

Feedback: Global Action Plan papers

This feedback is provided by the Action for Global Health Network UK, which represents over 60 global health organisations and stakeholders within the UK.

Outline of the Global Action Plan

1.3: Challenges and opportunities for collective action - suggest adding lack of access to safely-managed water and sanitation services (as a key driver of AMR and emerging and re-emerging epidemics), lack of adequate housing and energy, the threat of zoonotic diseases, and land insecurity. A One Health approach can be mentioned as an opportunity to address these challenges through a coordinated multi-agency effort.

2.5: Significantly more detail is needed on how the signatory agencies plan to support coordination in-country (while increasing their own meaningful participation in national and sub-national coordination). While examples of successful coordination will be included in a box, this needs to be supplanted by more detail on structural changes to how signatory agencies currently operate and fund country-level work.

5.2: Strongly support the notion of signatory agencies holding themselves to account for joint actions. Suggest the inclusion of strong process indicators around the “seven behaviours”, among others.

Accelerator discussion papers:

❖ Sustainable Financing

Broadly welcome the intent and specificity of the actions described here, and the alignment with existing health sector commitments. A couple of points:

Introduction: agency commitments should specifically refer to the need for reducing fragmentation and multiple reporting requirements for DAH, which have significant transaction costs and undermine alignment with national decision making and financial systems (as noted in the text below).

Driver 1: taxes on products harmful to health can be highly regressive, i.e. penalising the poorest. Support should be provided to countries to ensure that if such taxes are applied, they should be done according to context and with appropriate mechanisms to avoid unintended consequences. Such taxes should not be relied upon as a significant source of domestic resources for health spending.

‘Work better to align development assistance for health (DAH) with national priorities, use it to leverage more funds for health, and support maximising the impact of existing domestic resources.’ - Surrounding the commitment of participating agencies: the

current statement to 'work better to align development assistance for health' does not provide a concrete statement of an outcome orientated intent. Given the size, power and influence of the 12 agencies involved, a more systematic coordination mechanism is needed to ensure development assistance for health does not displace or undermine national priority setting.

'Figure 1: An overview of the four key themes and accelerator drivers' - On facilitating consensus building and knowledge sharing. Its is important to acknowledge in this section that health financing policies for UHC will be context specific and not widely applicable. To the point above, it is also unclear how this consensus building/ alignment to support government priorities will take place.

'Support country dialogue on scaling up or introducing of taxes on products and processes harmful to health (especially cigarettes, alcohol, sugar) and on broader domestic revenue mobilisation efforts such as global action against tax avoidance.' - In this section, it is important to also mention income taxation and other progressive taxation strategies. This focus on sin taxes needs to be taken in prospective especially given their revenue generation capacity relative to other taxation methods. It is positive to see a reference to global action against tax avoidance.

'Spotlight on: Convening Ministers of Finance' - It would be useful to mention the lessons learned from this forum and the potential/appetite for ensuring sustained engagement with ministers of finance throughout the process.

'Re -visiting the current aspirational targets for government spending on health (e.g. spending 15% of general government expenditures) to examine their logic, value, and feasibility, and the value of such targets for increasing health spending' - In addition to revisiting, there needs to be support for governments to implement strategies and approaches for reaching these targets sustainably.

'Support joint learning/dissemination/capacity building initiatives' 'At the country level': This country selection approach has also been highlighted in the 'Primary Health Care' paper. It would be useful to clarify whether there will be alignment across accelerators on which countries are selected and supported and how the different departments will work together.

'Spotlight on: Cote D'Ivoire: The government has made a commitment to increase domestic financing for health by 15% annually until 2024' - It would be good to know more about how agencies are now supporting the government to realise this commitment and how learning is being documented and shared (to meet other objectives set out in the accelerator).

❖ Primary Health Care

‘Figure 2 . SDG3+ GAP partners and additional agencies supporting the PHC Accelerator’ - From the list of partners outlined in the schematic, is this list aspirational or existing? Would be interesting to know why civil society is missing?

‘Figure 3. Align, Accelerate, Account through Global Coordination and Country Collaboration’- On the points around country collaboration it would also be valuable to mention the role of other ministries apart from MoH to deliver on a multi-sectoral, and sustainably financed, PHC commitment.
It would also be useful to see more information on how the two pillars of global and country collaboration will align and work together.

‘Exploring a key role for UHC2030 with links to a new G7 initiative for a knowledge portal for PHC: UHC2030 could be a suitable vehicle for global-level discourse on PHC,’ - This Mechanism should also provide a link between global and national level discourse on PHC instead of global level alone.

‘Global guidance on health systems assessment for PHC’ - It might be worth emphasizing that this should be led by national priorities and assessments of their own needs and gaps.

‘Global guidance on the operationalization of PHC’ - It is important to ensure that any indicators for the operational framework are linked to what else is being asked of countries to report on for the SDGs and not create parallel structures. This should also include the aspirational monitoring framework and associated metrics to be established.

‘PHC ACCELERATOR STRUCTURE AND PARTNERS’ - Community and civil society missing as key partners.

‘Action: Increase actions around health workforce’ - The Discussion Paper does not adequately reflect the challenge of the global shortage of health workforce, addressing this shortfall is key to making progress in PHC. The PHC workforce is described as an operational lever that is unique to this Accelerator Area, this is a flawed assumption as sustainable financing (Accelerator Area 1) is crucial to health workforce in the short, mid and long term.

❖ Community and civil society engagement

PROBLEM AND OPPORTUNITY STATEMENT

Paragraph: ‘Despite clear and proven benefits in engaging communities and civil society, there are a range of barriers that limit their effectiveness and influence, including a lack of resources, capacity and support, and challenging legal, social, and policy environments...’

This paragraph should better reflect the shrinking space for civil society, ref Civicus report <https://monitor.civicus.org/>. Shrinking space means less room and opportunity for CSOs to

play an active accountability role and advocate for important policy change. The expansion of the Mexico City Policy, now renamed PLGHA, is a case in point

Key inputs/contributions from interested signatory agencies: ‘Willingness to engage in mapping the funding mechanisms and modalities available to communities and civil society working on health and engage in discussions towards harmonizing funding approaches at country / sub-national level.’

How can we ensure GAP partners pool funds to fund national civil society to work on UHC and reduce the fragmentation of civil society. The CSEM of UHC2030 is keen to do this but getting money is very difficult. The money is all in the GHIs and they are also causing the fragmentation. This is partly represented in outcome of the CSO consultation in April (ref annex 1):

“Participants urged GAP signatories to increase resources to support engagement of communities and civil society in country, regional and global bodies and processes, and to align separate funding streams for civil society engagement for more efficient and rational allocation of funding and to move support out of thematic silos”

This needs to be even better reflected in the accelerator paper.

Objectives : ‘Adopt specific measures to increase opportunities for engagement in activities of global health organizations where such engagement is demonstrated to add value in delivering better policy and/or programmatic outcomes.’ - It needs to be underlined that this should also be the case at national level.

❖ [Determinants of Health](#)

Environmental determinants: proximity to animals, particularly livestock, in rural poor populations should be added as a determinant - especially since the reliance on livestock for livelihoods makes interventions to reduce exposure to zoonoses difficult, requiring action across multiple sectors (such as agriculture and veterinary public health). [Note - FAO’s absence as a signatory represents an additional challenge here as it plays a fundamental role in developing and implementing a One Health approach].

Joint actions: Actions on environmental determinants appears very thin. While efforts to ensure that the environmental impacts of GHOs is minimised, GHOs play a fundamental role in setting out normative guidance, delivering programming and undertaking coordination around addressing the environmental determinants. In some GHOs, work on environmental determinants is under-prioritised and under-resourced. This should be addressed here, at least by replicating the measures to be undertaken under the structural determinants action (reviewing, strengthening and budgeting).

Table 1: Structural determinants: joint action on universal access to WASH is welcome but should perhaps sit under environmental determinants. Consider rephrasing to “universal

access to safely-managed WASH services” since achieving health impact requires a higher degree of service quality, and this will also align with SDG6 targets.

❖ Research and development, innovation and access

Goal 1 - Access should be built into the R&D pathway - Use existing tools and norms to hold R&D development partners to account e.g. the access to medicine foundation expectation for pharmaceutical companies to consider R&D access planning at phase 2 of drug development.

‘The resulting 2018 ATMI methodology now incentivises companies to have access provisions in place for R&D projects regardless of whether they are conducted in-house or in partnership. Emphasis will be placed on projects in late stages of development (phase II clinical trials or later) by conducting a deeper analysis into the nature of access plans for product candidates that are closest to approval.’ (1)

1. Cole, C., Trolle, S. and Edwards, D. (2018). Developing the latest framework to measure and incentivise pharmaceutical industry contributions to health research and development. Health Research Policy and Systems, 16(1). Accessed via: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6090890/>. [Date Accessed: 27th June 2019]

Action 1 – Develop Global Good Access Practices for Innovation in Health. - As mentioned, most funders have 'access principles'. However, all too often, these principles are vague and non-binding. Operationalisation of these principles will require an accountability mechanism to ensure the access principles are adhered to once the product reaches the 'market'. Once such mechanism can involve the use of civil society as an accountability mechanism. e.g. CEPI's access policy and MSF awareness campaign.

Action 3 – Establish and maintain a new annual global forum to coordinate and accelerate the late stage pipeline of critical medical and health products (including diagnostics, medicines, vaccines and vector control). : ‘The WHO would maintain monitoring of a central pipeline, track progress and alert the community to delays in three categories (2-5 years from licensure, <2 years from licensure, filling licensure to access/impact gap).’ - Use existing mechanisms that track R&D pipelines to ensure a rich, comprehensive and coordinated database. E.g. Access to medicine Foundation R&D pipeline tracking for drug candidates for global R&D priority products.

Goal 3 - National voices should be heard : ‘There are also lessons to be learned in how to build local expertise and demand for research evidence to inform health decision-making.’ - Also research activities need to occur closer to the populations for which the innovations are intended. Therefore, an emphasis on building the local research capacity of LMIC's and the incorporation of data from these populations in global research. This will enrich the diversity of data inputs to ensure innovations capture population differences e.g. precision medicines and pharmacogenomic differences in the global south.

Action 5 – WHO to curate an evidence-based list of existing innovations that could be scaled. - We need to encourage stakeholders to report and share learning of lessons learned when innovation fails to meet expectation. The innovation literature suffers from publication bias in that only success stories are publicised whereby failures are not. This learning of failures is equally if not more valuable to know what did not work.

❖ Data and digital health

Action: In line with global commitments, include disability disaggregated data as a consideration in this Accelerator Area.

There are approximately one billion persons with disabilities globally, with numbers rising due to ageing populations and increases in chronic and mental health conditions.[1] Ensuring access to health for persons with disabilities is essential to achieve SDG3. The lack of gender, age and disability disaggregated data is a major challenge for monitoring the equity gaps in health status and access to services. That Accelerator Discussion Paper does not include disability in its discussion on data generation. UN agencies have made commitments to addressing this gap:

In June 2019, the [United Nations Disability Inclusion Strategy](#) was launched, with the aim of ensuring that the UN system is fit for purpose in relation to disability inclusion. With disaggregation of data included as an indicator for strategic planning, it notes that “[t]he lack of disability-related data, including qualitative and disaggregated data, is one of the major barriers to the accurate assessment of disability inclusion across both development and humanitarian contexts. This policy and accompanying accountability framework will address this gap.”[2]

Furthermore, both UNFPA and UNICEF are signatories to the [Inclusive Data Charter](#). Principle 2 of the Charter states: “All data should, wherever possible, be disaggregated in order to accurately describe all populations We recognize that data should be disaggregated by sex, age, geographic location, and disability status and, where possible, by income, race, ethnicity, migratory status, and other characteristics relevant in national contexts.”[3]

[1] World Health Organization and World Bank (2011). World Report on Disability. www.who.int/disabilities/world_report/2011/report.pdf

[2] https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/03/UNDIS_20-March-2019_for-HLCM.P.pdf

[3] http://www.data4sdgs.org/sites/default/files/2018-08/IDC_onepager_Final.pdf

Global Action Plan for Healthy Lives and Well-being: Input for the public consultation

We welcome this opportunity to provide input into the Global Action Plan for Healthy Lives and Well-being (GAP) and its accelerator discussion papers. Below, please find recommendations that the signatories would like to make in relation to (1) the process of preparing the GAP, (2) the accelerator on sustainable financing and (3) integrating due attention for addressing human resources for health challenges.

Process

The Global Action Plan for Healthy Lives and Well-being provides an important and urgently needed initiative calling on multilateral health organizations to accelerate, align, account for and assess their contributions to realizing health for all. While we appreciate the opportunity to provide feedback on the draft outline of the plan and its accelerator discussion frameworks, we are concerned about the process for civil society consultation.

Not only is this consultation coming at a very late stage, with the Plan to be presented in September 2019, it is also inviting feedback on incomplete papers (the GAP draft outline), that “do not necessarily reflect the views of the 12 Global Action Plan signatory agencies” (the accelerator discussion papers). Will be another opportunity for feedback once the papers are further developed and consensus is reached among signatory agencies?

We would rather see a proper consultation process, giving civil society the opportunity to share its expertise fully, taking more time, than a hastened process to finish the Plan by September 2019, and hence not fully grasping this important opportunity. We would like to state that, providing input into this consultation does not imply our endorsement of the process.

Accelerator 1: Sustainable Financing

The Sustainable Financing accelerator discussion paper indicates a number of very relevant areas for improving alignment, accountability, joint assessments and accelerating. We would like to suggest the following amendments in order to strengthen the equity and gender impact, integrating human resources for health challenges and filling the funding gap for Universal Health Coverage (UHC):

1. Strengthen the way in which equity is operationalized and to explicitly include gender equity. In the current version of the paper, equity is emphasized mostly in relation to health spending. However, if the resources raised for health spending, are raised in a manner that is regressive – placing a relatively large share of the burden on lower income groups – the net effect of equitable spending may be lost. Therefore, we suggest:
 - a. Adjusting the second bullet on page 1 as follows: “..., improve the efficiency and equity of health spending **and resource mobilization.**”
 - b. Expanding the section on “Inefficient and inequitable health spending” by adding “and resource mobilization” to the heading and pointing to the importance of (a) progressive tax systems for public funding of health and (b) “the need to shift to compulsory pre-paid financing arrangements for health services, which is critical for achieving universal health coverage and

for equity”, as was also highlighted by the Global Fund’s Technical Review Panel in its October 2018 report.

- c. Adding equity and gender equality as additional principles to govern the sustainable financing for health agenda;
 - d. Including the need for progressive taxation and compulsory pre-paid financing arrangements in driver 1, which currently emphasizes taxes on products harmful to health. While such ‘health-taxes’ can play a role to reduce consumption of unhealthy products, they generally do not contribute significantly to resource mobilization, and they tend to be regressive. Rather, wealth, corporate and personal income taxes should be scaled up.
 - e. Including the use of Human Rights commitments, tools and indicators in driver 5, in addition to the human capital index and investment plans.
2. Better integrate the challenge of filling the funding gap for human resources for health (HRH). In the current draft paper, HRH are approached mainly as an efficiency and public finance management (PFM) challenge. In doing so, the paper neglects the immense shortages of HRH in many low- and lower-middle-income countries and the fact that a shortage of funding – and not only inefficient use – is one of the major constraints towards expanding the health workforce. While acknowledging the fact that important improvements can and must be made to improve efficiency and PFM, we call on the GAP signatories to make an effort to fill this gap through a coordinated effort.
 3. Be more concrete and ambitious in relation to international efforts needed to mobilize more resources for health.
 - a. As indicated in the paper, Development Assistance for Health (DAH) has been stagnating, and a call is made to increase DAH. We suggest including a call to high-income countries to live up to their commitments and allocate 0.7% of their Gross National Income to Official Development Assistance as a driver.
 - b. We are glad to see that the paper mentions the need to address tax avoidance through global action. As indicated in SDG17 and in the recent Financing for Sustainable Development Report 2019, there are other important areas for global action to strengthen countries’ ability to mobilize public resources. In line with these, we recommend to call for a significant scale-up of global efforts to end tax avoidance and evasion, address tax competition to reverse the global decline of corporate tax rates, an effective debt work-out mechanism and revamping of the multilateral trading system”.

Human Resources for Health

A fit-for-purpose, educated, motivated and supported health workforce is considered to be the backbone of any well-functioning health system. However, the world is facing a global health workforce crisis, with a projected shortfall of 18 million health workers by 2030, with the biggest shortages in low and middle-income settings.

The current accelerator drafts make minimal mention of this challenge and make no effort to address it, even though the health workforce is a critical enabler for *all* accelerators. For example, even when digital solutions and technological innovations are widely implemented, 60-70% of government spending on health is on people: education, in-service training, and salaries. Also, the integrated service delivery

component elaborated in the Accelerator on Primary Healthcare is silent about the human resources implications of the ambition to deliver comprehensive care throughout the life course.

Ideally, a fit-for-purpose health workforce consists of a broad range of health worker cadres that together provide a continuum of care: promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. The exact composition of the health workforce (i.e. the required cadres in the required numbers) depends on the demographical and epidemiological profile of the population, and is therefore context-dependent; there is no blueprint for 'the' perfect health workforce composition.

The 12 multilateral global health and development organizations in the GAP are perfectly positioned to align their (sometimes very diverse) in-country health workforce strategies and practices, and to invest in a health workforce that contributes to all in-country health needs, and lays the foundation for an "SDG3-proof" health workforce in that country.

The Global Fund, in its [Technical Review Panel report of 2018](#) already identified some important points for improvement in this area:

- Ensure that incentive schemes for government workers are consistent within countries
- Adopt a standard salary scale among donors for (community) health workers
- Shift to supporting pre-service, rather than in-service training, and make use of distance learning possibilities for continuous learning
- When targeting expansion of community health workers, make sure that these include appropriate budget allocations and referencing to the supporting systems required.

We call upon the actors in the GAP to specifically look at HRH implications of all accelerators and formulate adequate strategies and plans to address HRH challenges.

These recommendations are endorsed by the following organizations and individuals:

1. Wemos Foundation (Netherlands)
2. Afrihealth Optonet Association (Nigeria)
3. Association of Malawian Midwives (Malawi)
4. Club des Amis du Monde (Guinea)
5. Cordaid (Netherlands)
6. Dakshayani and Amaravati Health and Education (India)
7. Dr Uzo Adirieje Foundation (Nigeria)
8. Femmes Unies pour la Paix dans la Région des Grands Lacs (Burundi)
9. Femmes-Santé-Développement (Cameroon)
10. Good Health Community Programmes (Kenya)
11. Gorik Ooms, Professor of Global Health Law & Governance, London School of Hygiene & Tropical Medicine (United Kingdom)
12. International Alliance of Patients' Organizations
13. International Association for Hospice and Palliative Care

14. Lok Kalyan Seva Kendra (India)
15. Medical IMPACT (Mexico)
16. Muslim Family Counselling Services (Ghana)
17. Nigerian Women Agro Allied Farmers Association (Nigeria)
18. Positive-Generation (Cameroon)
19. Remco van de Pas, Vice-chair Medicus Mundi International network
20. Society for Conservation & Sustainability of Energy & Environment in Nigeria (Nigeria)
21. Zimbabwe AIDS Network (Zimbabwe)

Friday, 28 June 2019

To: SDG3_Secretariat@who.int

Subject: General comments for the *Invitation for public comment: Global Action Plan for Healthy Lives and Well-being*

Comments from the Civil Society Advisory Group for the Global Action Plan:

The world is not on track to meet the ambitious goals set out in UN Sustainable Development Goal 3, and other related health Goals. Less than half the world's population has access to the health care they need, and each year 100 million people are pushed into extreme poverty in the course of accessing essential health care.¹

The Global Action Plan for Healthy Lives and Well-Being for All (the GAP) is a timely opportunity to take stock of the state of progress towards SDG3 (and beyond), and to revitalise efforts to achieve these goals.

The Global Action Plan Civil Society Advisory Group (the Advisory Group) congratulates the Heads of State of Germany, Ghana and Norway for their initiative in calling for a Global Action Plan, as well as the twelve signatory agencies for their willingness to engage in the GAP.

We appreciate the willingness of the signatory agencies to open the draft version of the GAP to public comment. We believe that buy-in from end users of the fruits of the GAP—in particular civil society, communities and non-state actors, will be critical to the plan's eventual implementation and success.

The Advisory Group was formed in February 2019 through an expression of interest process, encouraged by the GAP Secretariat, and supported by the UHC2030 Civil Society Engagement Mechanism Secretariat. Its role is to advocate for, and provide input from civil society and communities across the GAP. As such we confine these comments to general observations about the GAP as a whole, rather than detailed commentary on specific accelerators.

I. An Opportunity for Leverage

As noted in the GAP Draft Outline paper accompanying this consultation, the GAP is not a roadmap for achieving SDG3. Rather, it is a plan to harmonise the activities of the twelve signatory agencies, in particular as they pertain to the areas of health contained in the seven key accelerators.

This distinction is critical in terms of managing the expectations of stakeholders, and the clarifying plan subtitle (*Strengthening collaboration among multilateral health organizations to accelerate country progress on the health-related Sustainable Development Goals (SDGs)*) is a welcome addition.

Globally, donor funding for health (including those funds disbursed by the GAP signatory agencies) accounts for approximately 1% of overall health spending.² By far the bulk of global health spending comes from national governments. It is unrealistic, therefore, to hold the twelve GAP signatory agencies responsible for the achievement of SDG3, or to expect this of the GAP.

Nevertheless—and this is the opportunity embedded within the GAP—the twelve signatory agencies play a critical role in enabling progress in many countries, particularly LICs and LMICs.

¹ Tracking Universal Health Coverage: 2017 Global Monitoring Report, WHO

² Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda, IHME

It is essential, therefore, that the signatory agencies to the GAP align their activities behind national-level processes, in line with the seven IHP+ behaviours for aid effectiveness, and those of the UHC2030 Global Compact.

In the context of progress towards SDG3, we also stress the importance of country ownership. In the past, country projects and programmes have been largely donor guided. Sustainability of such activities is very poor, since projects become dependent on continued donor funds.

It is therefore imperative that policymakers and implementers in the country accept ownership from the planning phase. Country-based action plans should include gradual weaning off from donor funding, and it is the responsibility of GAP signatory agencies to assist in this transition.

2. Country-level Impact

Following on from 1), the success (or otherwise) of the implementation of the GAP will sit squarely in terms of its ability to change behaviours and patterns of collaboration at the country level.

Global-level plans, meetings, and public goods are necessary and important. Too often, however, these global activities remain stuck at the global level, and do not result in any meaningful changes in practice at the country level.

The GAP cannot be one of these.

We welcome the addition of the fourth “A”—Account—and suggest that in assessing the effectiveness of GAP implementation, focus be given to country-level activities and change.

At present, knowledge of the GAP among civil society, communities and non-state actors at the country level is extremely limited; an understanding of how the GAP is likely to be relevant to the people within these communities even more so.

While it is important that the plan launched at UNGA in September is comprehensive, what happens next in terms of country consultation and implementation is even more important.

3. Support for Civil Society at the Country Level

To pursue 2) further, civil society, communities and non-state actors are, at present, chronically under-resourced to respond to GAP implementation at the country level.

In addition to lack of knowledge about the GAP, national-level civil society platforms equipped to work on broad-based health issues (i.e., across SDG3 as a whole, rather than on particular specific health issues) are virtually non-existent.

The GAP affords a prime opportunity for the twelve signatory agencies, all of whom engage with civil society and communities in some way already, to align their skills and resources behind the development of these national platforms.

The role of civil society in holding governments accountable for their commitments on health is well acknowledged. The capacity to do so, across the whole spectrum of SDG3 (and related health goals), is not there yet. With the assistance of the GAP signatory agencies, it could be.

Such assistance could include the allocation of funding from each of the signatory agencies to a pooled funding mechanism for civil society, to support coordination and aligned advocacy and accountability activities, towards common goals and national priorities that impact all of the signatory

agency action areas.³

It could also include joint support for national and regional meetings and trainings to bring key civil society organisations, communities and other non-state actors together with their respective governments, in order to engage in meaningful dialogue and promote a shared vision relating to the implementation of the GAP.

4. Civil Society Involvement Across the Whole GAP

The Advisory Group welcomes the inclusion of a specific accelerator (Accelerator 3) dedicated to community and civil society engagement, as recognition of the critical role communities have to play in making progress towards SDG3.

We also urge the recognition civil society, communities and non-state actors are most effective when their contributions are recognised across the spectrum of health-related issues contained within SDG3 and the GAP.

As examples, communities can play a key role in budget tracking (pertaining to Accelerator 1: Sustainable Financing) and in the collection and use of health data (Accelerator 6: Data and Digital Health); civil society organisations have played an important role in advocacy and demand generation for immunisation and family planning at community level (Accelerator 2: Primary Health Care).

We therefore ask that communities and civil society be included in conversations at the earliest stages of GAP implementation. Ultimately, this will result in a GAP which is better understood and welcomed by its end users.

5. The GAP as an Act of Political Will

Finally, we wish to highlight that fact that the collaboration of the twelve GAP signatory agencies is not just a task of technical coordination. Rather, it is an act of political will, and it is exactly this political will which will determine whether we reach SDG3 or not.

We recognise that a commitment to the promises of the GAP on behalf of the signatory agencies will, in some cases, require a realignment of the way the agencies have operated for some time.

We welcome this commitment and, in this spirit of collaboration, would ask that the door be left open for other interested development partners to join the work of the GAP.

On behalf of the people and communities we represent, who cannot wait any longer for access to effective, essential health care, we thank you for undertaking this important planning work, and urge you to continue it with the end users in mind.

The Advisory Group thanks you once again for the opportunity to participate in this consultation and stand ready to assist in any way we can.

³ Global Health Initiatives' Support to Civil Society Organisations: Analysis and Recommendations, *PMNCH, UHC2030, GHV, Global Health Advocates*, 2019

GAP Civil Society Advisory Group:

- Justin Koonin, ACON, Australia, (AG co-chair)
- Loyce Pace, Global Health Council (GHC), (AG co-chair), US
- Prof. Dure Samin Akram, Health Education and Literacy Program (HELP), Pakistan
- Dr. Fabian Cataldo, International Planned Parenthood Federation (IPPF), Brazil
- Dr. Aminu Magashi Garba, Africa Health Budget Network, Nigeria
- Angela Nguku, White Ribbon Alliance (WRA), Kenya
- Alan Jarandilla Nuñez, International Youth Alliance For Family Planning (IYAFF), Bolivia
- Ngoueko Marie Solange, Public Health International Consulting Center (PHICC), Cameroon

To:

World Health Organization

SDGs Secretariat



RE: General comments on the Global Action Plan Primary Health Care Accelerator

A coordinated global palliative care response submitted by The African Palliative Care Association

1. What do you see as the key opportunities offered by *Global Action Plan for Healthy Lives and Well-being for All*?

One of the major opportunities for the Global Action Plan for Healthy Lives and Well-Being for all is to address the major neglect of the development of health systems that are there for people **throughout their lives** and to ensure that the most vulnerable and those with the highest health needs are not left behind. The focus on primary health care is crucial and for progress to be made we must ensure that primary health care covers the spectrum from health promotion, prevention, treatment, rehabilitation and palliation as outlined in the Astana Declaration and within the UHC definition. Addressing the health system and community response to the palliative care part of the spectrum cuts across work by all signatory agencies, yet with the exception of WHO palliative care is rarely mentioned, leaving millions of the most vulnerable behind.

There is currently no specific recognition in the primary health care acceleration paper or the Global Action Plan itself of the need for healthcare throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation and palliative care. From years of working in palliative care, we know that if the full spectrum is not explicitly referenced, the palliative carer part of the spectrum will be neglected, will not be financed, and the 61.5 million adults and children who need it, will continue to live and die in serious pain and distress. Women and girls will continue to be left to care for people in their homes and communities unsupported and ill-equipped creating a knock-on effect on mental and physical well-being, gender inequality and household poverty. Palliative care must therefore be integrated into the primary health care system response. Access to palliative care is something that the majority of us will need at some point, however much financing is dedicated to prevention and promotion. By failing to recognise a response that ensures health systems and primary health care throughout people's lives, we are failing the most vulnerable in our societies.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

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There is little effective response to date by the signatories on accelerating impact in countries on access to palliative care as part of health systems. Much can be learned however from UNAIDs collaborative work on access to ART treatment and care and the Global Fund coordinating and financing mechanisms. WHO's technical assistance needs to be coupled with effective financing.

Comments on the accelerator discussion papers:

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

1a. Utilise language that explicitly discusses primary health care systems throughout people's lives including the spectrum of essential health services from promotion, prevention, treatment, rehabilitation and palliative care.

1b. Remain constantly mindful of the most vulnerable and marginalised in societies including those facing multiple conditions, stigma and societal fears of death and dying and include people with palliative care needs in all consultations and planning exercises.

1c. We would like to have the UN Women included in this accelerator as the impact of inadequately resourced primary health care services is likely to fall on women and girls due to caregiving responsibilities.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

2a. Ensure that the in country needs assessments and the subsequent plans, financial analysis and monitoring include the need for primary health care **throughout people's lives**, including palliative care, and include women and girls who are often their caregivers, so that the most vulnerable do not continue to be left behind. Also focus on: 1. Community health workers. 2. Access to medicines and equipment. 3. Leaving no one behind.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

Yes, our organisation works with organisations at national level, regionally and globally to advocate for, and access financing to support, initiatives to ensure palliative care is integrated into primary health care, particularly in low and middle-income countries in Africa.



Dr Emmanuel Luyirika
Executive Director

SDG3_Secretariat

From: stanley idika ukpai [REDACTED]
Sent: Tuesday, June 25, 2019 10:45 PM
To: SDG3_Secretariat
Subject: Community and Civil Society Engagement

Follow Up Flag: Follow up
Flag Status: Completed

Dr Stanley Ukpai
Technical Officer,
Representing : development Research and Project Center (Partnership for Advocacy in Child and Family Health at Scale) Nigeria.

Comments.

In Improving alignment of community and civil society funding and capacity strengthening at country level, it is important to note that the civil society space is a spectrum which ranges from community based organisation to faith based organizations and even professional associations. For most, their classification on this spectrum underpins their capacity and more often than not their ability to attract funding and remain sustainable. For some of these organizations, the technical capacity is low, but this does not negate the fact that they yield outputs/results and meet targets even in areas with poor access sometimes more than the more technical professional organizations. An approach that may yet yield results of improved alignment may be to leverage on intermediary organizations to identify and build capacity of these organizations in lower scale of the spectrum and provide funding and financial accountability as an approach to financing of community and the civil society space.

Sent from Yahoo Mail on Android



Promoting fair and
effective criminal justice

World Health Organization: Global Action Plan for Healthy Lives and Well-being – Accelerator Discussion Paper 4, Determinants of Health

Submission by Penal Reform International, 24 June 2019

Penal Reform International (PRI) welcomes the opportunity to provide feedback to the World Health Organization on the *Accelerator Discussion Paper 4, Determinants of Health, Global Action Plan for Healthy Lives and Well-Being for All*.

In this submission, PRI presents the key issues for a vulnerable and underserved group - prisoners. With over 10 million people detained globally at any one time, many with unique health issues including communicable diseases, promoting the right of prisoners is critical to achieving the Sustainable Development Goals.

Also see, PRI/TIJ, [Global Prison Trends, Special Focus 2017: The Sustainable Development Goals and criminal justice](#), 2017¹ and the [Special Focus on prison healthcare of the Global Prison Trends Report 2019](#).

Introduction

Every human being has the right to the highest attainable standard of physical and mental health and, when a State deprives someone of their liberty, it takes on the duty of care to provide medical treatment and to protect and promote their physical and mental health and wellbeing. In other words, prisoners retain their right to health enshrined in Article 12 of the ICCPR and Principle 9 of the Basic Principles for the treatment of Prisoners.²

International standards, including the revised Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and the UN Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (UN Bangkok Rules), require the provision of adequate healthcare in prison and emphasise state responsibility for healthcare. These standards detail how prison health should be delivered, recognising the equivalence of care and requiring the applicability of medical ethics that apply in the community.

People in prison, health and poverty – Prisoners are left behind:

The interrelatedness between poverty and the realisation of the right to health is evident for people who come into conflict with the law. Poverty is a cause and consequence of imprisonment and while in prison, the right to health of prisoners is often violated – inadequate health services, unhealthy conditions and overcrowding are common and frequently prisoners' health deteriorates.

¹ Available at:

https://cdn.penalreform.org/wpcontent/uploads/2016/06/Global_Prison_Trends_2017_Special_Focus.pdf.

² Special Rapporteur on the right to health (6 August 2010), Report submitted by Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/65/255.

The rates of disease, substance dependency and mental illness among prisoners are much higher than in the community. In fact, mortality rates have been shown to be as much as 50 per cent higher for prisoners than for people in the community.

Despite these complex health issues, and the fact that 'prison health is public health' as the majority of prisoners return to their communities at some point, the provision of healthcare for prisoners is routinely underfunded, understaffed and lacks the full spectrum of treatment available in the community. Understaffing of healthcare staff in prisons is a problem affecting many countries (see target 3.c on the financing and recruitment, development, training and retention of the health personnel), even those that are high-resourced. In France, prisoners reported being on a waiting list for one to two years to have an initial appointment with a psychologist. In Colombia, for example, the Ombudsperson found that there was only one doctor for every 496 prisoners.³

It should be noted that the lack of healthcare and failure to provide access to medicines to prisoners can constitute cruel, inhuman or degrading treatment. For example, in a joint letter to the Chairperson of the fifty-second session of the Commission on Narcotic Drugs, the UN Special Rapporteur on Torture and the Special Rapporteur on the Right to Health noted that 'the failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment.'⁴

Continuity of care

Access to healthcare for people in criminal justice systems is frequently interrupted. Although many people leaving prison have communicable diseases or mental health needs, among other health issues, their treatment and care may be halted when they leave prison, or are transferred to another facility.

The UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)¹⁸ emphasise the importance of continuity of care, particularly for HIV and TB patients, requiring coordination between prison and community health services, among other measures. However, there is often a lapse of treatment or services been cut off upon release from prison.

Healthcare for women in prison

Women prisoners have different and greater primary healthcare needs in comparison to male prisoners. This is partly due to physiological differences, and partly because of their typical backgrounds, which often include physical or sexual abuse, drug use and unsafe sexual practices. However, as a minority in the prison population and gender-based discrimination prison health is ill-adapted for women. The UN Special Rapporteur on violence against women has summarised the lack of gender-specific healthcare provision in prison stating: "The mere replication of health services provided for male prisoners is (...) not adequate."⁵

³ See PRI/TIJ, Global Prison Trends, Special Focus 2017: The Sustainable Development Goals and criminal justice', 2017, p4.

⁴ A/HRC/22/53 para. 56.

⁵ Quoted in Rick Lines, The right to health of prisoners in international human rights law, International Journal of Prisoner Health, 2008, Vol. 4 Iss: 1, pp.3 – 53, p13.

HIV and other sexually transmitted and blood-borne diseases are more prevalent among female prisoners than their male counterparts, due to the combination of gender inequality, stigma and women's vulnerability to contracting sexually transmitted infections and diseases. Although women prisoners are more likely to contract HIV in prison than men, they have less access to preventive and treatment programmes than their male counterparts. This has an impact on mother-to-child transmission rates.

Conclusion:

Prisoners have complex and unique health needs that are frequently unmet. The right to health for specific groups within the prison population including women, children, and prisoners with mental health issues are also violated.

Contributing factors to violations of the right to health in places of detention include: inadequate number healthcare staff, poor material conditions, overcrowded facilities and a lack of harm reduction measures to reduce the transmission of communicable diseases.

The Sustainable Development Goal 3 on healthcare will not be achieved if the right to health for people deprived of their liberty continues to be deprioritised. PRI supports the provision of healthcare under the 'whole-of-government' approach as endorsed by WHO and the UN Office of Drugs and Crime (UNODC).

PRI asks that both the Global Action Plan and Accelerator Discussion Paper 4 make specific commitments to provide prisoners with adequate healthcare in line with international human rights standards

/END.



Public comment: Global Action Plan for Healthy Lives and Well-being

27 June 2019

The International Alliance of Patients' Organizations (IAPO) is an alliance of patient groups in official relationship with the WHO and representing the interests of patients worldwide. We have over 270 member organizations based in over 70 countries covering over 50 different disease areas.

IAPO welcomes the Global Action Plan for Healthy Lives and Well-being to support the strengthening of collaboration among multilateral health organizations to accelerate country progress on the health-related Sustainable Development Goals. This has come at a very opportunistic movement as the Member States start making decisions and investing in their healthcare workforce and health systems needed to deliver universal health coverage by 2030.

General comments on the Global Action Plan:

1. What do you see as the key opportunities offered by *The Global Action Plan for Healthy Lives and Well-being for All*?

The GAP is very important for our patients. They may be vulnerable but they do/ and can also play an important part in their society as employers, employees and students with prospects. If we assure them accessible, affordable, safe and quality healthcare under SDG 3, they can transform their lives and their societies. SDG 3 is very important for patient centricity and transforming vulnerable patients' lives (gender and age (children and adolescents)).

IAPO believes that the 2030 Agenda for Sustainable Development will strongly reinforce and prioritise health (SDG3) for our patients as a political, development and humanitarian priority for all countries. SDG3 puts health into all agendas and is directly linked to the achievement of other SDGs.

The 16 other SDGs need health to transform our patients' lives through poverty eradication, reducing inequality, food security, education, gender equality, climate action and peace, justice and strong institutions. We specifically want to back the 50 targets across 14 goals that are critical to ensuring health and wellbeing,

highlighting the importance of multisectoral collaboration and leveraging shared gains across the SDGs.

2. Which previous collaborations across the signatory agencies have proven to be effective in accelerating impact in countries and could be recommended as good practice / for scaling-up?

Gavi, the Global Financing Facility (GFF) and the Global Fund have all been very important for our immune compromised and younger patients and the Global Fund particularly good to improve access to essential medicines.

Comments on the accelerator discussion papers:

This applies to all papers. Expert-Patient participation, engagement and collaboration in decision-making and in the co-designing, co-producing and co-delivering of programmes, projects and services are vital in all the parts of SDG 3 domains:

- Sustainable Financing
- Primary Health Care
- Community and civil society engagement
- Determinants of Health
- Research and development, innovation and access
- Data and digital health
- Innovative programming in fragile and vulnerable states and for disease outbreak responses

1. Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

The 12 should tap the insight, experience, perspectives and care pathway traversing skills of our expert-patients in co-designing, co-producing and co-delivering primary healthcare services. TB, HIV Aids , Polio, Hep B/C patients can all add value through participation, engagement and official collaboration.

2. Regarding the proposed actions, do you have suggestions for improvement to more effectively provide joint support to countries to accelerate progress towards the health-related SDGs?

As in 1 above, the global patients' movement must be engaged in co-designing, co-producing and co-delivering the national healthcare institutional, policy, clinical practice and standards frameworks to accelerate progress. The expert-patients must be included as a resource in the technical support given to WHO Member States in LMIC.

3. Is your institution involved in, or planning, an initiative to support countries accelerate progress toward the health-related SDG targets that could align with the accelerator actions described?

IAPo will be engaged in the WHO Global action on patient safety to ensure that our members and their expert-patients engaged in co-designing, co-producing and co-delivering patient safety systems and cultures in the future universal health coverage. This will accelerate progress in SDG 3 as:

Patient safety is a central pillar of a compassionate and effective healthcare. Putting patient safety first in universal health coverage will reassure communities that they can trust their health care systems to keep them and their families safe. By implementing the recommendations of the WHO Global action on patient safety report, Member States will be ensuring that their planning and resourcing processes of universal health coverage delivery do not using flawed and wasteful models of care. This will get value for money and accelerate progress in SDG 3.

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General Comments on “The Global Action Plan for Healthy Lives and Well-being for All”

Full Name: Susan Papp, spapp@womendeliver.org
Title: Managing Director, Policy and Advocacy
Affiliation: Women Deliver
Date: June 27, 2019

Women Deliver has been actively engaged in the development of the Global Action Plan (GAP). We are pleased to see an emphasis on gender equality in the determinants of health discussion paper, as well as recognition of the role of gender equality in health for all in the full GAP draft outline—reflecting our input and perspective from past consultations with GAP signatories.

Reiterating our feedback from prior conversations and consultations, determinants of health are diverse, interconnected, and crosscutting—and gender equality is a prime example. Gender equality affects all of the other six accelerators, and leaving no one behind requires addressing it in each. Examples follow below:

- Sustainable financing:
 - How are health finance systems gender responsive, and designed to provide affordable access for all genders and minimize out of pocket expenditures, which are especially burdensome for women?
- Primary health care:
 - How is health care at the primary level recognizing and responding to girls’ and women’s basic health needs across the life course, including access to comprehensive sexual and reproductive health services?
- Community and civil society engagement:
 - How are the GAP signatory agencies prioritizing meaningful engagement with women’s groups, particularly those at the national and grassroots levels?
- Research and development, innovation and access:
 - How does health research and innovation recognize and address the unique health needs of girls and women throughout the life course, and utilize evidence from sex- and age- disaggregated data?
- Data and digital health:
 - How does health data recognize and reflect the lived realities of all genders and ages? How do digital health technologies accelerate health access for all genders and ages?
- Innovative programming in fragile and vulnerable states and for disease outbreak response:
 - How is programming for humanitarian and fragile contexts responding to the unique health needs and lived realities of girls and women?

We continue to strongly advocate for a gender lens to health to be applied across the entire GAP, including within each of the accelerators. Applying a gender lens to health is not an option – it’s a necessity. Girls and women face distinct health issues from boys and men, which are often under-resourced and under-prioritized. A gender-responsive approach to health that promotes and upholds equality and equity is needed to achieve real and meaningful change and help realize the right to health for all.

We were heartened to hear in past consultations that GAP signatories were dedicated to incorporating an action item on gender in each of the accelerators. We do not see this commitment reflected in current drafts of the accelerator action papers, and urge follow through. We have provided examples of collective actions related to gender equality for each of the accelerators below:

- Sustainable financing:
 - Example: Implement gender budgeting and auditing to help ensure sufficient allocation of resources to meet the distinct health needs of people of all genders, and girls and women in particular.
- Primary health care:
 - Example: Promote primary health care that respects human rights and “[delivers] continuous, integrated services that are people-centered and gender sensitive,” as put forth in the Astana Declaration.¹ Encourage, help co-design and implement primary health care programs that recognize and address girls’ and women’s health needs, including their sexual and reproductive health and rights, across the life course.
- Community and civil society engagement:
 - Example: Partner with, and invest in, women-focused and youth-focused community, grassroots and civil society organizations in the development of more effective, rights-based, people-centered health policies.
- Determinants of health:
 - Example: Prioritize commitment to gender equality and addressing the gender determinants of health in policies and programs advanced by GAP signatories, and in their work with national governments.
- Research and development, innovation and access:
 - Example: Promote and fund research and innovation that addresses the unmet health and access needs of girls and women throughout the life course in support of the health-related SDG targets, recognizing that medical research has traditionally been male-focused.
- Data and digital health:
 - Example: Align on categories for data disaggregation—including by gender, age, sex, caste, ethnicity, geographical location and income level—and mandate and

¹ Declaration of Astana, <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>

fund disaggregated data collection to ensure inclusive, appropriate health service delivery and promote accountability. Encourage the development of people-centered digital health technologies to help address girls' and women's unmet health needs.

- Innovative programming in fragile and vulnerable states and for disease outbreak response:
 - Example: Recognize and address the gender inequities in health that are unique to fragile and humanitarian settings with dedicated funding, policies and programs.

Clearly defined collective actions will be critical for ensuring the success of the GAP and supporting countries to achieve the health-related SDG targets. Since these and other important sections are noted as “under development” in the GAP outline, **we stress the need to reopen the outline for public comment after these details have been drafted.**

We share these suggestions to continue to fuel the consultative process with civil society on a robust and representative GAP that appropriately prioritizes gender equality as a critical driver of health for all. Women Deliver is committed to work with partners and support this process. Thank you this opportunity and we look forward to continued conversations.

Submission of Family Planning NSW

Global Action Plan for Healthy Lives and Wellbeing

Comments in relation to:

- 1) Global Action Plan Draft Outline
- 2) Accelerator Discussion Paper 4: Determinants of Health

Submitted to SDG3_Secretariat@who.int
June 2019



Family Planning NSW welcomes this opportunity to make a submission the World Health Organization in relation to the Global Action Plan for Healthy Lives and Wellbeing. Please find attached comments in relation to:

- 1 Global Action Plan Draft Outline
- 2 Accelerator Discussion Paper 4: Determinants of Health

About us

Family Planning NSW is one of Australia's leading providers of reproductive and sexual health services. Internationally, we operate as Family Planning Australia. Since 1926 we have provided independent, not for profit clinical services and health information to men and women. Our work is underpinned by evidence and a strong commitment to sexual and reproductive health and rights.

We are accredited by the Department of Foreign Affairs and Trade to conduct development assistance in Pacific Island countries and territories including Papua New Guinea, Timor Leste, Fiji, Vanuatu, Tonga, Tuvalu, Samoa, the Solomon Islands and the Cook Islands.

1. Global Action Plan Draft Outline

What do you see as the key opportunities offered by the *Global Action Plan for Health Lives and Wellbeing for All*?

1.1 Commitment to strengthen their collaboration and advance collective action

Civil society organisations (CSOs) contribute on the ground expertise across a range of areas, from clinical to research. This expertise could be better utilised in planning for global health.

Family Planning NSW recommends increased opportunities for CSOs to engage in UN processes. For instance, the process by which CSOs are provided with ECOSOC status is lengthy and opaque.

1.2 Progress in health is also closely linked to the achievement of other SDGs

Family Planning NSW commends the WHO for acknowledging links across and between SDGs, and emphasises the important role that sexual and reproductive health and rights will play in attainment of all Sustainable Development Goals (SDG), including SDG 3.

Empowering women and their families to decide on the number, timing, and spacing of their children is not only a matter of health and human rights but also affects non-health sector issues. Family planning is vital to sustainable development including gender equality, education, climate change, justice and the economy.

1.3 Challenges and opportunities for collective action

Pacific Island countries and territories have significant healthcare needs, and yet are under-served and under-represented in relation to other regions. In particular, Pacific Island countries face:

- Unacceptably high rates of physical and sexual violence
- Women die of cervical cancer at up to 13 times the rate in Australia
- High rates of adolescent births
- Low use of contraception
- Unreliable supply of contraceptives
- Lack of training opportunities for clinicians
- Women reporting unsafe abortions.

It is important that Pacific voices be heard at international forums. While populations might be smaller, their need is just as great as larger countries in other parts of the world.

Climate change

Family Planning NSW concurs with these growing threats and highlights the role that the health system, through family planning, can play in supporting mitigation of and adaptation to climate change. The International Planned Parenthood Federation has identified that promoting SRHR enables women and girls to plan their families with autonomy and dignity¹. In turn, smaller and

¹ International Planned Parenthood Federation. Think sexual health isn't linked to climate change? Think again. 2019. [Updated 2019 Apr 29; cited 2019 May 30]. Available from: <https://www.ippf.org/sexual-health-climate-change>

healthier families in stronger economic positions are better able to engage with their communities and to adapt to crises. They also place less pressure on scarce resources such as food and water, and the promotion of women's leadership builds resilience in communities facing the most severe effects of climate change.

Serious consideration as to the role family planning could play in climate change is vital given its potential impact. The Intergovernmental Panel on Climate Change estimates that addressing currently unmet family planning need could reduce CO2 emissions by as much as 30 per cent by 2100, at the same time as improving child and maternal health². Family planning is an appropriate and important strategy given that no single action will be enough to address this complex issue: we need to 'link adaptation and mitigation with other societal objectives'³.

Unprecedented pushback against sexual and reproductive health and rights

Family Planning NSW adds to this list of threats and challenges a particular threat to one aspect of universal health care: sexual and reproductive health and rights. In 2018 a group of independent experts including Australia's former Sex Discrimination Commissioner Elizabeth Broderick reported to the United Nations that "an unprecedented pushback has been progressing across regions by an alliance of conservative political ideologies and religious fundamentalisms" and noted the urgent need for action on women's reproductive and sexual health rights, including access to contraception and abortion care⁴.

Concerted opposition to extension of the mandate of the Independent Expert on violence and discrimination on the basis of sexual orientation and gender identity during the Human Rights Council 41st session⁵ and the re-implementation and extension of the Mexico City rule⁶ are two examples of this threat. The named challenges will have significant consequences for the health of women and LGBTIQ communities and must be systematically opposed by all international human rights and development bodies.

1.3 Strengthening capacities to collect and use health data effectively

Robust data on sexual and reproductive health and rights (SRHR) is particularly challenging to obtain. Yet the data is urgently needed to identify areas of need, to hold governments to account, and to evaluate and improve service provision and access. For instance in Australia, the most recent

² Intergovernmental Panel on Climate Change. Climate change 2014: Impacts, adaptation and vulnerability. Part A: Global and sectoral aspects. [Internet] 2014. [Cited 2019 May 21]. Available from: https://www.ipcc.ch/site/assets/uploads/2018/02/WGIIAR5-PartA_FINAL.pdf p.740

³ Intergovernmental Panel on Climate Change. Climate Change 2014 Synthesis report summary for policymakers. [Internet]. 2014. [Cited 2019 May 28]. P.26. Available from: https://www.ipcc.ch/site/assets/uploads/2018/02/AR5_SYR_FINAL_SPM.pdf

⁴ Human Rights Council. Report of the Working Group on the issue of discrimination against women in law and in practice. [Internet]. 2018. [2018 Jul; cited 2019 May 28 May]. p.7. Available from: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/132/85/PDF/G1813285.pdf?OpenElement>

⁵ ILGA. Defending the independent expert on protection against violence and discrimination based on sexual orientation and gender identity at the 71st session of the United Nations General Assembly. 2017. [Cited 2019 June 27]. Available from: <https://ilga.org/defending-un-ie-sogi-unga71-ilga-arc-ishr-outright>

⁶ The IPPF has identified the impact of this rule: fewer people will be able to access healthcare, thus rates of sexually transmitted infections including HIV, unsafe abortion and preventable deaths may rise. IPPF. Policy briefing: the impact of the global gag rule. 2019. [Cited 2019 June 27]. Available from: <https://www.ippf.org/sites/default/files/2019-01/PPF%20GGR%20Policy%20Briefing%20-%20January%202019.pdf>

national data we have for abortion rates relies upon data from 2003 and is based on a number of estimates and adjustments⁷.

The situation in Pacific Island countries is even more challenging, and research is required in the Pacific to enable a baseline of SRHR need, which can then help to define success and design programmes that can make a sustainable impact. The UNFPA has identified the need for improved monitoring of SRHR commitments, including the need for support of information and data collection and analysis [2]. More foundationally, available data on the Pacific does not consistently refer to the same region, countries and territories are commonly grouped under different names such as Oceania, East Asia and the Pacific, Western Pacific and the Asia-Pacific⁸.

⁷ Grayson N, Hargreaves J, Sullivan EA. Use of routinely collected national data sets for reporting on induced abortion in Australia. Sydney, NSW: AIHW National Perinatal Statistics Unit; 2005.

⁸ Shrestha R and Fifer D. Pacific data in multi-national development agency reports (with particular reference to data on women). [Internet] 2015. [Cited 2019 May 28]. The Pacific Women's Network. <https://www.pacificwomensnetwork.com/wp-content/uploads/2018/05/Missing-Data-Missing-Region-Missing-Women-Report.pdf>

2. Accelerator Discussion Paper 4: Determinants of Health

Regarding the paper, do you have suggestions for improvement, to further leverage the potential of closer collaboration and alignment between the 12 organizations?

1. Environmental determinants

As per above (*under 1.3*), Family Planning NSW highlights the role that the health system, through family planning, can play in supporting mitigation of and adaptation to climate change. The International Planned Parenthood Federation has identified that promoting SRHR enables women and girls to plan their families with autonomy and dignity⁹. In turn, smaller and healthier families in stronger economic positions are better able to engage with their communities and to adapt to crises. They also place less pressure on scarce resources such as food and water, and the promotion of women's leadership builds resilience in communities facing the most severe effects of climate change.

Serious consideration as to the role family planning could play in climate change is vital given its potential impact: the Intergovernmental Panel on Climate Change estimates that addressing currently unmet family planning need could reduce CO2 emissions by as much as 30 per cent by 2100, at the same time as improving child and maternal health¹⁰. Family planning is an appropriate and important strategy given that no single action will be enough to address this complex issue: we need to 'link adaptation and mitigation with other societal objectives'¹¹.

2. Structural determinants

Family Planning NSW calls for abortion to be consistently identified as a core element of universal healthcare, and barriers to accessing safe abortion care called out as discrimination. The United Nations Office of the High Commissioner on Human Rights has noted that criminalising health services that only women need (such as abortion) is a form of sex discrimination¹². The continued existence of discriminatory laws, such as those that criminalize on the basis of sexual orientation or gender identity can significantly affect health and access to health care.

⁹ International Planned Parenthood Federation. Think sexual health isn't linked to climate change? Think again. 2019. [Updated 2019 Apr 29; cited 2019 May 30]. Available from: <https://www.ippf.org/sexual-health-climate-change>

¹⁰ Intergovernmental Panel on Climate Change. Climate change 2014: Impacts, adaptation and vulnerability. Part A: Global and sectoral aspects. [Internet] 2014. [Cited 2019 May 21]. Available from: https://www.ipcc.ch/site/assets/uploads/2018/02/WGIIAR5-PartA_FINAL.pdf p.740

¹¹ Intergovernmental Panel on Climate Change. Climate Change 2014 Synthesis report summary for policymakers. [Internet]. 2014. [Cited 2019 May 28]. P.26. Available from: https://www.ipcc.ch/site/assets/uploads/2018/02/AR5_SYR_FINAL_SPM.pdf

¹² Information Series on Sexual and Reproductive Health and Rights: Abortion. OHCHR. [Internet]. [Cited 2019 May 28]. Available from: https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf

**COMMENTS ON DRAFT DISCUSSION PAPERS RELATING TO SEVEN ACCELERATORS AS IDENTIFIED FOR
THE GLOBAL ACTION PLAN.**

By Health, Education and Literacy Programme (HELP), Pakistan

Member CSEM

GENERAL COMMENTS:

1. Opportunities offered by GAP for Healthy Lives and Well Being.

The linkages between 12 partners at global level is a great opportunity to expedite efforts towards reaching SDG3. But these should be translated into workable collaboration between these partners.

Country resources are usually fragmented between vertical programs being run through donor funding. The opportunity provided by GAP in pooling resources (monetary and others) to work in a coordinated manner at national and sub national levels will be much more cost effective. Such coordination between some of the 12 partners is being done especially with UNICEF and WHO. By concentrating on PHC delivered at community level and with community and civil society participation will be a great saving in time and human resources. It will improve documentation of activities and results and prevent community health care providers from filling out lengthy registers and reports freeing up their time for providing better health care to patients.

Collaboration between Gavi and its partners which include WHO, UNICEF, CDC and CSOs at global and at country level, is a good example. Without such comprehensive support LICs would not have been able to control infections. Thereby, it has saved lives and enabled well-being of children in these countries.

The Gavi model has accelerated vaccine uptake, introduction of new vaccines to low income and lower middle income countries. It has been instrumental in reducing vaccine prices and striving towards achieving equity in reaching the unreached. By partnering with CSOs in fragile countries and areas of conflict, refugee affected countries, Gavi has been able to provide coverage with core partners as well as with extended partners.

General comments on the Accelerator Discussion Papers:

Although collaboration between Partners is repeatedly mentioned in all of the Accelerator Papers but pathways for collaboration have been superficially outlined in most of the Discussions.

Each Accelerator should graphically or verbally indicate which of the Partners will be collaborating at Central/Regional, national, sub- national level.

Also, linkages between Accelerators have been mentioned but not spelt out. In Acc.2, (PHC), there is mention of linkages with Acc. 1, and 6, but exactly what and how is not clear.

Again, Acc.3 (CSOs), is a cross cutting Accelerator and has important linkages with most others, especially Acc. 2 and Acc. 7. These linkages should be indicated in 'Action' terms.

Comments on Accelerator 2: Primary Health Care.

The Objective of this particular Accelerator is to work with three synergistically inter-related components; Multi-Sectoral approach combined with community involvement and integrated primary health care services to reach UHC and remove inequity.

Challenges outlined in the Discussion Paper are very accurate and well defined. Added challenges are working to empower communities in countries which are low income, with high illiteracy rates, lacking monetary and other resources coupled with poor health care services.

It is very important to have country ownership, equity and no political interference.

In Section A on Coordination:

- There is a danger that there may be too many partners involved with duplication of efforts, resources and the documentation requirements by each partner may become cumbersome and take away from actual care given especially at grassroots level.
- Dictation to countries with funding incentives should be avoided.
- Sustainability of implementation should be inbuilt into the Action Plan.
- Ultimately, implementation should be delivered by in- country effort. Aid and subsidies should be weaned off gradually with in-country resources utilized.

B. Global Guidance on HSS:

Assessment for PHC; This is a development guidance which should be country owned, coordinated by Partners.

C. Accelerating Progress through Action at Country level:

This Section has important linkages with Acc. 1, 3 and 6. It will be dependent on country capacity to sustain the implementation and documentation.

Although there is mention of coordination with CSOs in the discussion but no explicit partnership is indicated at country level with local CSOs/NGOs either in formulation of PHC Policy at country level or in strategizing and implementation of PHC at national or sub national level.

Coordination with Civil Society should be included as also the link between Acc. 2 and 3 which should be emphasized.

Comments on Accelerator 3: Involvement of Civil Society.

The Discussion is well articulated. There should be references in Action 2 (Improving Alignment). In Action 3, linkages with Accelerator 2 (PHC) and Accelerator 7(Fragility) should be emphasized.

Annex 3 added to Accelerator 3, can be transferred as an Annex to Accelerator 2, discussion Paper. And referenced under Section C of Accelerator 2 Discussion Paper.

Comments on Accelerator paper 6: Data and Digital Health.

1. The Challenges related to the need for digital data on health has been well outlined. Other factors which could be added are facts relating to countries with poor transport and communication infrastructure. Data on births and deaths are often not recorded or registered. There may not be enough human resources, optimum outreach activity.
2. Challenges also exist related to amount of investments made by governments in infrastructure, equipment and its maintenance, building and retaining human capacity.
3. Solutions and strategies which have been suggested may not be possible in the very countries where these are needed most. The strategies seem more aligned to middle income countries. Most of the lower income countries have poor physical and networking infrastructure, lack of electricity, low literacy rates and poor quality human resources.
4. Countries with conflict, fragility and low resources may not consider digital systems as a priority due to multiple constraints. Therefore, digital systems should be phased investments by GAP partners which can enable provision of equipment, and training. These should start at health facilities and central registries, then digitization of outreach can be added in a phased manner.
5. Advocacy by GAP partners can convince governments for a 'buy-in'. Sustainability can only be achieved by governments 'owning' the system.

Comments on Accelerator 7: Fragile States.

Challenges of working in fragile states especially in LICs harboring refugees, facing internal displacement, or conflict, have been very well articulated in the opening statement. It would be good to state the challenges

And opportunities of fragile countries and those with refugees and /or in conflict, should be dealt as separate challenges and therefore differing strategies. Although these situations often co-exist but there are 'fragile' counties with gross inequities at sub-national levels even if they do not have the added burden of conflict etc. In both situations disease outbreak risk is greatly increased.

One of the challenges in conflict zones maybe lack of a government (there may be multiple agencies governing different areas as in S. Sudan. Or the government may neglect certain sections of their population if they are termed as rebels or belong to a rival ethnic/religious group. In such scenarios, Action Plans will require partnering with CSOs who are functioning in these 'no-go' areas. Also, partnering with a government may not be possible (S. Sudan or Syria) if they are not able or willing to reach certain parts of the population.

Accelerator Discussion Paper 2: Primary Health Care

Julia Robinson, Senior Program Manager, and Casey Adams, Health Alliance International, Seattle WA USA

We heartily endorse the key objective of this Accelerator, which is to “relentlessly focus on the elimination of inequity and the progressive achievement of UHC,” and the initiative of the GAP to include more civil society voices in its consultation. The three components described under this Accelerator place people and communities at the center of PHC are welcome components.

However, both the process and the content of this Accelerator demand improvement. There is an undeniable omission in the SDG3+ GAP partners for this paper (as well as most of the others): substantial, developmental contributions from governments to inform the priorities and actions in pursuit of the overall objective. Both the GAP partners and the additional partners for PHC described in Figure 2 represent the same list of rich countries, donor agencies/philanthropies, and bilateral/multilateral partners that created and perpetuate a system where PHC struggles to thrive.

This paper also fails to adequately hold accountable the untold number of NGOs and INGOs working in the aid industrial complex. Though NGOs have contributed to the advancement of PHC in some ways - including providing resources (financial, human, material); implementing programs that advance PHC; improving accessibility by implementing programs in rural areas or underserved areas or to vulnerable/marginalized populations; working towards policy change that improves PHC; and advancing science /technology/innovation that has improved PHC - they have also hindered or reversed gains made towards sustainable, nationally led PHC.

As the NGO Code of Conduct for Health Systems Strengthening notes, it is clear that NGOs, if not careful and vigilant, can undermine the public sector and even the health system as a whole, by diverting health workers, managers and leaders into privatized operations that create parallel structures to government and that tend to worsen the isolation of communities from formal health systems. This contributes to internal brain drain that leaves communities and countries devoid of essential health personnel that are critical to attain high quality and accessible PHC. Furthermore, many short-term projects hire workers away from the public sector without taking into account the long-term impacts of these actions.

To truly inform a Global Action Plan for PHC, we need to include language that commits NGOs to true health system strengthening, which means fair and just hiring and compensation schemes, minimizing the management burden on government due to hundreds or thousands of NGO projects in their country, and providing better support to government systems through policy advocacy.

We feel that addressing NGO behavior and impact on health systems as a whole should be included in all of the key actions, but particularly in Action A: Coordination.

Accelerator Discussion Paper 4: Determinants of Health

Julia Robinson, Senior Program Manager, and Casey Adams, Health Alliance International, Seattle WA USA

We enthusiastically endorse the goals of this Accelerator Paper in acknowledging, challenging, and disrupting environmental, commercial, and structural determinants of health to spur progress in achieving the SDG targets. As the paper points out, determinants of health are complex, diverse, and intersectional, and should be a focus when addressing goals and actions put forth by all other Accelerators in order to drive sustainable health equity.

Despite the fact that the paper claims to focus on “poverty and economic inequalities, stigma, discrimination, and gender inequality”, it is alarming that there exists no mention of the discrimination, stigma, and lack of legal protections faced by LGBTQ+ individuals in many countries which leaves them highly vulnerable to poor health outcomes. Further, the paper fails to propose any actions that could be taken towards progressing the rights of this historically marginalized group.

With their access to international power and authority, the GAP partners have an opportunity to urge national governments to rethink the way their laws, policies, and societal structures may discriminate against this population. Although LGBTQ+ rights can be a highly controversial topic and this group experiences very different levels of marginalization depending on specific country’s laws, policies, culture, etc., it is necessary to acknowledge the collective vulnerability of this population on a global scale. Furthermore, action steps must be articulated in order for the GAP partners to actively engage in dismantling systems of oppression that restrict the rights of LGBTQ+ individuals and deprive them of equal access to health services.

Although we commend the Accelerator for its focus on a broad range of determinants of health, LGBTQ+ individuals have been ignored for too long and must be included in the dialogue and action plan fighting for UHC and a right to health for all. Thus, we strongly recommend that this Accelerator propose action steps to ensure equal access to care and the right to health that the LGBTQ+ community deserves.

Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access

Julia Robinson, Senior Program Manager, and Casey Adams, Health Alliance International, Seattle WA USA

This Accelerator Paper is commendable in its focus on concrete, immediate actions that address current problems in today's global R&D, innovation, and access systems. The stated goals demonstrate a commitment to both short- and long-term impact, and the corresponding action statements establish a clear path to achieving these goals.

However, we feel that the paper does not place adequate emphasis on local expertise and recognition of local research accomplishments. The problem statement correctly indicates that national research, health and development priorities are not always driving the agenda, but the paper does not present a sufficient commitment from the co-leaders of this Accelerator Paper to make the systemic changes that are fundamental to true collaboration with and recognition of national partners. And although Goal 3 indicates that national voices must be "fundamental parts of a well-functioning global research for health system", and that international funders must be responsive to national voices and agendas, there is no clear plan for enhancing the agency and centering of local voices in research.

Donor cycles of funding hinder LMICs while strengthening already-powerful institutions (government, philanthropic, private funders) that oftentimes act according to their own agendas. Action 4 should commit to channeling funding to develop local expertise and local authorship. It is not enough to acknowledge the under-funding of local entities. Substantial efforts should be focused on bridging the gap between rich countries that often exploit and export data from poor countries, all to further the careers of rich country academics. More diversity in the research community, and more equally shared power dynamics coupled with collaboration and research/data sharing among national and international partners will lead to rapid advancement of innovation, research, and development.

In conclusion, this Accelerator needs to outline explicit actions that will lead to deliberate investment in capacity building for LMIC researchers to contribute to the R&D agenda. As the MDGs prioritize health advancement and equity in LMICs, we must focus on empowering local research communities rather than allowing highly funded institutions to determine the research agenda without the input or recognition of local expertise.

Accelerator Discussion Paper 1: Sustainable Financing

Julia Robinson, Senior Program Manager, and Casey Adams, Health Alliance International, Seattle WA USA

There is much to praise in this paper, which links UHC to adequate funding of public health systems. As the paper points out, there are many countries reeling from crisis - including conflict or post-conflict settings, shocks from natural disasters, or outbreaks like Ebola - that are only expected to increase in number and grow in severity in the coming years and decades. We especially commend this paper's commitment to placing the highest priority on pro-poor and pro-health fiscal policies.

However, we feel that the paper does not place enough emphasis on transforming the macroeconomic policies and pressures that have pushed countries into a situation of financial vulnerability such that there is not adequate or sustainable financing for health. Macroeconomic policies created and sustained by the International Monetary Fund (IMF) continue a legacy instituted by structural adjustment policies that tie the hands of governments in deciding how their national budgets may be used. It is the conditionalities placed on loans - that persist to this day - that ensure countries will "give a relatively low, and in some cases decreasing, priority to health in budget allocations." Servicing crushingly high loan payments and disallowing the fiscal space of deficit spending are major contributors to the lack of domestic resources for health, and this paper does not adequately acknowledge and challenge that.

Specifically, we recommend that IMF reform is more explicitly mentioned in both the More Money for Health theme and the More Health for Money theme. Driver 1 mentions a "dialogue" with the IMF, but it should more forcefully demand the end of conditionalities and debt forgiveness. Driver 2 similarly encourages a "dialogue" on "broader fiscal reforms to mobilize more public revenues for health" but it needs to explicitly state that the IMF's own policies need to radically change (including the end of conditionalities and debt forgiveness), rather than keeping broad language that can put the onus on LMICs to further restrict their already paltry budgets they are allowed to allocate for health.

Ultimately, this Accelerator Paper needs to take a more forceful stand against policies that favor rich countries over poor ones and favor profits over people. If we are serious about accelerating sustainable financing for health, we need to end IMF conditionalities, cancel debt, and finally, actually, commit to working with local communities to build health systems that can deliver UHC.

Accelerator 2: Primary Health Care (PHC)

Suggested actions to improve the accelerator area – Sightsavers' comments

- **Action:** Success of the GAP will entail engagement beyond Ministries of Health. The Accelerator Area should therefore reflect how it will work with other key ministries, including Ministries of Finance.

While Ministries of Health are a key partner in implementing this Accelerator Area, it would be valuable to reflect the role of other ministries and how the signatories will work with them. In particular, it is critical that Ministries of Finance are part of the dialogue to improve PHC. While the role of Ministries of Finance is recognised in Accelerator 1: Sustainable Finance, it also essential their role is explicitly included in this Accelerator Area, to ensure sustainable financing for PHC.

- **Action:** Increase actions around health workforce.

The Discussion Paper does not adequately reflect the challenge of the global shortage of health workforce, addressing this shortfall is key to making progress in PHC. The Discussion Paper needs to draw on existing evidence and recommendations to ensure efforts are made to expand the health workforce for PHC, as well as considering ongoing support and retention of the health workforce. We encourage the signatories to reflect on the Global Strategy on Human Resources for Health: Workforce 2030; Call to Action: Addressing the 18 Million Health Worker Shortfall; and the recommendations on human resources for health in the Global Fund's Technical Review Panel's report on Resilient and Sustainable Systems for Health Investments in the 2017 – 2019 Funding Cycle.

The PHC workforce is described as an operational lever that is unique to this Accelerator Area, we would challenge this assumption as sustainable financing (Accelerator Area 1) is crucial to health workforce in the short, mid and long term. It is equally relevant to other Accelerator Areas, including data and digital health and innovative programming. It is therefore vital that the Discussion Paper is updated to adequately reflect the cross-cutting nature of the PHC workforce on other Accelerator Areas.

- **Action:** Incorporate commitments under the recently launched [United Nations Disability Inclusion Strategy](#).

In June 2019, the United Nations Disability Inclusion Strategy was launched, with the objective of providing the foundation for sustainable and transformative change on disability inclusion through all pillars of the UN's work. As the GAP is finalised in the coming months, it is critical that the commitments under the Strategy are integrated in this Accelerator Area to ensure that the PHC is disability inclusive and contributes to the UN achieving its objective of ensuring genuinely inclusive development progress.

- **Action:** Reflect civil society as partners supporting the PHC Accelerator (Figure 2)

The Discussion Paper highlights the need for community and civil society engagement but it overlooks the role civil society often plays in supporting service delivery and other aspects of the health system in the primary health care setting. It is vital that the Discussion Paper accurately reflects that civil society are also a critical partner supporting PHC.

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28 June 2019

Accelerator 3: Community and Civil Society Engagement

Suggested actions to improve the accelerator area – Sightsavers' comments

- **Action:** Civil society and communities are best placed to monitor engagement with UN agencies on the Global Action Plans (GAP). This should be reflected concretely.

On pg. 3, the Discussion Paper states that “engagement with communities and civil society will be monitored by interested signatory agencies”. We would flag serious concerns with this approach as communities and civil society are best placed to monitor how the UN agencies engage with them. National and international civil society groups, such as UHC2030, should be empowered to fulfil this role.

- **Action:** Invest in mapping “disenfranchised and marginalised people” at national level.

Building on the GAP consultation, held in New York on 30th April, it was clear that there is a need to understand who is being left behind in SDG 3 in order to ensure that civil society and community engagement is representative. In order to do this, as discussed at the GAP consultation, a mapping exercise is required in each country the signatories work in. It cannot be assumed that groups of people who are marginalised are mobilised and actively engaging in available forums. This activity should be added to Action 1 and framed within the objectives in terms of understanding who the groups of people currently marginalised in society are in the countries in which the signatories are working in. This data is also required in order to meaningfully monitor and evaluate progress of Action 3 in the Discussion Paper.

- **Action:** Add a proposed pooled funding mechanism for community and civil society engagement as a consideration under Action 2.

There was a clear appetite at the New York consultation for UN agencies to develop a pooled funding mechanism for community and civil society engagement. This should be referenced as a potential output under Action 2. Equally, the signatories could consider piloting this approach in one to two countries to gauge how effective it could be in practice.

- **Action:** Ensure reasonable accommodation and accessible information, tools and resources are explicitly considered within this Accelerator Area.

In June 2019, the [United Nations Disability Inclusion Strategy](#) was launched, with the aim of ensuring that the UN system is fit for purpose in relation to disability inclusion. A cross-cutting element is the principle of universal design: “The United Nations will implement and apply the principles of universal design in all its policies and programmes. Barriers to accessibility should be properly identified, addressed and removed. Persons with disabilities engaging with the United Nations in any capacity and staff with dependents with disabilities have the right to reasonable accommodation.”¹ It is critical that this Accelerator Area reflects on this principle to ensure the representation and participation of persons with disabilities in community and civil society engagement.

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28 June 2019

¹ https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/03/UNDIS_20-March-2019_for-HLCM.P.pdf

Accelerator 4: Determinants of Health

Suggested actions to improve the accelerator area – Sightsavers' comments

- **Action:** Increase actions on environmental determinants.

Joint actions under environmental determinants of health needs to be expanded. This aspect of the Discussion Paper also needs to specifically refer to enhancing the resilience of people and health systems through effective climate change adaptation, disaster risk-reduction (DRR), and in humanitarian action. The Discussion Paper would be significantly strengthened by acknowledging the potential impacts environmental risks on the broader health system, but also the potential impact of strengthening health systems to better cope and respond to associated risks. All investments across the GAP need to be undertaken giving consideration to strengthening resilience, particularly Accelerator Area 2 on Primary Healthcare (PHC).

- **Action:** Incorporate commitments under the recently launched [United Nations Disability Inclusion Strategy](#).

In June 2019, the United Nations Disability Inclusion Strategy was launched, with the objective of providing the foundation for sustainable and transformative change on disability inclusion through all pillars of the UN's work. Disability is noted under the category of structural determinants of health. Globally, there are approximately one billion persons with disabilities, with numbers rising due to ageing populations and increases in chronic and mental health conditions.¹ However, the Discussion Paper does not go into any detail about the physical, attitudinal, social, structural, and financial barriers which people with disabilities face in accessing quality health services. It is critical that the Discussion Paper is updated to better incorporate the rights of people with disabilities.

Equally, as the GAP is finalised in the coming months, it is critical that commitments under the Strategy are integrated across all Accelerator Areas to ensure that the GAP is disability inclusive and contributes to the UN achieving its objective of ensuring genuinely inclusive development progress.

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28 June 2019

¹ World Health Organization and World Bank (2011). World Report on Disability. www.who.int/disabilities/world_report/2011/report.pdf

Accelerator 6: Data and Digital Health

Suggested actions to improve the accelerator area – Sightsavers' comments

- **Action:** In line with global commitments, include disability disaggregated data as a consideration. There are approximately one billion persons with disabilities globally, with numbers rising due to ageing populations and increases in chronic and mental health conditions.¹ Ensuring access to health for persons with disabilities is essential to achieve SDG3. The lack of gender, age and disability disaggregated data is a major challenge for monitoring the equity gaps in health status and access to services. However, the Accelerator Discussion Paper does not include disability in its discussion on data generation. UN agencies have made commitments to addressing this gap:

In June 2019, the [United Nations Disability Inclusion Strategy](#) was launched, with the aim of ensuring that the UN system is fit for purpose in relation to disability inclusion. With disaggregation of data included as an indicator for strategic planning, it notes that “[t]he lack of disability-related data, including qualitative and disaggregated data, is one of the major barriers to the accurate assessment of disability inclusion across both development and humanitarian contexts. This policy and accompanying accountability framework will address this gap.”²

Furthermore, both UNFPA and UNICEF are signatories to the [Inclusive Data Charter](#). Principle 2 of the Charter states: “All data should, wherever possible, be disaggregated in order to accurately describe all populations. We recognize that data should be disaggregated by sex, age, geographic location, and disability status and, where possible, by income, race, ethnicity, migratory status, and other characteristics relevant in national contexts.”³

This Accelerator Area must be further strengthened to make better align to existing commitments on disability disaggregated data.

- **Action:** Map agencies areas of strength/experience for increased understanding of joint actions. In the current format, it is not as clear as it could be who will carry out what activities. This will create challenges from an accountability perspective. It would be useful to map the strengths of each agency in this accelerator area. For example, UNDP tend to be the lead agency in supporting civil registration, while UNICEF might support birth registration as well as health worker capacity building. This is a significant gap in the Discussion Paper that could be addressed.

- **Action:** Evidence statements by adding more sources and examples. The Discussion Papers do not provide evidence to support key statements and comments. Adding references to literature and other sources of evidence, as well as practical examples, would strengthen the papers considerably and ensure that best practice and the substantial evidence base on health is being utilised.

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28 June 2019

¹ World Health Organization and World Bank (2011). World Report on Disability.

www.who.int/disabilities/world_report/2011/report.pdf

² https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/03/UNDIS_20-March-2019_for-HLCM.P.pdf

³ http://www.data4sdgs.org/sites/default/files/2018-08/IDC_onepager_Final.pdf

General Comments on the Global Action Plan (GAP) for Healthy Lives and Well-being for All – Sightsavers' comments

Introduction

The Global Action Plan (GAP) for Healthy Lives and Well-being for All, is an ambitious, yet timely, undertaking. While it is clear that the 12 signatories to the GAP have invested significant time in developing the Accelerator Area Discussion Papers, there is a significant opportunity to further strengthen the papers and enhance coherence across the overall GAP. Below we highlight four areas for consideration.

Suggested actions for improvement across the GAP

1. Incorporate commitments under the recently launched [United Nations Disability Inclusion Strategy](#)

In June 2019, the United Nations Disability Inclusion Strategy was launched, with the objective of providing the foundation for sustainable and transformative change on disability inclusion through all pillars of the UN's work. As the GAP is finalised in the coming months, it is critical that commitments under the Strategy are integrated across all Accelerator Areas to ensure that the GAP is disability inclusive, and contributes to the UN achieving its objective of ensuring genuinely inclusive development progress.

2. Map agencies areas of strength/experience for increased understanding of joint actions in each Accelerator Area

In the current draft Discussion Papers, it is not clear which signatories will carry out what activities under each Accelerator Area. This will create challenges from both an implementation and accountability perspective. It would be useful to map the strengths, experience and/or value add of each agency against the Joint Actions in the Accelerator Areas to provide a clearer picture of how Joint Actions will be implemented in practice.

3. Incorporate the health workforce across all aspects of the GAP

Globally, there is a health workforce crisis, with a projected shortfall of 18 million health workers by 2030, with the biggest shortages in low and middle income settings.¹ The current Accelerator Area Discussion Papers make minimal mention of this challenge and do not propose joint actions to address it, even though the health workforce is a critical enabler for all Accelerator Areas. We encourage the signatories to reflect on the Global Strategy on Human Resources for Health: Workforce 2030; Call to Action: Addressing the 18 Million Health Worker Shortfall; and the recommendations on human resources for health in the Global Fund's Technical Review Panel's report on Resilient and Sustainable Systems for Health Investments in the 2017 – 2019 Funding Cycle. Joint action on the health workforce is critical to both consolidating gains and making further progress on SDG 3.

4. Action: Evidence statements by adding more sources and examples

The Discussion Papers do not provide evidence to support key statements and comments. Adding references to literature and other sources of evidence, as well as practical examples, would strengthen the papers considerably and ensure that best practice and the substantial evidence base on health is being utilised.

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28 June 2019

¹ <https://www.who.int/hrh/news/2019/addressing-18million-hw-shortfall-6-key-messages/en/>

Response to the draft Global Action Plan for Healthy Lives and Well-Being for All
Strengthening collaboration among multilateral health organizations to accelerate country progress on the health-related Sustainable Development Goals (SDGs)

General comments on the Global Action Plan

EuroHealthNet welcomes the [draft Global Action Plan for Healthy Lives and Well-Being for All](#), which, overall, is a good overview of strategic approaches to strengthening collaboration among multilateral health organisations to accelerate country progress on the health-related SDGs throughout several ‘accelerator’ areas identified. It offers an accurate description of both the needs and challenges of advancing the joint commitment to work together to identify and tackle key barriers and seize new opportunities in health, adopt new ways of working, build on existing successful collaborations, and jointly align their support around countries’ national plans and strategies to help achieve SDG3 and related health and development goals.

Our response is very much in line with our REJUVENATE Framework for Action to achieve the Agenda2030¹, where we emphasise on promoting health in a rapidly changing world, integrated and sustainable policy making, building and applying new knowledge, and reorienting health systems. All mechanisms should champion the importance of strengthening health promotion, preventative services and public health. We need to transform struggling curative services into health promoting health systems, which are proactive to emerging challenges and resilient to shocks and crises.

With this in mind, we welcome priority-setting exercise by 12 signatory agencies² that culminated in putting forward the following accelerator areas: (1) sustainable financing; (2) primary health care; (3) community and civil society engagement; (4) determinants of health; (5) research, development, innovation and access; (6) data and digital health; (7) innovative programming in fragile and vulnerable states and for disease outbreak responses. Notably, we make a comment accelerated progress and boosted collaboration on the sustainable and equitable achievement of the health-related SDGs is also highly relevant for the Member States of the European Region, the EU ones including. Gains in life expectancy has started to falter, with persisting and growing health inequalities within and between European countries. It is our understanding that equity is mainstreamed throughout the areas. However, with no explicit focus on unequal distribution of health and social outcomes there is a risk of it slipping further down the agenda. In the context of rapidly-changing environments for health systems and delivery of care, financing and governance for health, this Action Plan can serve as a means of promoting equitable, affordable, and universal access to health, as well as fairer opportunities and wellbeing outcomes for all. For these reasons precisely, we would recommend an area dedicated to health equity.

If implemented in accordance with its vision, it can better address the needs of groups that are

¹

<https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/EuroHealthNet%20Health%20Promotion%20Statement%20-%20Short.pdf>

² 12 signatory agencies to the Global Action Plan for Healthy Lives and Well-Being for All: GAVI – the Vaccine Alliance; Global Financing Facility; Global Fund to Fight AIDS, TB and Malaria; Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); United Nations Children’s Fund (UNICEF); UN Women; Unitaid; World Bank Group; World Food Programme (WFP), and the World Health Organization (WHO).

vulnerable in the context of socially unjust disparities in money, power and resources, namely related to demographic change and socio-economic gradients.

Comments on the accelerator discussion papers

While EuroHealthNet supports strategic approaches and forward-thinking set out throughout the accelerator discussion documents, we believe that important equity-related issues should be addressed and further strengthened in the final Global Action Plan for Healthy Lives and Well-Being for All.

1. **Sustainable Financing**: the draft document states that one of the most effective ways to reach the SDG3 targets is to rapidly improve the generation, allocation, and use of public and 'pooled' funds for health. Continuing with business, as usual, will not achieve universal health coverage (UHC) or the broader set of SDG3 and related targets. Beyond seeking to increase domestic public and private spending on health, reducing out-of-pocket expenditures, inefficient and inequitable health spending, support to implementation of equity-proofed, pro-health economic and fiscal policies, preventative approaches and health-enhancing, integrated services should be accounted for. Joint funding mechanisms to leverage additional external funding for health and increased deployment of innovative funding approaches can be a good point of departure (e.g. social and/or health impact/outcome bonds). We note with interest suggestions to compile and work from a common set of data, as well as mapping the human capital index and Human Capital Investment Plans to SDG3 indicators, expansion of social health insurance. Health and social equity should be central to this.
2. **Primary Health Care**: the draft document notes that health systems anchored in primary health care (PHC) are associated with better health outcomes, improved equity and better cost efficiency. Despite this recognition, however, PHC remains inadequately translated into the policies, actions and services required to generate optimal health and wellbeing, particularly for those most in need. This includes some European countries. We would prioritise multisectoral action that systematically addresses social, economic, environmental and commercial determinants of health (incl. though impact assessments and set of common indicators) through evidence-informed public policies and actions. Integrated systems and service delivery addressing people's health needs throughout the life course and social gradients are essential. This ensures countries competence and ownership while supported by international and European processes and funds. EU SDGs and health equity/access to health monitoring would be important to be looked into. Empowering communities and regions to take actions in this regard should be on the radar of cohesion and regional funds. Last but not least, adequate human resources and health workforce should be supported, including through raising awareness of health professionals in addressing inequalities in health.
3. **Community and Civil Society Engagement**: adequate, appropriate and effective capacity building of health professionals, public health experts at national, regional and local levels in the field of health equity, health promotion and disease prevention through cross-sector collaboration should be better prioritized. Since many of policies, including ones in health and related fields are organized, managed and delivered through decentralized systems, it will be even more crucial to invest in capacity of its workforce to communicate and collaborate across the expertise.

4. **Determinants of Health:** the draft document emphasizes that in order to accelerate progress on SDG3 and related SDGs requires unified efforts to address the determinants of health and the health inequities or disparities such determinants perpetuate. WHO Commission on the Social Determinants of Health and the Rio Political Declaration on Social Determinants of Health have been instrumental to put the health determinants on the agenda but strong and sustained progress in addressing them has to date been insufficient. While we are getting better now in knowing what works, the scope of the determinants of health agenda, lack of political will, insufficient resources and capacity have so far slowed the progress. We welcome the inclusion of such determinants of health as environmental (where we would recommend replacing 'climate change' with 'climate emergency/crisis'), commercial and fiscal (while recognising that many private sector actors are or can significantly support efforts to positively advance health and sustainable development broadly), and structural (which should include political determinants). The latter should once more reiterate commitment to poverty eradication, social justice and social protection. Role of taxation of health-harming products, macro-economic determinants (austerity), protection from ill-health/disability-induced financial hardship, and financing for prevention are indeed important to deal with here.
5. **Research and Development, Innovation and Access:** promoting needs-driven research, while focusing on better transferability and scaling of good and promising evidence-based innovations (including social) can accelerate and improve the health response at global, regional and local levels. We note with interest that innovation was considered to have a broad scope, going beyond just biomedical products, to also include interventions in the social sciences, service delivery and other related areas. Ensuring sustainable and affordable access and equity should be core driving principles at each stage of research process to enable early access to innovations by those who need them. We are curious about an idea to develop a Global Good Practice for Innovation in Health since our focus on innovative financing for health in a European context. Exchange between European and other regions could accelerate learning and enable leapfrogging in some cases, while acknowledging each country and region unique context.
6. **Data and Digital Health:** In the context of large and persistent health inequalities between and within countries, digital health and improved data capacity should serve as a means of closing the health gap by improving equity, affordability and accessibility of health(-enhancing) services and practice. Digital health is changing the way health systems are run, how health and care are co-created and delivered across populations. As with any other paradigm in the health field, it should not leave considerations of inequalities unchecked. Ensuring for fair distribution of opportunities, health and social wellbeing outcomes across social gradients should be put central to design and implementation of new digital health strategies. It should be reflected as such in this Action Plan. Indeed, risks associated with exacerbating health inequalities are not highlighted enough. While digital health can improve sustainability and quality of health systems, it also can generate health inequalities. Digital health can benefit individuals only if they are in a position to access it, afford it, and comprehend and utilise the knowledge gained properly (*health and digital health literacy* factor). Given the pace and extent of digital innovation in and transformation of the health sector (and society at-large), digital health literacy is a critical element of any digital health strategy. This is not only crucial for users but also for health professionals, who often struggle to keep up with the fast-paced development of digital technologies. Exclusion can reduce or nullify the benefits of digital health on health systems due to its potential negative impact on vulnerable groups, namely older people and low socio-



economic populations. Last but not least, this accelerator paper should be aligned with the WHO Global Strategy on Digital Health.

7. Innovative Programming in Fragile and Vulnerable Settings and for Disease Outbreak Responses: we have nothing to add as it extends beyond scope of our work.

Please submit your response by **23:59 CET, Sunday, 30 June 2019** to SDG3_Secretariat@who.int

In the subject line of your email response, include the title of either (a) the accelerator discussion paper(s) on which you are submitting comments, and/or (b) general comments.



IRC Feedback on the Global Action Plan

The International Rescue Committee welcomes the Global Action Plan, and strongly supports its aims to achieve greater coordination, harmonization, and efficiency for the achievement of Sustainable Development Goal 3. The IRC further supports the Align, Accelerate, Account, Assess approach outlined in the current draft Global Action Plan. We would like to share the following feedback, which would strengthen the Global Action Plan and help ensure that its potential for impact is maximized:

- In addition to leveraging current country-led planning processes to identify opportunities for harmonization across existing platforms, the IRC recommends that civil society and implementing partners also be consulted during each country's assessment. These partners can offer a different perspective that will be useful for identifying harmonization opportunities. Especially in fragile and conflict-affected settings, implementers and other NGO actors may have an outside role in health service delivery, and they should be consulted throughout this process.
- The IRC supports the accelerator area "innovative programming in fragile and vulnerable states." Fragile and conflict-affected states are a unique context with many factors influencing progress towards SDG 3. They certainly bear a specific deep dive, and the IRC supports examining innovations and new research that can improve efficiency and health outcomes in these contexts.
- Over the past four years, the IRC has researched new approaches for treating acute malnutrition. Our research has produced a new approach that combines treatment for severe and moderate acute malnutrition. Under the current system, children with severe and moderate acute malnutrition, although suffering from a condition on a spectrum, are treated separately, at health facilities supported by separate UN agencies. This system is duplicative and wastes resources in the field. It is especially important that a combined approach to treatment be adopted in humanitarian contexts, where high rates of acute malnutrition often go hand-in-hand with conflict and fragility. The IRC strongly recommends that the Global Action Plan, under the accelerator area 7, "innovative programming in fragile and vulnerable states and for disease outbreak response," examine the treatment system for acute malnutrition as an easy- and urgent- opportunity for UN reform that strengthens harmonization, efficiency, and better outcomes.

Response to the consultation on the Global Action Plan for Healthy Lives and Well-being for All

General comments on the Global Action Plan

HelpAge International welcomes the Global Action Plan for Healthy Lives and Well-being for All and the commitment of the 12 leading signatory agencies to advance collective action to accelerate country progress towards Sustainable Development Goal 3 – ensure healthy lives and promote well-being for all at all ages, and related health and development goals, including universal health coverage.

We believe the Global Action Plan presents a critical opportunity to recognise demographic and epidemiological transitions and to **strengthen and re-orient health systems and services to meet the needs of increasing numbers of older people with a higher prevalence of chronic conditions and complex health and care needs**. However, we are concerned that the Global Action Plan does not give enough attention to these issues and **we are concerned that it does not include older people specifically as a group at risk of marginalisation**.

We welcome the focus on taking country-level action and supporting countries based on their priorities and needs. This must include taking concrete steps to **provide guidance to build capacity at the national level and within health and care systems to address the needs of ageing populations**.

We recognise that the Global Action Plan complements existing agency-specific strategies and builds upon ongoing efforts among global health actors to streamline coordination on health. **WHO's Global Strategy and Action Plan on Ageing and Health** must be recognised within this.

Finally, we welcome the importance placed on **accounting for the delivery of collective results**, including through the development of a set of mid-point milestones for nearly 50 health-related targets across 14 SDGs that provide countries and the international community with a critical checkpoint to determine where the world stands in 2023 and whether it is on track to achieve the targets by 2030. **Action to account for delivering collective results on health-related SDGs must ensure older people are recognised, counted and included so that no one is left behind**. The 2030 Agenda commits to the SDG indicators being disaggregated by income, sex, age, race, ethnicity, disability, geographical location and migratory status, including the indicators to measure progress towards SDG3, including UHC. Despite this commitment, however, older people are still excluded from the data currently collected against many indicators. We have responded to this issue in more detail below, under the section on 'Accelerator Discussion Paper 6: Data and Digital Health'.

Accelerator Discussion Paper 2: Primary Health Care

High-quality and well-functioning primary health care services are critical for older people who have multiple health and care needs. We therefore welcome the focus given to Primary Health Care in the Global Action Plan and the ambitions for:

- (1) Multisectoral action that systematically addresses broad determinants of health through evidence-informed public policies and actions across all sectors;
- (2) Empowering people, families, and communities to take control of their health as self-carers and caregivers, as co-developers and as advocates; and
- (3) Integrated service delivery that ensures people's main health problems are addressed through comprehensive care throughout the life course, including in old age.

An integrated and holistic approach that ensures that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services that they need throughout the life course, including in older age, is essential.

However, we are concerned that the discussion of people's 'main' health problems does not adequately reflect the reality of growing numbers of older people facing multiple and complex conditions. To be effective, integrated primary health care must be people-centred and meet the diverse health, care and support needs of older people.

HelpAge welcomes the recognition of ageing populations and changing patterns of diseases in terms of evolving health needs in the paper. As part of meeting these evolving health needs, **we urge signatory agencies to ensure older people are adequately recognised in the development of global guidance on Primary Health Care and that the specific barriers older people face in accessing appropriate, targeted health and care services are addressed.**

We would also like to urge, more generally, the recognition of: **the gendered dimensions of care** – women are responsible for a far greater proportion of paid and unpaid care throughout the life course, including in older ages, and **the necessity of embedding an understanding of what support is necessary for older women and men to take control of their own health and care** – 'empowering' must explicitly be linked to other forms of social protection.

Finally, the PHC Accelerator document discusses the establishment of a **common monitoring framework for PHC** to be made available at global level for adaptation by countries, with improved metrics, including on PHC financing. **To leave no one behind, signatory agencies must ensure that older people are included within this framework.**

Accelerator Discussion Paper 3: Community and Civil Society Engagement

HelpAge welcomes the emphasis given by the signatories to community and civil society engagement in achieving the Sustainable Development Goal 3 and related health and development goals, including universal health coverage. As an organisation working for a world in which all older people can lead a dignified, healthy and secure later life, HelpAge works globally to ensure that older people have the opportunity to meaningfully engage in development processes and are able to effect change. We are therefore concerned that older people are not included within the groups identified as being at risk of marginalisation in the paper. **Older women and men often experience stigma and discrimination as a result of bias and ageism. They should be named specifically to ensure they are not excluded and are able to meaningfully engage in processes for achieving the SDGs.**

Accelerator Discussion Paper 6: Data and Digital Health

HelpAge welcomes the attention given in the GAP to the need for timely, reliable and actionable health data and the recognition of the critical importance of this for ensuring equity in achieving the SDGs. We are pleased to see the commitment to strengthen sustained country capacity on the cycle of data generation (including disaggregated data by age, sex, geography, and socioeconomic status), analysis, reporting, application to inform policy-making, and dissemination to close data gaps for tracking and accelerate accountability for health SDGs.

The 2030 Agenda commits to the SDG indicators being disaggregated by income, sex, age, race, ethnicity, disability, geographical location and migratory status. Despite this commitment, however, older people are still excluded from the data currently collected against many indicators. For example, current measures of UHC, including the UHC index and financial protection indicators, don't effectively measure older people's access to financial support and their access to health services, or inequalities within the population, as the index includes age-standardized indicators and lacks indicators of cognitive health, while financial protection indicators are calculated at a household level.

HelpAge recognises and welcomes positive work on this agenda taking place, including the establishment of the Titchfield City Group on ageing-related statistics and age-disaggregated data, and the emerging development of conceptual and analytical frameworks for ageing-related statistics collected over the life course. We also welcome WHO's initiative to develop an impact framework to monitor UHC across the life course as part of the 13th General Programme of Work (GPW13) for 2019-2023. Alongside age inclusive data collection and adequate age disaggregation across the range of other tracer interventions to be measured, collecting this data would be a positive step in ensuring better measurement of the inclusion of older people in efforts towards UHC. These potential changes by WHO would also provide an opportunity to make progress with the SDG indicator 3.8.1 through similar additions. However, it is not clear how this will translate into national plans and how quickly.

Together with AARP, HelpAge has recently published a global report including a discussion of these issues. The Global Age Watch Insight publication is available at www.globalagewatch.org/reports/global-agewatch-insights-2018-report-summary-and-country-profiles/

HelpAge urges the 12 signatory agencies to ensure that older people are recognised, counted and included in action to account for delivering collective results on health-related SDGs so that no one is left behind. In particular, we would urge multilateral agencies, governments and national statistical offices to ensure that:

- older people are counted and included in statistical systems, and at all stages of data collection, analysis and use
- age caps are removed from international surveys
- statistics frameworks incorporate a life-course approach, providing more nuanced and useful data on ageing, health and functional ability
- data is disaggregated by age, gender, disability and location, and that age-specific results are published
- use of the ageist concept of "premature mortality" is discontinued

- Lower Middle Income Countries are adequately supported in the development of CRVS and that capacity is built in their national statistical offices measurements of UHC are extended to include indicators on older people
- data is collected for a better understanding of the relationship between poverty and health across the life course and, specifically, in later life
- the deliberations and outputs of the Titchfield City Group on ageing-related statistics and age-disaggregated data are proactively supported, disseminated and used.

HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

www.helpage.org



Submission for the Global Action Plan for Healthy Lives and Well-Being
June 30, 2019

The Engaging America's Global Leadership (EAGL) coalition and its members welcome the opportunity to provide these comments to the 12 international organizations working together on the Global Action Plan for Healthy Lives and Well-Being ("Global Action Plan," or GAP).

EAGL is a broad coalition of U.S.-based private sector organizations working directly and with international business counterparts to promote member state engagement at critical international institutions and mission-focused activities that are transparent, inclusive, sustainable and built on science- and evidence-based approaches that advance global goals. EAGL members represent millions of businesses and workers across sectors such as food and agriculture, chemicals, pharmaceuticals, plastics, biotechnology, footwear and apparel, medical devices, and consumer products that contribute to critical health outcomes for hundreds of millions of global citizens.

EAGL and its members fully support efforts to advance global health and healthy lives around the world, with experience showing the need for a comprehensive, inclusive approach to improving health in areas relevant to the scope of this plan. Such efforts must include collaborative efforts to align action and programming among U.N. agencies, member states, the private sector, civil society and other stakeholders to advance progress towards relevant United Nations Sustainable Development Goals (SDGs), including SDG-3 on health and SDG-17 on partnerships. The private sector is committed to working with the GAP's signatory agencies, other international organizations and member state governments to accelerate progress on these issues through cost-effective, sustainable policies and programs.

EAGL and its members are pleased to offer the following comments on the GAP and specific accelerator documents.

Global Action Plan Outline and Plan Development

EAGL and its members appreciate the GAP's goal of aligning approaches and workstreams across the 12 signatory multilateral organizations and streamlining and strengthening effective collaboration with partners, including the private sector. The plan presents specific areas for further action that create opportunities for multi-sector private sector engagement, including improving the effectiveness of research and development and innovation, improving opportunities in digital health, and strengthening health systems. EAGL and its members appreciate that these documents highlight critical themes such as leveraging innovation and expanding public-private partnerships. Accelerating the pace of private sector innovation, spurred by effective incentives and protections for intellectual property, and embracing an open partnership model in all sectors will both be essential to improving global health.

First, EAGL and its member organizations have concerns about inadequate transparency in developing the GAP and limited consultation with both member states and stakeholders. Given

the GAP's ambitious goals and apparent attempts to introduce new policy recommendations, the secretariat must consult and incorporate input from member states and stakeholders before moving forward.

Second, the draft GAP is not aligned with, and does not adequately reflect, existing consensus outcomes adopted by member states in multiple forums, including the United Nations General Assembly, World Health Organization and other international organizations. EAGL and its members strongly believe that the GAP must align with and incorporate previously negotiated outcomes, such as the 2018 Political Declaration on the UN High-level Meeting on NCDs ("NCD political declaration"), that lay out important building blocks for success in achieving the GAP's goals, including a "whole of government, whole of society" approach to these issues and member state pledges to "engage with the private sector" and other stakeholders for their "meaningful and effective contribution to the implementation of national responses" to these health challenges. The discussion drafts of the GAP and its accelerators, unfortunately, do not fully reflect the inclusive approaches and vision laid out in those consensus documents.

Specifically, across these documents, EAGL and its members respectfully suggest that language in the GAP and all related documents:

- Must align fully with the multi-stakeholder partnership vision of the 2030 Agenda, and fully embrace public-private sector engagement more broadly in the development and implementation of policies and programs to promote healthy lives and well-being; and
- Cannot undermine the GAP's beneficial goal of strengthening collaboration and coherence among relevant multilateral organizations by introducing policy recommendations that do not reflect the latest global political consensus.

Second, the final GAP and discussion papers include new policy recommendations that have not been adequately vetted by member states, who in some cases considered and declined to include these policy recommendations in previous consensus documents. Policymaking is the prerogative of member states, who are ultimately responsible for setting policies appropriate to national conditions. Past GAP processes have adequate opportunity to provide inputs to those recommendations. Past GAP processes have given member states a full opportunity to review substantively any policy recommendations, and this one must do the same. Further member state review should be conducted before any further action is taken to finalize the current draft GAP or its discussion papers.

Third, EAGL offers more detailed comments on Accelerator 4 (determinants of health) below. In general, all accelerator discussion papers should be reviewed and revised as appropriate to ensure improved alignment with the goals above and to best leverage the significant expertise and resources the private sector can contribute to achieving the SDGs. EAGL and its members call particular attention to discussion papers on Accelerator 1 (sustainable financing), Accelerator 2 (primary health care), Accelerator 4 (determinants of health) and Accelerator 5 (R&D, innovation and access) as needing such a review.

Discussion Paper on Accelerator 4 ("Determinants of Health")

EAGL and its members are concerned that this discussion paper sets forth a far too narrow, cautionary approach towards engagement with the private sector, which is inconsistent with past U.N. consensus-based political declarations as well as SDG 17 (multisectoral partnerships). The restrictive approach described in this paper is also inconsistent with previously negotiated member state consensus documents, such as the NCD political declaration and the WHO's own Framework for Engagement with Non-State Actors (FENSA).

Past experience at a variety of international organizations clearly shows that tackling major policy challenges, such as public health, requires collaboration, innovation and open dialogue at both the international and national levels. Such dialogue must operate in a transparent, inclusive and accountable manner with all stakeholders, including the private sector and other nongovernmental actors. Deeper engagement through multisectoral partnerships fosters the development of strong, sustainable and widely supported outcomes that are built on science- and evidence-based approaches, and that ensure a stable of supportive and engaged partners to implement effective programs. Such partnerships have been endorsed by the leadership of key signatory agencies, including World Health Organization Director-General Dr. Tedros Adhanom Ghebreyesus in repeated public statements.

Although the draft includes some reference to public-private partnerships and some industry players supporting positive public health outcomes, overall the discussion paper takes an unjustifiably negative view toward the private sector, with a significant focus on “commercial determinants” as an inherent obstacle to progress on public health. The paper inappropriately calls out “pervasive industry interference,” labels specified industries as “health-harming,” and targets legitimate product marketing activities as reasons why policymakers should limit engagement with the private sector. Even the broader term “commercial determinants of health” is problematic, as there is no clear member state consensus supporting the use of this term and it has been repeatedly and explicitly excluded from past negotiated texts due to its ill-defined, negative connotations towards the private sector. Continued inclusion of such language would likely shut down open and constructive dialogue needed to make progress and would also undermine the ability of member states and international organizations to engage with the private sector as a legitimate stakeholder and partner. Moreover, these views are at odds with both the SDG 17 and positions taken by agency leadership.

Collaboration with industry, as the WHO recently recognized in its support for food industry efforts to eliminate industrial trans-fats, can be an important driver for public health benefits. Failing to include public-private partnerships in all sectors as a key component of a whole-of-society approach is a missed opportunity to promote development of innovations that address public health challenges, and final language for inclusion in the GAP should align with the multi-stakeholder partnership vision of the 2030 Agenda.

In particular, EAGL and its member organizations strongly urge that the language in the final version be substantially revised to align with global consensus views, addressing problematic language above and more clearly affirming that the private sector is an important stakeholder.

Additionally, this discussion paper includes specific policy recommendations that have not been fully vetted by member state representatives across the U.N. system, and reflects language considered and rejected by member states representatives during negotiations for the political declaration following the September 2018 High-Level Meeting on Non-communicable Diseases. The most problematic language that needs to be stricken is the following:

- Language calling for stronger regulatory frameworks to “protect public policy from vested commercial interests,” a vague term that could be construed to exclude industry and economic determinations from public policy discussions; and
- Language explicitly encouraging member states to adopt taxes on specific products deemed to be “health harming,” language that was considered but not supported by member states in negotiations the NCD political declaration;
- Language calling for stronger legal, policy, and regulatory frameworks “for increasing access to affordable medicines, services and health technologies,” which could

inadvertently fuel a focus on policies focused solely on increasing access alone at the expense of other goals, as opposed to policies that work to increase access in coordination with other important policy objectives, such as innovation and intellectual property; and

- Policy terms, suggestions and recommendations that have not been subjected to adequate member state consultation and for which there are no clear definitions, such as “health-centered approaches” relating to environmental impact, energy, and agriculture.

Some of the policy recommendations included under the Accelerator 4 discussion paper, such as taxation approaches, are also reflected in language under Accelerator 1 (sustainable financing), meaning that revisions here should also be reflected in final language for that draft.

Thank you for the opportunity to submit these comments. EAGL and its members look forward to working with you to support the goals shared by the 12 signatory organizations, their international organization counterparts, member states and countless other stakeholders across business, civil society, and communities in promoting health lives and well-being.

SDG3_Secretariat

From: Ann Keeling <ann.keeling@womeningh.org>
Sent: Tuesday, July 2, 2019 8:16 PM
To: SDG3_Secretariat
Cc: Roopa Dhatt
Subject: SDG 3 General Comments from Women in Global Health

Dear SDG3 Secretariat

Below are comments from Women in Global Health on the SDG 3 Global Action Plan.

Global Action Plan for Health Lives and Well-being for All

Feedback from Women in Global Health

General Comments

1. Women in Global Health strongly support the proposed coordinated approach by the 12 agencies based on a Global Action Plan to accelerate progress on SDG3.
2. The 4 GAP principles Assess, Align, Account, Accelerate echo the 5 core Principles of the Paris Agreement on Aid Effectiveness 2005 ie Ownership (countries set their own development strategies), Alignment (Donor countries and organisations bring their support in line with these strategies); Harmonisation (Donor countries and organisations co-ordinate their actions, simplify procedures and share information to avoid duplication); Managing for results (Developing countries and donors focus on producing – and measuring – results); Mutual Accountability (Donors and developing countries are accountable for development results). It is hoped that the GAP will build on learnings from the Paris Agreement. Although the GAP documents stress country ownership it is not one of the four guiding principles and yet will be critical for success.
3. We note that the 12 signatory organisations differ in status with some being UN ie membership organisations driven by and accountable to member states. This will have implications for accountability and decision making.
4. We acknowledge the importance of focusing on SDG 3, understanding how health and well being are driven by other SDGs including gender equality and in turn, how SDG3 is an essential driver for other SDGs.
5. WGH Fully support the commitment to leverage existing collaboration and platforms, aligning with existing country led planning and assessment processes. There are a large number of coordination platforms to build on, including UNDAF assessing priorities at country level; UNOCHA Common Country Assessments of complex emergencies and natural disasters; UN SWOP on Gender; and the Global Health worker Network. - WGH urge signatory organisations to pool resources, play to the strengths of leading organisations, align on policy approaches, methods and tools (for example, on gender mainstreaming) and be accountable for joint results. This streamlining and greater coherence should, in principle, lead to more effective use of resources and stronger impact. Existing platforms have their own plans, commitments, targets and momentum that may be hard to change or shut down. GAP's success will depend on strong collective leadership to address this and avoid adding a new layer of bureaucracy.
6. We support the focus on UHC with PHC at its centre, as a major opportunity for health systems strengthening and equity.

Recommendations

1. WGH recommend separating out Gender Equality from Determinants of Health and making it an Accelerator in its own right, given the critical importance for health outcomes of the gender determinants of health and health related rights, such as Sexual and Reproductive Health and Rights, taking an intersectional approach and building on existing coordinating mechanisms. Gender equality is central to all areas of the GAP's work to accelerate SDG 3 and it therefore merits separate focus as an Accelerator. Addressing gender equality and women's rights would be one of the most effective means of accelerating achievement of SDG3.

2. WGH recommends adding the Health Workforce as an Accelerator. Demographic changes and rising health care demands are projected to drive the creation of 40 million new jobs by 2030 in the global health and social sector. In parallel, there is an estimated shortfall of 18 million health workers, primarily in low- and middle-income countries, required to achieve UHC and the other health targets in SDG3. Since women account for 70% of the health and social care workforce, gaps in health worker supply will not be closed without addressing the gender dynamics of the health and social workforce, including the considerable burden of unpaid care work done by women. Coordination platforms exist, primarily the Global Health Workforce Network, Global Strategy on Human Resources for Health: Workforce 2030, and the WHO/ILO/OECD Working for Health five-year action plan (2017–2021). WHO has also established thematic Hubs (including Gender Equity and Youth Hubs) under the Global Health Workforce Network to bring together stakeholders, strengthen evidence and drive policy guidance on key aspects of the health workforce. Since health systems cannot function without trained health workers, the critical shortage of health workers must be addressed to deliver SDG3. Coordinated approaches and action by the 12 agencies on the health workforce are therefore imperative, preferably joining existing platforms to work on gender transformative change in the health workforce.

3. Although 70% of jobs in global health are held by women, they hold only 25% senior roles. Women are underrepresented in decision making roles from global to community levels, with the result that women's perspectives are not equally represented in the design and delivery of the health systems they run and potential talent and innovations are lost. Diverse decision making teams, by gender and intersectionality, have proven better at addressing complex problems and finding sustainable solutions. **WGH recommend the GAP Vision include gender equity in decision making and representation at all levels from global to community.**

4. WGH support the focus in Accelerator 3 Community and Civil Society Engagement on the role of communities and civil society in realising SDG3 and trust that, despite the disclaimer notice at the top of the paper, the 12 signatory organisations will support the approach in this paper. We endorse the barriers limiting the effectiveness and influence of civil society including 'lack of resources, capacity and support and challenging legal, social and policy environments'. WGH support the four actions proposed, recognising, however, that women's organisations are typically underfunded. A March 2019 OECD report showed that in 2016-7 only 1% gender focused aid went to women's organisations, especially in the Global South. The majority of the funds went to international organisations working in donor countries. **WGH recommend the Accelerator 3 Paper add a specific point on funding women's organisations, especially in the Global South**, in order to strengthen gender equality as the GAP notes is critical.

5. Under Accelerator 3 Community and Civil Society Engagement Action 4 Strengthening/Building a Virtual Platform WGH recommend evaluating the UHC2030 Civil Society Engagement Mechanism (CSEM) with members and reviewing alternative models before adopting CSEM as the GAP Virtual Platform.

Women in Global Health

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General Comments on the Global Action Plan for healthy lives and well-being for all

Strengthening collaboration among multilateral health organizations to accelerate country progress on the health-related Sustainable Development Goals (SDGs)

We welcome the reaffirmation of health as a political and humanitarian priority for all countries.

We reinforce the fact that progress in health is closely linked to the achievement of other SDGs, including poverty eradication, reducing inequality, food security, education, gender equality, climate action and peace, justice and strong institutions.

We recommend the following:

Linking health care and social welfare

The global action plan and the accelerator discussion papers repeatedly emphasize the importance of reaching the most vulnerable and poor, and the importance of social factors for health. In fact, Social workers are employed in both the health care and the social sector. Knowing both systems, social workers offer helpful psycho-social services and effectively connecting people who are affected by poverty. Social work does naturally form a strong bridge between SDG 1 and SDG 3 (and many more). Successful treatment of patients can only be achieved if their social and personal situation is considered (family support, help from the community, state support, financial situation, workplace situation, domestic situation, sanitary conditions, organization and financing of the transport to the next doctor's appointment, etc.) Preventive work can be improved through methods of community work and community capacity building. Stable social conditions decisively increase the success of treatment.

The International Federation of Social Workers is constantly motivating its national professional associations to cooperate with others. IFSW strongly advises states to support and collaborate the national professional social workers associations as they are a particularly important partner for states. National social work associations know national conditions and can support state bodies in analyzing the problems and implementing sustainable aid. We recommend that national representatives of social work are involved in the development of national action plans at both strategic and operational levels.

Health is always closely linked to social issues, hence the Minister of Health and the Minister of Social Affairs should always be involved - from the outset when drawing up the national action plans for healthy lives and well-being for all.

International Federation of Social Workers, 27.06.2019

Bruno Keel

Representative to the United Nations- Geneva

Main area of work Health, WHO

Accelerator Discussion Paper 3: Community and Civil Society Engagement

We are delighted with this paper.

It describes the form of cooperation with civil society and its contribution in an excellent way. So far, unlike other UN Organizations, we have found WHO to be more cautious in its dealings with civil society. This paper fills us with hope and can be a very valuable template for a basic paper for shaping future cooperation between WHO and civil society. This will be extremely helpful in implementing the GAP at national level.

International Federation of Social Workers, 27.06.2019

Bruno Keel

Representative to the United Nations- Geneva

Main area of work Health, WHO

SDG3_Secretariat

From: Jacob Schouenborg <js@isca-web.org>
Sent: Thursday, June 20, 2019 10:16 AM
To: SDG3_Secretariat
Cc: Mogens Kirkeby; Rachel Payne
Subject: (b) general comments to Global Action Plan for Healthy Lives and Well-being

Dear Sir or Madam

On behalf of International Sport and Culture Association ISCA, I am submitting our response to the Global Action Plan for Healthy Lives and Well-being – general comments:

- 1) ISCA welcomes the draft Global Action Plan for Healthy Lives and Well-being. Health and well-being as SDG3 is a key driver for our sector – grassroots sport and physical activity – to provide value to citizens globally.
- 2) ISCA is particularly supportive of the strong focus on involvement of and support to civil society and communities, as described in accelerator 3. As the biggest civil society movement in the world in terms of citizens' involvement, grassroots sport and physical activity have an important contribution to make
- 3) Civil-society based grassroots sport and physical activity are a key component in advancing regular health-enhancing physical activity on a local level, at a low cost, and adapted to local needs and the needs of specific, and hard-to-reach groups, thus both advancing health promotion/prevention and tackling of a range of non-communicable diseases.
- 4) ISCA recommends to enhance the focus on the action plan on how civil society organisations not only advance advocacy and accountability in promoting health and well-being for all, but also independently deliver positive health outcomes on a daily basis, such as health-enhancing physical activity
- 5) ISCA welcomes further engagement and dialogue and remain at disposal for any further input to the important development of the action plan

Yours sincerely

Jacob

Jacob SCHOUENBORG
Secretary General

Mobile: +45 28588444
Email: js@isca-web.org



INTERNATIONAL SPORT AND CULTURE ASSOCIATION

Vester Voldgade 100, 2
DK-1552 Copenhagen V - Denmark

Dear Madam, Dear Sir,

On behalf of the Global Health Technologies Coalition, a coalition of more than 25 nonprofit organizations, academic institutions, and aligned businesses advancing policies to accelerate the creation of new drugs, vaccines, diagnostics, we would like to compliment the World Health Organization (WHO) and the other signatory agencies on the commitment to develop the Global Action Plan for Healthy Lives and Well-being for All, and align their efforts to more effectively support countries to achieve the health-related targets of the Sustainable Development Goals (SDGs).

We have the pleasure to submit the following comments to the draft chapter 5 (Research and development, innovation and access) of the Global Action Plan:

- We endorse the vision of the paper that it is of paramount importance to ensure that access considerations are included in all stages of the Research and Development (R&D) pathway, right from the target product profile onwards. We support the application and further development of good access practices across the R&D pathway. The needs of affected people particularly the most vulnerable, must remain at the heart of research and innovation decision making and priorities, and engagement of national health authorities is crucial.
- We would like to see emphasized in this paper the need to ensure a sustainable pipeline of new and adapted health technologies, in addition to the acceleration of those in late stage production, in order to meet continuing and evolving health needs. We would also like to see acknowledged in this paper that the development of innovative health technologies is a complex process requiring a global, longer-term plan, highly technical expertise, flexible management of risky portfolios and funding sustainability.
- When looking at the key bottlenecks hindering access, it is also important to include reference and follow-up action to smooth the policy pathways for guidelines and prequalification, to make the process more predictable, structured and time-bound, also with the support of independent experts, so as to ensure the earliest possible access to innovative health technologies whilst ensuring patient safety. Such policy pathways are important not only in endemic countries but also in the international governance and funding mechanisms themselves.
- The draft paper recommends the establishment of an annual global forum to coordinate and accelerate the late stage pipeline of critical medical and health products. We underline the need for civil society and other partners to be engaged in this forum, and have the ability to provide feedback to WHO, other multilateral institutions, and countries on the process and programs that relate to global health R&D. Furthermore, the forum should include a focus on financing mechanisms, including innovative financing models, public private partnerships and public resource mobilization for global health product development, particularly for products which lack a commercial market.



General comments on Global Action Plan for Healthy Lives and Well-Being for All – Draft Outline

White Ribbon Alliance (WRA) is a locally led, globally connected network whose mission is to activate a people-led movement for reproductive, maternal, and newborn health and rights. We are comprised of diverse individual and organizational members in the tens of thousands with chapters in 14 countries.

It is widely documented that women and girls in low- and middle-income countries are acutely affected by poor health and human rights violations. Women and girls often lack access to the most basic health care services; face stigma, discrimination, and violence; and suffer from high rates of maternal mortality and morbidity, HIV and sexually transmitted infections, and noncommunicable diseases, to name a few.

One of the largest opportunities for Global Action Plan is to place women's and girls' demands for their own health and well-being at the forefront of the signatory agencies' funding, policy, and programming priorities for SDG3. This means proactively reaching out and listening to women and girls, especially those at the margins of society, such as those who are poor, disabled, of racial or ethnic minority, and/or of refugee status.

As a starting point, WRA urges the signatory agencies to review and act on the [findings](#) of our year-long [What Women Want](#) campaign. *What Women Want* asked women and girls a powerful, open-ended question: "What is your one request for quality reproductive and maternal healthcare services?" We collected nearly 1.2 million demands across 114 countries. The top five responses are 1) respectful and dignified care; 2) water, sanitation, and hygiene; 3) medicines and supplies; 4) increased, competent, and better supported midwives and nurses; and 5) increased, fully functional, and closer health facilities. Later this year, WRA will release detailed findings for the eight countries with the most surveys collected (India, Kenya, Malawi, Mexico, Nigeria, Pakistan, Tanzania, and Uganda) which will inform the development of country-specific, targeted roadmaps for action—to which signatory agencies in each country should contribute and leverage.

Given the historic nature of this demand-based campaign and its findings, WRA further recommends the signatory agencies take the following actions:

- Ensure that each agency not only has a robust mechanism in place for engaging individual women and girls in health system decision-making but is also held accountable for incorporating women's voices in investment decisions and policy and program guidance.
- Elevate respectful and dignified care, including improved interpersonal dynamics between providers and patients, across the signatory agencies' priorities. As *What Women Want* demonstrates, more than any singular health service, women and girls want to be treated respectfully and politely when they seek care, they want to be listened to, and they want to feel there is shared trust with their providers.
- Maintain the strong focus on collaborating across sectors, integrating services across the health spectrum and the life-course, and addressing the structural determinants of health—all critical for ending preventable maternal mortality and promoting women's health and well-being.

Comments on behalf of the White Ribbon Alliance are submitted by Kimberly Whipkey, Advocacy Manager, kwhipkey@whiteribbonalliance.org.



Comments on the Accelerator Discussion Paper 3: Community and Civil Society Engagement

White Ribbon Alliance (WRA) is a locally led, globally connected network whose mission is to activate a people-led movement for reproductive, maternal, and newborn health and rights. We are comprised of diverse individual and organizational members in the tens of thousands with chapters in 14 countries.

WRA commends the signatory agencies for recognizing community and civil society engagement as a critical accelerator for SDG3. We agree that when women, families, and communities have a direct say in the health policies and programs that affect their lives, resulting solutions are more effective and sustainable. Additionally, WRA offers the following feedback on how to further strengthen the joint actions proposed by the signatory agencies.

- Prioritize the engagement of citizens and grassroots people, especially women and girls in all their diversity, in signatory agencies' community and civil society engagement mechanisms. Too often civil society participation is made of 'elite' health and development professionals largely based in urban areas. To really accelerate progress on health goals, signatory agencies must deliberately make space at the table for local community members, including the most marginalized and vulnerable who have been traditionally excluded from civic participation.
- Ensure a true 'feedback loop' in signatory agencies' engagement processes with communities and civil society. While establishing such processes and holding regular dialogue as noted in the joint actions is vital, it is not enough. Signatory agencies must be willing to actively listen to the needs and priorities of people and respond accordingly. A metric for the incorporation of people's perspectives into the signatory agencies' engagement mechanisms and action plans should be developed.
- Signatory agencies should incorporate support for organizational strengthening into their efforts to enhance community and civil society funding and capacity building. While it is true that civil society organizations (CSOs) and community-based organizations (CBOs)—including WRA National Alliances—express a desire for capacity strengthening on advocacy, accountability, and budget tracking, a singular focus on activities obscures the very real challenges CSOs/CBOs face with respect to sustaining their organizations. In the mapping of their own funding mechanisms and modalities, signatory agencies should note where the gaps and opportunities are regarding support for longer term organizational strengthening, including but not limited to fundraising capacity, financial management, leadership, and human resources.

Finally, WRA is leading several initiatives that contribute to health-related SDG targets and accelerator actions related to community and civil society engagement. We would be pleased to share findings and lessons learned, as well as collaborate with signatory agencies globally and in-country, to drive change.

- [What Women Want](#) campaign: WRA's year-long campaign asked women and girls a powerful, open-ended question: "What is your one request for quality reproductive and maternal healthcare services?" We collected nearly [1.2 million demands](#) across 114 countries, with respectful and dignified care coming in as the top request. We are now collaborating with local partners in the eight countries with the greatest number of responses to analyze their country data and create advocacy roadmaps. We are also exploring the digitization of *What Women*



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Want information collection to facilitate government adoption of this mechanism for community feedback.

- *UHC for Me:* This fall, WRA anticipates the launch of a new program in Kenya and Uganda focused exclusively on marginalized and vulnerable populations (including women and girls, refugees, and people living with disabilities in poor counties/districts) and supporting them to voice their interests and engage in UHC policy, program, and accountability processes. Our program will address two learning questions of great relevance to the accelerator actions:
 - How effective are traditional social accountability approaches in overcoming barriers to civic participation for marginalized populations?
 - How can established CSOs better reflect, represent, and partner with those at the margins?

Comments on behalf of the White Ribbon Alliance are submitted by Kimberly Whipkey, Advocacy Manager, kwhipkey@whiteribbonalliance.org.

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SDG3_Secretariat

From: Karlee Silver <karlee.silver@grandchallenges.ca>
Sent: 30 June 2019 19:17
To: SDG3_Secretariat
Cc: Jocelyn Mackie
Subject: Comments on Accelerator Discussion Paper 5: R&D, Innovation and Access

Many thanks for the opportunity to comment on the working paper regarding R&D, innovation and access. Due to the timeline of the comment period, this is brief by design. I am more than willing to facilitate discussions between the authors and IDIA and/or Grand Challenges Network as we are spending a great deal of discussion time to solve this same scaling challenge and would welcome the opportunity to collaborate with the accelerator on this point.

To provide context for these comments: Grand Challenges Canada is dedicated to supporting Bold Ideas with Big Impact®. Funded by the Government of Canada and other partners, Grand Challenges Canada funds innovators in low- and middle-income countries and Canada. The bold ideas Grand Challenges Canada supports integrate science and technology, social and business innovation – known as Integrated Innovation®. Grand Challenges Canada has supported a pipeline of over 1,000 innovations in 95 countries. Grand Challenges Canada estimates that these innovations have the potential to save up to 1.6 million lives and improve up to 35 million lives by 2030.

We applaud the vision of focusing on better scaling of evidence-based innovations that have already been identified at small-scale and that can accelerate and improve the global health response. The development innovation ecosystem is now matured to stage where there are considerable number of innovations that are well aligned with country priorities; have been selected for support through multiple sequential innovation competitions whose selection processes include world experts and voices from the country where the innovation is currently located; have evidence of positive health impacts that has been validated at both small and larger scales; and have evidence of the approach to scale and sustainability that improves value for money for public systems. **Currently, the link between the mainstream actors who are currently focused on universal health coverage and the most promising of the approaches that have developed through the development innovation ecosystem is too weak to be effective.** Any tangible, action-oriented and urgent ways to strengthen this link would accelerate progress at country level for SDGs.

We would urge that in the formation of such an accelerator the following elements are considered:

- Regarding the idea to develop a set of Good Access Practices: There are a set of actors who have already generated consensus on principles to inform the practice of innovation, e.g., IDIA's Insights Papers on [Scaling Innovation](#) and [Good Practices for Scaling Innovation](#); and G7 Development Ministers' endorsed [The Whistler Principles to Accelerate Innovation for Development Innovation](#). These include the focus on prioritizing innovations being developed where the challenges they are designed to tackle are most acute.
- Regarding the idea to develop WHO-curated lists of existing evidence-based innovations to facilitate country-led decision-making: It is a logical first step. The danger of this approach is that it will very quickly become a bottleneck hindering progress. The traditional approach to norm setting that the WHO has employed for prequalification of drugs and vaccines are not appropriate to use for the broader set of tested innovations. It would be more helpful for the accelerator to focus on demonstrating its value in accelerating scaling innovations by national authorities rather than focusing on norms setting at this early stage. The most promising innovations, which are the ones set to transform how countries address specific health challenges, could not have been predicted. Therefore, the product profiles are not possible to have defined in advance. It may be more helpful to have a minimum set of criteria that seeks to be inclusive rather than exclusive in order to increase awareness of promising innovations while limiting poor evidence base. Some attempts at this approach are underway with the [Every Woman Every Child Innovation Marketplace](#), and the [Million Lives Club](#).
- Regarding global forum to coordinate and accelerate late stage pipeline of critical medical and health products: This would draw on a key strength of the WHO, i.e., its convening power, in a very appropriate way. I would recommend that devices are also included in this because it is a different pathway vis a vis regulatory and procurement pathways but is another area where key advances in value for money for critical devices and the training that is necessary alongside the devices have been brought about through innovation. Again, the global forum could be a huge value add if it is focused most on highlighting key needs from countries, promising

innovations (actual examples rather than in the abstract), and progress on the forum actually resulting in increased scale.

- Regarding shifting the centre of gravity of decision making to countries and regions: Mechanisms that would facilitate securing commitments to scale from national authorities and partners if a study achieves a pre-defined outcome would be extremely powerful to drive further investment in transitioning to scale innovations from donor governments, funders and foundations. We have been successful in funding the transition to scale of innovations in a manner that crowds in municipal, county/state/provincial, and sub-national commitments, however not as systematically as we would have hoped. The key elements required are
 - (a) Mechanisms that bridge the gap between intention to support and the reality of how long it can take to convert intention into budget line items. The new approach of [Laerdal and Norad with the Global Financing Facility](#) is an interesting experiment to inform this, as it the work of UNITAID to tap into multilateral financing facilities that concentrate procurement decision making.
 - (b) Mechanisms to raise the profile of promising innovations (especially those developed within the country of interest) that are ready for mainstreaming in public systems to the appropriate national decision makers.
 - (c) Mechanisms to support the national decision makers to make informed decisions about the innovations.

We appreciate the level at which the WHO's draft list of evidence-based innovations for scaling that require collective action (i.e., it is target based rather than too prescriptive about how it needs to come about). Grand Challenges Canada will be very interested in doing our part of the collective action to accelerate impact of promising innovations that we have helped to seed and transition to scale. We were surprised to not see the following within the list:

- SDG 3.2 - Appropriate management of diarrhea and pneumonia (acknowledging related to both diagnostics and treatment).
- SDG 3.2 – Approaches to manage preterm births that complement KMC.
- SDG 3.4 – Expanding cost-effective, community-based approaches to managing severe mental illness.
- SDG 3.7 – Expanding access to sexual and reproductive health-care services (as a critical foundation for gender equality).
- SDG 3.8 - Tested models (that draw on digital / AI technologies) to extend human resources to best address the health care needs of the hardest to reach populations, including in humanitarian contexts.

Finally, when providing compendia of health devices, equipment, assistive products and other technologies, it will be very critical for this to be updated at least annually (i.e., requires resources to be done quickly) in order to remain relevant. Innovation moves very quickly – and there are companies who are currently investing private resources into R&D and innovation, and have developed products that speak to critical challenges national authorities have prioritized that are not on the list and who are questioning their ability to stay in this field if the system remains a series of bottlenecks. Currently, the 2016/17 device compendium is out of date.

I hope this is the first of several interactions on this topic.

Best regards,
Karlee

Karlee Silver, DPhil
Co-Chief Executive Officer

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BOLD IDEAS WITH BIG IMPACT

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Global Action Plan for Healthy Lives and Well-Being for All

Submitted by Anthony D. So, MD, MPA, Prateek Sharma, MSc and Joshua Woo on behalf of the IDEA (Innovation+Design Enabling Access) Initiative and ReAct—Action on Antibiotic Resistance, Johns Hopkins Bloomberg School of Public Health

The Global Action Plan seeks to align how 12 leading health, development and humanitarian agencies will work together, adopt new approaches, and support country national plans to achieve SDG3. The draft acknowledges the need to tackle “growing threats and challenges” including antimicrobial resistance. A litmus test of success would be the successful application of a set of these approaches to a challenge like antimicrobial resistance (AMR) in a way that advances SDG3. A special case for attention to AMR might be made because 1) the current SDG indicators fail to measure directly progress on AMR; 2) its intersectoral nature will demand new ways of working together; and 3) AMR poses a serious threat to achieving SDG milestones, particularly for SDG3. Three million newborns are afflicted with sepsis each year, and [three out of every ten deaths from neonatal sepsis](#) results from drug-resistant pathogens. Multi-drug resistant TB claims [240,000 lives each year](#), and [treating these cases can be 312 times more expensive than first-line TB treatment](#). Effective antibiotics are also key to the treatment of non-communicable diseases, e.g., treating drug-resistant infections that occur after cancer chemotherapy, with diabetic foot ulcers, or from surgical site infections after coronary artery bypass grafts.

The Global Action Plan will complement “existing agency-specific strategies” and leverage the capacity of the UN system and contributions from multisectoral partners. To harness the collective power of the signatory agencies, we hope that the Global Action Plan might consider:

1. *Pathways for alternative production:* To overcome drug shortages and failures to supply needed antibiotics, the lessons of product development partnerships for neglected diseases, government-owned production, and even private sector efforts to establish non-profit production (e.g., [CivicaRx](#)) provide evidence of the feasibility of an alternative pathway for bringing new health technologies to market. The first generic drugs identified by CivicaRx for non-profit production were two antibiotics, [daptomycin and vancomycin](#). Such alternative pathways also provide a benchmark for what are fair returns on public investment in such R&D.
2. *Pooled procurement:* As the [UN IACG report on AMR](#) notes, “Leveraging and learning lessons from existing pooled procurement mechanisms in human health...could help secure both the supply of quality-assured medicines, ensure predictability of demand for manufacturers and promote sustainable procurement practices” (page 11). The leading agencies involved in this Global Action Plan could support such public sector efforts, building on the experiences of groups like UNICEF, UNDP and the Global Drug Facility.
3. *Innovative financing:* Improving the targeting of existing resources and mobilizing new resources are key to achieving SDG3. To address AMR, a strong case can be made to pay now rather than pay much more later. By investing today in more effective infection control and prevention, we can avert future treatment costs for drug-resistant infections. Taking such measures requires new financial instruments that mobilize up front public and private sector funding (e.g., social impact bonds). Participating agencies can formulate the business plan for such innovative financing or provide seed funding to pilot such approaches.
4. *Communications for behavior change and collective action.* Mobilizing the front-line workers in healthcare delivery is also critical. This will require moving into campaign mode and adopting multi-modal approaches that draw upon behavioral economics and related disciplines. Examples of such efforts can be found for AMR in the [UN IACG’s discussion paper on communications and collective action](#).
5. *Monitoring for accountability.* In taking stock of “Actions to improve global alignment” (section 4.3) and “Tracking joint action” (section 5.2), standardized data collection and measures are vital for holding agencies accountable. These should be publicly transparent, so that civil society can also help ensure Member State and policymaker support for these goals.

None of these approaches would require creation of new platforms but rather builds on existing ones to forge an end-to-end approach, whereby innovation advances the twin goals of affordable access and effective stewardship under SDG3.

Accelerator Discussion Paper 5: Research and Development, Innovation and Access

Submitted by Anthony D. So, MD, MPA, Prateek Sharma, MSc and Joshua Woo behalf of the IDEA (Innovation+Design Enabling Access) Initiative and ReAct—Action on Antibiotic Resistance, Johns Hopkins Bloomberg School of Public Health

This discussion paper highlights the value and need for coordination among stakeholders engaged in global research and innovation for health. From the case studies, a common lesson from the process of scaling was the “effectiveness of end-to-end programmes that develop or adapt innovation to suit the context and take on implementation and access considerations in early stages of R&D and use this knowledge to carry out the implementation with appropriate partners.” The four goals seek to remedy this lack of coordination, but also could be more purposefully directed. With each goal, there are means well within the ambit of the leading agencies signatory to this Global Action Plan that might be more effectively applied. In particular, “growing threats and challenges” such as antimicrobial resistance (AMR) may focus these four goals in a way that advances SDG3.

Goal 1—Access should be built into the R&D pathway. This section describes challenges that “limit the early adoption and scale-up of innovations,” but is silent on the barriers to the innovation process itself that these agencies as facilitators and funders of procurement of these innovations might encourage. For example, support of the [public transparency of clinical trial results](#), [diagnostics interoperability standards](#), and [open access publication](#) give foundation to an effective innovation ecosystem. The need for “promoting openness and transparency in data from all research, monitoring and surveillance sources, including overcoming data protection provisions that restrict such data sharing” was also highlighted in the [UN IACG Report on AMR’s Recommendation B3 \(page 16\)](#). A foundation of open science and R&D transparency will serve as an accelerator to innovation.

Goal 2—Better coordination and alignment of research priorities with the health-related SDG targets. Direct measure of AMR is a glaring omission among the indicators of health-related SDG targets. Yet a key message in the [UN IACG report on AMR](#) was “Antimicrobial resistance is a global crisis that threatens a century of progress in health and achievement of the Sustainable Development Goals.” Either the health-related SDG targets need to take better account of AMR, or the better coordination and alignment of research priorities among these agencies must do so.

Goal 3—National voices should be heard. Access to the building blocks of knowledge is the cornerstone to ensuring innovation is not just for disease-endemic populations, but also [by these populations](#). Creating the enabling environment for LMIC participation in the innovation ecosystem, co-production of research results, and co-ownership of the resulting products that address their local disease burden could be the focus of new funding approaches. Imagine if we could scale a platform like the [iChip](#), enlist all countries in the search for promising novel antibiotics, and crowdsource such solutions.

Goal 4—A more optimized innovation system. An effective pharmaceutical R&D value chain depends on the flows of information, finances and product from bench to bedside. We agree that the “lack of information for domestic and international funders on what works” is important, but that is more a symptom than solution. What is the dynamic process needed to identify **continuously** opportunities to support innovation scale-up? Where is the support for systems-level thinking and the design process for ensuring that such innovation leads optimally to access, and in the case of AMR, to effective stewardship? And where are the measures for monitoring collective accountability to these goals by the lead agencies? How might such monitoring data be placed transparently into the hands of civil society for critical and independent accountability? Examples of such monitoring for accountability for AMR are given in the UN IACG discussion paper, [“Meeting the Challenge of Antimicrobial Resistance: From Communication to Collective Action” \(Component 5: Monitoring for Accountability, page 27\)](#).

The Global Action Plan itself should describe how the coordinated deployment of these approaches might be meaningfully applied to challenges, like antimicrobial resistance, to advance SDG3.

From: Queenan, Kevin <kqueenan3@rvc.ac.uk>
Sent: Tuesday, July 2, 2019 11:47 PM
To: SDG3_Secretariat
Cc: Haesler, Barbara; Kock, Richard
Subject: General comments: Global Action Plan for healthy lives and well-being

The Global Action Plan presents an opportunity to move towards a broader, systems approach to ensuring health and well-being for all. Several links have been recognised between the 17 Sustainable Development Goals and the Global Action Plan goes some way in identifying links between human health and specific SDGs as outlined in Section 1.2. However, it fails to recognise the key links between human health and the health of the terrestrial and marine ecosystems, and the life forms within them. Arguably, SDG 3 cannot be achieved without promoting the health of the animals, plants and ecosystems upon which our existence depends. Current trends of deteriorating biodiversity and ecosystems services, often as a consequence of human development, threaten to undermine and even reverse the gains made in human health over the last century. In recognition of this, the One Health and EcoHealth movements have, over the past decade, advocated for a wider-lens approach to finding health solutions. This approach has also gained support through the UN's tripartite agreement between the WHO, FAO and OIE. A One Health, broad systems approach to health, to include health of humans, animals, ecosystems and the planet will benefit the Global Action Plan's operational approach by:

- ensuring a broader assessment of all elements of the systems affecting health
- creating better alignment and encouraging sharing of responsibilities across multiple agencies involved in the subsystems of One Health
- accelerating progress through breaking down silos and inter-institutional barriers
- seeking long term solutions, which consider wider implications and avoid unintended consequences and vicious cycles, and which result in greater accountability

In light of this, there is a gap in the list of agencies involved in the Global Action Plan and invitations should be considered to include FAO, OIE and UNEP as well as other One Health stakeholders and practitioners; bringing elements of health from animal, plant and ecosystem health. In conclusion, we recommend that a One Health approach is used to become an accelerator for the achievement of the Global Action Plan.

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Dr Barbara Häslér bhaesler@rvc.ac.uk
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SUN Movement input on the Global Action Plan for Healthy Lives and Well-being

General comments:

- The Scaling Up Nutrition (SUN) Movement welcomes the Global Action Plan for Healthy Lives and Well-being for All (GAP) as a critical opportunity for accelerated, coordinated action to achieve all the health-related Sustainable Development Goals (SDGs), by building on what exists at country level, reducing duplication and committing to deliver and be accountable for joint results.
- The purpose of GAP is to accelerate progress on all health-related SDGs, yet throughout the plan and in the accelerator discussion papers, focus is almost exclusively on SDG 3. When other SDGs are mentioned, we note that SDG 2 is frequently left out, although SDG 2 - in particular targets 2.1 to end hunger and ensure access by all people to safe, nutritious and sufficient food; and target 2.2 to end all forms of malnutrition - are fundamental to achieve good health for all. We propose to consistently refer to the health-related SDGs throughout the GAP and to ensure SDG2 is included.
- While we welcome the inclusion of several important milestones relating to nutrition, we encourage a stronger focus on how to achieve these, by making nutrition an explicit joint priority across the operational approach: assess, align, accelerate and account, and the detailed joint actions.
- Malnutrition is the single largest risk factor for ill-health and death globally, contributing to around 45% of preventable deaths of children under 5 years and the increasing burden of noncommunicable diseases (NCDs). Chronic malnutrition during the first 1,000 days makes children vulnerable to infections and illness, and irreversibly impacts their physical and cognitive development. Stunting is one of the GAP milestones that is furthest off-track; where scaled up, coordinated action is most needed to make progress.
- In implementing the GAP, it is critical to build on existing platforms for multi-stakeholder coordination and implementation. [The SUN Movement](#) brings together multiple sectors and stakeholders for the common goal of ending malnutrition in all its forms in 61 member countries and 4 Indian States, supported by over 3,000 civil society organisations, some 500 businesses, UN agencies and a group of international donors and foundations who are part of the SUN Networks. There are now active Multi-Stakeholder Platforms in 55 SUN countries that bring together different sectors of government with other stakeholders for coordinated action on nutrition. 42 SUN countries have national multi-sectoral nutrition plans, bringing together different stakeholders around a common plan for action and results.
- Several of the signatory agencies are members of the SUN Movement, and most are actively collaborating through the SUN Movement Multi-Stakeholder Platforms at country level. We recommend to explicitly highlight the SUN Movement in *Section 2.5: Leveraging existing collaborations and platforms*, and in several of the accelerators, including 2, 3, 4 and 7. We also recommend GAP partners to build on and leverage existing SUN Multi-Stakeholder Platforms when implementing the plan.

Comments on accelerator discussion papers 2, 3, 4 and 7

Primary Health Care

- Given the scale of the global burden of malnutrition, and its impact on health, it is critical to include essential nutrition actions in the basic package of interventions delivered through the Primary Health Care (PHC) system to everyone, especially the most vulnerable. These nutrition actions are among the low-cost, high-impact interventions that must be prioritised in implementing Universal Health Coverage, especially in low and middle-income countries.
- We recommend a stronger focus on nutrition, ensuring meaningful integration of nutrition across all the main building blocks of the health system (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance.
- In implementing this accelerator, there are opportunities to leverage existing SUN Movement Multi-Stakeholder Platforms at country level, ensure UHC roadmaps and other policies and plans relating to PHC are integrated with national multi-sectoral nutrition plans, and leverage the SUN Movement Joint Annual Assessments to inform planning, and as a forum for building momentum for action.

Community and civil society engagement

- There are opportunities to leverage existing SUN Multi-Stakeholder Platforms and SUN Networks for community and civil society engagement. There are active SUN Movement Civil Society Alliances in 40 SUN countries, bringing together over 3,000 international, national and community-based non-governmental organisations for joint action.
- [The SUN Movement Pooled Fund](#) can provide a model of how funding can be pooled from different donors, enabling joint civil society action for greater impact. In 2018, 2 funding cycles were launched, focused on strengthened participation of in-country non-state actors in Multi-Stakeholder Platforms to implement scaled up nutrition plans. In the 1st cycle, 21 projects were funded and continue to be implemented by national SUN Civil Society Alliances.

Determinants of Health

- Given the wide mandates and reach of the GAP partners, we encourage more ambitious action on the determinants of health, at least in the medium to longer term.
- We recommend to consistently refer to the health-related SDGs, and explicitly include SDG 2.
- Given the importance of sufficient food and good nutrition as determinants of health, and the fact that one in three people globally suffer from one or several forms of malnutrition, we recommend focusing on nutrition and nutrition-sensitive food systems in this accelerator. Good nutrition, and the availability, access and utilisation of nutritious, sustainably produced food, are critical to make progress on the identified environmental, commercial and structural determinants of health.
- Food systems have an impact on, and are impacted by, natural resources and ecosystems. Climate change and environmental degradation increasingly challenge the possibilities to not just feed but also nourish a growing world population – within planetary boundaries. Global food production is a major emitter of greenhouse gases, and constitutes the single largest driver of environmental degradation and transgression of planetary boundaries.
- Transforming food systems requires coordinated efforts by multiple stakeholders, across sectors. This must go beyond increasing agricultural production towards building demand for nutritious and

sustainably produced food, making food affordable and accessible for all, and creating the right regulatory environment for sustainable production, transporting and disposal of healthy food.

- Addressing environmental and commercial determinants of health will require ensuring that businesses adhere to standards and regulations for safe and nutritious food that is produced in a sustainable way, while minimising waste. Businesses must also be part of finding effective solutions for transforming food systems, including by changing core business models and products. The SUN Movement works with businesses at global and national level, ensuring that they are part of the solution to end malnutrition. Businesses are active in SUN Multi-Stakeholder Platforms across 28 Countries.
- Furthermore, since malnutrition is a key driver of intergenerational poverty and exclusion, investing in good nutrition will help make progress on structural determinants of health. Well-nourished children are given the best conditions to develop to their full physical and cognitive potential in order to learn and do well in school, and to have well-nourished children themselves later in life . Improving children's nutrition boosts productivity and contributes to lift individuals, families and nations out of poverty.

Innovative programming in fragile and vulnerable states and for disease outbreak responses

- We recommend a stronger focus on hunger and malnutrition in this accelerator. After steadily declining for over a decade, global hunger is on the rise. 821 million, or 1 in 9, were undernourished in 2017. The situation is worsening in sub-Saharan Africa and South America, in particular, with women and girls being most affected.
- Conflict, fragility and climate-related shocks increasingly undermine food security and good nutrition. The proportion of undernourished people who live in countries in conflict and protracted crises is almost 3 times higher than that in other low and middle-income countries.
- Hunger is both a cause and a consequence of conflict. Insurgents are frequently using hunger among civilians as a weapon, causing massive displacements and preventing humanitarian access. Hunger exacerbates crisis, creating ever greater instability and insecurity. In the worst-case scenario, conflicts can lead to famines. Exposure to complex, frequent and intense climate extremes is a key contributor to hunger, threatening to erode and reverse nutrition gains made in recent years.
- A world without hunger and malnutrition by 2030 will not be possible without urgent action to improve food security and nutrition in fragile and conflict-affected contexts. Humanitarian funding and long-term resilience-building must be scaled up. Innovative partnerships are needed to address the multiple forms of malnutrition, support climate adaptation and peacebuilding. Nutrition must be prioritised in humanitarian responses – with a greater focus on preventing stunting.

Dear Madam, Dear Sir,

We, the Chief Executive Officers and Executive Directors of Drugs for Neglected Diseases *initiative* - DNDi, the Foundation for Innovative New Diagnostics - FIND, the Global Antibiotic Research and Development Partnership – GARDP, the International AIDS Vaccine Initiative - IAVI, the Innovative Vector Control Consortium – IVCC, Medicines for Malaria Venture - MMV, PATH, TB Alliance, the TuBerculosis Vaccine Initiative – TBVI, would like to compliment the World Health Organization and the other signatory agencies on the commitment to develop the Global Action Plan for Healthy Lives and Well-being for All, and align their efforts to more effectively support countries to achieve the health-related targets of the Sustainable Development Goals (SDGs).

We have the pleasure to submit the following comments to the draft chapter 5 (Research and development, innovation and access) of the Global Action Plan:

- We fully endorse the vision of the paper that it is of paramount importance to ensure that access considerations are included in all stages of the Research and Development (R&D) pathway, right from the target product profile onwards. We support the application and further development of good access practices across the R&D pathway. The needs of affected people, particularly the most vulnerable, must remain at the heart of research and innovation decision making and priorities, and engagement of national health authorities is crucial.
- We would like to see emphasized in this paper the need to ensure a sustainable pipeline of new and adapted health technologies, in addition to the acceleration of those in late stage production, in order to meet continuing and evolving health needs, including mitigating the risk of emerging or potential resistance, which, if not pre-emptively addressed, has the potential to undermine current disease control and elimination efforts. We would also like to see acknowledged in this paper that the development of innovative health technologies is a complex process requiring a global, longer-term plan, highly technical expertise, flexible management of risky portfolios and funding sustainability.
- We would like to see mention of the role of not-for-profit innovators, such as product-development partnerships (PDPs), in the context of the Global Action Plan. PDPs and other not-for-profit innovators act as a bridge, promoting collaborations between governments, academia, industry and non-governmental organizations in disease-affected and partner countries, and play a major role in the acceleration of R&D impact for the SDG3. By pooling together funding and high technical expertise, this approach is crucial in de-risking the R&D environment, encouraging engagement from a variety of stakeholders, aligning and integrating their efforts and reducing redundancy, with the ultimate goal of delivering much required, innovative health technologies to the people in need.
- We would like to see reference to existing good practices in alignment and coordination. Our organizations support the goal of the Global Action Plan to strengthen coordination with a view to increasing access to innovation. In this context, it should be recognized that several, if not all, PDPs and other not-for-profit innovators currently develop their plans, including on access, in alignment and as a response to the needs identified in the WHO global strategies – and that WHO is on several of their governance bodies. Similarly, representatives from affected countries are included on the Boards of these organizations and on scientific and product access advisory committees. Acknowledging and strengthening this healthy practice in the relation between WHO's normative work and the broader R&D processes will greatly help ensure alignment and coordination while recognizing the role of the unique expertise, experience and partnership model that the various R&D partners, including PDPs, bring in.
- We commit to working with technical and funding agencies to improve policy pathways as part of the bottlenecks to be addressed by the Global Action Plan to accelerate impact. The Global Action Plan comments correctly that access should be built into the R&D pathway. When looking at the key bottlenecks hindering access, it is also important to include reference and follow-up action to smooth the

policy pathways for guidelines and prequalification, to make the process more predictable, structured and time-bound, also with the support of independent experts, so as to ensure the earliest possible access to innovative health technologies whilst ensuring patient safety. Such policy pathways are important not only in endemic countries but also in the international governance and funding mechanisms themselves.

- The draft paper recommends the establishment of an annual global forum to coordinate and accelerate the late stage pipeline of critical medical and health products. Indeed, this is very important. PDPs are convening a workshop in July 2019, together with the Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO, to better understand and help address this issue and bottlenecks in access. We commit to support a review of this pilot to see if this can evolve into the proposed annual global forum, involving these stakeholders, as well as other partners from countries, industry and civil society.

Yours faithfully,

Dr Manica Balasegaram, Executive Director, Global Antibiotic Research and Development Partnership – GARDP

Dr Catharina Boehme, Chief Executive Officer, Foundation for Innovative New Diagnostics – FIND

Dr Steve Davis, President and Chief Executive Officer, PATH

Dr Nick Drager, Executive Director, TuBerculosis Vaccine Initiative – TBVI

Dr Mark Feinberg, President and CEO, International AIDS Vaccine Initiative - IAVI

Dr Nick Hamon, Chief Executive Officer, Innovative Vector Control Consortium - IVCC

Dr Bernard Pécoûl, Executive Director, Drugs for Neglected Diseases initiative – DNDi

Dr David Reddy, Chief Executive Officer, Medicines for Malaria Venture – MMV

Dr Melvin Spigelman, President and Chief Executive Officer, TB Alliance

Berlin, 30.06.2019

To whom it may concern,

the Global Health Research Team at the German Institute for International and Security Affairs (Stiftung Wissenschaft und Politik / SWP) commends WHO for its work on the SDG 3 Global Action Plan for Healthy Lives and Well-Being for All (SDG 3 GAP). The opportunity to comment on the existing documents is highly appreciated. We would firstly, like to share some general remarks on the plan and secondly, offer our feedback along the "quadruple a-approach", which the plan proposes.

General remarks

Global health governance lacks coordination and accepted leadership, is fragmented and still largely reflects the Millennium Development Goals. ^{i,ii} To build an SDG 3 global health architecture, a disruptive governance shift is overdue. ⁱⁱⁱ We fear the plan might perpetuate existing challenges and miss transforming global health governance towards achieving SDG 3. Given the current global political environment, the likelihood of major governance shifts towards the SDGs is low. Moreover, a preliminary comparison between the SDG 3 related targets and indicators and those covered by the signatories reveals gaps. ^{iv} With the addition of the fourth "a" – to assess – the plan's focus on the member states has evolved. This will in our view contribute to fostering national ownership of the plan.

Feedback on the quadruple a-approach

Assess: We welcome the addition of the fourth "a", as we had also proposed during a policy dialogue on the SDG 3 GAP held at our institution in April. However, the assessment should extend beyond the operational/country level. The plan could provide the political momentum to reflect upon and address governance challenges at the global level. This should include an open dialogue about shared but also conflicting interests of the signatories. Some of the organizations' (vertical) mandates don't align with the inherently integrative approach of the SDGs across policy areas. Highlighting underrepresented areas within organizations' portfolios may enable targeted advocacy, reform or consolidation of existing organizations.

Align: Alignment must succeed at global and national levels. An initial analysis reveals contradictions between the accelerators and the SDG 3 targets; some of the accelerators seems to represent institutional priorities being unlinked to the SDGs. For example, the sustainable financing accelerator emphasizes pandemic preparedness to the detriment of a focus on health systems. It thereby contradicts SDG 3.8, which focuses on achieving universal health coverage. Such misalignments need to be identified using a normative lens on the accelerators, focusing on the right to health and leaving no one behind as common ground of all accelerators. Deviations from these SDG-principles in any of the accelerators need to be revised prior to the finalization of the discussion frames.

Accelerate: National acceptance and ownership of the plan is crucial to accelerate progress towards SDG 3 achievement. Therefore, the accelerators' content and foci need to be in line (or highly adaptable) to national priorities. To this day, critical SDG 3 components are overlooked: e.g. the global shortage and unequal distribution of human resources for health, which would merit a separate accelerator. National focal points and governance research for all plan-related matters could support the implementation.

Account: Governments could create a shared accountability mechanism, allowing feedback from civil society and international institutions. Furthermore, the proposed mid-point milestones could be used to assess health-related SDG indicators alignment across organizations and between global and country levels. National SDG implementation mechanisms and regulations to ensure their incorporation into national policies are conceivable and already exist in many cases. Therefore, a GAP review and follow up roadmap could be launched with the final version in September 2019. We believe the establishment of and adherence to a shared accountability mechanism by the signatories will be an indication of their true commitment to the plan.

With kind regards,

Daniel Gulati, Susan Bergner and Maike Voss

For feedback and questions please contact: Daniel Gulati (Daniel.Gulati@swp-berlin.org)

ⁱ Marten R, Kadandale S, Nordström A, Smith Richard D. Shifting global health governance towards the sustainable development goals. Bulletin of the World Health Organization 2018;96:798-798A. doi: <http://dx.doi.org/10.2471/BLT.18.209668>

ⁱⁱ Held D, Kickbusch I, McNally K, Piselli D, Told Michaela. Gridlock, Innovation and Resilience in Global Health Governance. Global Policy 2019; 10:2 <https://doi.org/10.1111/1758-5899.12654>

ⁱⁱⁱ Buse K, Hawkes S. Health in the sustainable development goals: ready for a paradigm shift? Globalization and Health 2015;11:13 <https://doi.org/10.1186/s12992-015-0098-8>

^{iv} WHO. Background document towards a Global Action Plan for Healthy Lives and Well-Being for All. https://www.who.int/sdg/global-action-plan/GAP_mapping_doc.pdf (accessed May 13, 2019)

SDG3_Secretariat

From: Winkler, Andrea <andrea.winkler@tum.de>
Sent: Tuesday, July 2, 2019 11:11 AM
To: SDG3_Secretariat
Cc: John Amuasi; Ingeborg K Haavardsson; Harrison, Wendy E; Eric.Fevre@liverpool.ac.uk; Carabin Hélène; Jakob Zinsstag; Peter Daszak; Anna.Okello@aciara.gov.au; Wieler, Lothar; Leendertz, Fabian
Subject: One Health as an Accelerator for the Global Action Plan
Importance: High

Dear SDG3_Secretariat,

We are the two Lancet One Health commission co-chairs: Dr. Dr. John Amuasi (Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR) at the Kwame Nkrumah University of Science and Technology (KNUST) and Prof. Dr. Dr. Andrea Winkler (Centre for Global Health (CGH) at UiO, Norway, and CGH at the Technical University of Munich, Germany).

We consider NOT including One Health as an accelerator for the GAP as a missed opportunity. The One Health approach aims at demonstrating the synergistic benefit and added value of an integrated approach to human, animal and environmental health, thereby dismantling the disciplinary silos which continue to persist, for the benefit of the ecosystems that support human, animal and plant life. One Health is closely aligned with the Sustainable Development Goals and is intrinsically inter- and trans-disciplinary.

In an interdependent world, health sector actors are less likely to achieve their goals without efficient multi-disciplinary collaboration. Global health threats such as climate change, emerging infectious disease epidemics, neglected diseases of poverty, antimicrobial resistance, non-communicable diseases, in addition to food security and nutrition, require coordinated action across multiple disciplines. One Health policies and programmes involve both public and private sectors, research institutions and governments, to implement effective solutions to complex issues of global concern. A One Health approach is necessary to inform a coordinated response to the aforementioned health threats, thereby accelerating the GAP.

WHO itself is actually advocating for a One Health approach <https://www.who.int/features/qa/one-health/en/>. So is OIE and FAO and relevant documents have been published. The World Bank is suggesting a framework as to how this could work. Please see the three references below.

World-Bank, People, pathogens and our planet: Volume 1: Towards a One Health approach for controlling zoonotic diseases. 2010. Report No. 50833-GLB: p. 56.

World-Bank, People, pathogens and our planet: Volume 2: The economics of one health. 2012. Report No. 69145-GLB(Report No. 69145-GLB): p. 50.

World Bank, Operational framework for strengthening human, animal and environmental public health systems at their interface. 2018. Working Paper No 123023, Vol 1.

We hope that One Health can be considered as an accelerator for the SDG3 under the GAP and remain at your disposition should you have any further questions.

John Amuasi

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EDCTP feedback on the Global Action Plan for healthy lives and well-being for all

30 June 2019

Full name: Dr Michael Makanga

Title: Executive Director

Affiliation: European & Developing Countries Clinical Trials Partnership (EDCTP)

General Comments

EDCTP would like to take the opportunity to comment on the Global Action Plan (GAP) for healthy lives and well-being for all, which we read with great interest. EDCTP commends the World Health Organization (WHO) and the other 11 GAP signatory agencies on the joint commitment to align efforts and more effectively support countries in achieving the health-related targets of the 2030 Agenda for Sustainable Development. EDCTP considers the GAP to be a great initiative that presents an opportunity to streamline the visions, goals, priorities, implementation strategies and lines of communication between the multiple players in the global health and development field. EDCTP generates valuable new policy relevant evidence on medical interventions and how they can best be implemented in practice, and enhances the capacities of the countries involved. In order to achieve this major undertaking, EDCTP endeavours to engage early with WHO at the global policy-making and research gaps identification level, to complement the bottom-up efforts through country level engagements. Through the envisaged closer coordination and alignment between the 12 organisations united by the GAP, EDCTP sees an opportunity for greater cooperation with other partners working with WHO who are involved in poverty-related diseases research and development (R&D), in order to ensure well coordinated and aligned strategies and R&D investments that address both local and global priorities. As the GAP signatory agencies currently miss some of the major funders in health R&D, we strongly recommend that such partners are fully engaged in the planned joint actions. Thank you for the opportunity to comment on these draft papers; we look forward to seeing how the proposed joint actions take shape in the coming months and years and to contributing, where appropriate, to the implementation of the final GAP.

Accelerator Discussion Paper 5: Research and Development (R&D), Innovation and Access

Goal 2, Action 2

We recommend engaging regional bodies such as the New Partnership for Africa's Development (NEPAD)/the Africa Union Development Agency (AUDA), African regional economic communities such as the West African Health Organisation (WAHO), the Organization of Coordination for the Fight against Endemic Diseases in Central Africa (OCEAC), the East African Community (EAC), the Southern African Development Community (SADC) and Intergovernmental Authority on Development (IGAD), as well as Africa Centres for Disease Control and Prevention (Africa CDC). Furthermore, given the importance of regulatory systems and ethical review capabilities to research priority setting in Africa, we recommend involving the African Vaccine Regulatory Forum (AVAREF) and the African Medicines Regulatory Harmonisation (AMRH) Partnership Platform. With respect to the latter, AMRH provides a good example of existing collaboration between GAP signatory agencies Gavi, World Bank Group and WHO, together with EDCTP and others, with the aim of improving the coordination of regulatory systems strengthening and harmonisation activities in Africa to ensure access to essential medical products and technologies.

In order to boost country ownership and alignment with specific national health research needs, in 2018 we collaborated with WHO-AFRO on a National Health Research Systems (NHRS) survey project using an NHRS 'barometer' questionnaire developed by WHO-AFRO to support EDCTP's African Participating States (PSs) in assessing and strengthening their health research systems. The results were presented in August 2018 at a high-level meeting of African Union policymakers, strategic partners and African EDCTP PSs during the WHO African Regional Committee in Dakar, Senegal. In 2019, we plan to implement an ongoing dynamic data collection process and to organise follow-up training in sub-Saharan Africa which builds on the recognition of the revised NHRS barometer as a key tool for assessing NHRS and informing progress towards the achievement of Universal Health Coverage (UHC). We recommend that this ongoing activity is taken into account when implementing proposed joint actions 2 and 4.

To avoid duplication of efforts and promote synergies we would like to encourage R&D funders to consider mechanisms which better link our funding opportunities to one another. This can be done by creating specific follow-up funding opportunities across funders to researchers who have successfully executed R&D projects.

Goal 3, Action 4

The results of our NHRS survey showed that, while 62% of the 47 member countries of the WHO Africa region have a dedicated budget line for health research, only 8% invest at least 2% of their budget, while donors and international NGOs are the primary funders of research, with the governments only in third place. A strategy to increase domestic financing of research would improve prioritisation of locally relevant research and generate home-grown solutions.

Maintaining our flexibility in financing cannot be overemphasised. This is particularly important in case of late stage development which involves industry partners and requires efficiency of implementation and quick decision making. Furthermore, funding approaches should be diversified to include modalities which look at promising R&D initiatives in late stage where others have interest to cofund.

On the issue of suboptimal research management in LMIC, EDCTP maintains an approach that capacity development (which includes development of financial and project management capacity) should be an integral part of an R&D programme. This ensures optimal capacity utilisation, better outcomes and sustainability of capacity. Furthermore, networking provides added value to capacity development where south-south knowledge building and mentorship can be coupled with south-north collaboration and technology transfer. It should be noted that the ESSENCE on Health Research initiative is currently discussing how best to develop research management capacity in LMICs. Additionally, ESSENCE is developing a good practice document on Implementation Science (IS), with an overview of current IS programmes, initiatives, and training opportunities. The GAP R&D Accelerator might serve as guidance for impact-oriented investments in IS, including in capacity development for IS.

EDCTP strongly endorses the need to reinforce the WHO Global Observatory on Health R&D to serve as an evidence-based list of innovations for scaling up and ensuring capitalisation of research results. While the WHO's Observatory provides a very comprehensive source of data, information, and analyses on R&D investments (inputs) and processes, it also recognises that much of the information on health R&D is not yet standardised or easily accessible, especially concerning research output and impacts. This is fully understandable given that funders have different strategies as well as diverse monitoring systems. However, a certain level of commonality exists, particularly in expected results, and funder platforms such as ESSENCE and the Product Development Partnership Funders Group (PFG) could provide a valuable source of information regarding best practices for harmonising R&D indicators. In addition to harmonisation efforts, funders should be encouraged to improve the quantity and quality of R&D monitoring data, and to make them as open as possible by contributing to initiatives such as G-FINDER, World RePORT and other investment tracking surveys.

Accelerator Discussion Paper 6: Data and Digital Health

The sharing of clinical trial data is increasingly required by research publishers, regulatory agencies, ethics committees, and funding bodies. Despite these requirements, there are currently no clear standards, best practices or guidelines on how, where and when researchers should share their data. In an effort to support and facilitate data sharing, EDCTP is collaborating with The Global Health Network to develop a cross-cutting knowledge hub for data sharing. This hub will help researchers find the optimal repository for their clinical trials data, and to collect and organise their data in an appropriate format that is ready for sharing. We have created an online platform, The Knowledge Hub (<https://edctpknowledgehub.tghn.org/>), which provides free and accessible guidance on data sharing for clinical trials, plus access to a virtual research community. This includes resources relevant to all stages of data sharing, from data processing and management, through preparation of metadata and documentation, to guidance on choosing an appropriate repository for data deposition. The aim of this Hub is to become a core resource for researchers worldwide that can guide and support the data sharing process and it may also be a useful tool for some of the aspects to be addressed under this accelerator. Ongoing feedback from the research community will be essential to refine and validate the usefulness of this resource.

Joint Action 4 – Strengthen country capacity for digital health in focused countries

One of EDCTP's capacity development schemes focuses on the strengthening of sub-Saharan African countries' ethics and regulatory capacities, which are a key aspect of national health research capacity. Despite ongoing efforts by different partners and agencies, ethics and regulatory oversight in sub-Saharan African countries require targeted attention to address: the growing amount and complexity of research activities in the African region requiring better systems and technologies (including digitisation) to improve harnessing of external expertise, processing of review of research applications, handling of documentation, as well as data handling and its analysis; and the growing need for efforts towards open data access and the need to promote linkages between ethics and regulatory functions with clinical trial registration and systematic research reviews. Amongst other aspects, EDCTP is supporting work aimed at improving the efficiency of the functioning of National Ethics Committees and National Regulatory Agencies through the introduction of innovative systems, reliance practices and/or technologies that would facilitate the various functions of these bodies with better quality outputs and improved timelines. This work may be complementary to the planned GAP joint actions.

Accelerator Discussion Paper 7: Innovative programming in fragile and vulnerable settings and for disease outbreak responses

Action 1, Multi-sectoral governance and coordination

In terms of sustainable and coordinated financing, fast execution is also key in the context of responding to public health emergencies. For example, in 2018 EDCTP launched an emergency funding initiative in response to the Ebola virus diseases outbreak in the Democratic Republic of the Congo (DRC). After a ten-day call for proposals and speedy external expert review, we managed to give within one month the go-ahead to 5 projects conducted by 24 institutions in Africa and Europe. This was made possible through the activation of the EU-supported Emergency Funding Mechanism, as well as good coordination with WHO and other relevant partners. In this case, a number of research organisations and funders liaised with WHO's Deputy Director-General of Emergency Preparedness and Response for guidance on the research priorities for response and preparedness in the context of the DRC EVD outbreak and how best to coordinate support to address these priorities. This type of approach to coordinated financing is strongly encouraged for future such outbreaks.

Action 2 (Emergency Preparedness) and Action 3 (Outbreak Response)

Many LMICs, particularly in sub-Saharan Africa, have weak health systems. This makes them very vulnerable to the devastating effects of infectious disease epidemics and their negative impact on national health programmes. Population movement, immigration and global warming serve to increase the geographical impact of these epidemics. Therefore, it is a global political priority to galvanise the emergency preparedness of health systems and services, including their capacity to conduct necessary clinical research in response to these health emergencies.

In 2017, with the financial support of the EU, Germany, Sweden and the United Kingdom, EDCTP invested in two large multidisciplinary consortia involving 18 sub-Saharan African countries and 6 European countries: the Pan-African Network for Rapid Research, Response, Relief and Preparedness for Infectious Diseases Epidemics (PANDORA-ID-NET, 22 partners) and the African Coalition for Epidemic Research, Response and Training (ALERRT, 21 partners). The ALERRT consortium will ensure that African countries are better prepared to carry out research during emergency infectious disease outbreaks and the PANDORA-ID-NET Consortium is enhancing the capacity of African regions to detect and respond to infectious disease outbreaks through a 'one health' approach encompassing human and animal medicine. ALERRT and PANDORA-ID-NET have already been called into action, following a formal request from the DRC for help with control of an Ebola outbreak in 2018. The consortia provided advice on local surveillance activities and diagnostic tools, and organised training on the rapid and rigorous review of research proposals for emergency situations. The 2014–16 Ebola epidemic illustrated that the world was poorly prepared to organise and coordinate clinical research during outbreak situations, when vital information could have been obtained on new vaccines and drug treatments. Alongside global initiatives to coordinate research during emergency situations, the PANDORA-ID-NET and ALERRT consortia will ensure that African countries are better prepared to prevent, respond to and minimise the impact of infectious disease outbreaks. We strongly recommend that they are also involved and consulted in relevant activities conducted under joint actions 2 and 3.

Additionally, the aforementioned work that EDCTP is supporting on the strengthening of NHRS and ethics and regulatory capacities in sub-Saharan Africa could be relevant in the context of these joint actions. The strengthening of NHRS will facilitate country contributions to clinical research, improve linkages of NHRS with Regional Economic Communities in Africa, and enhance preparedness for clinical trials and public health emergencies.