6. Political Declaration of 3rd HLM of UNGA on NCDs

Contents

In focus

The Secretariat advises:

> A report will be submitted (EB148/7) in response to the request in decision WHA72(11) (2019) to the Director-General "to consolidate reporting on the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health with an annual report …, annexing reports on implementation of relevant resolutions, action plans and strategies, in line with existing reporting mandates and timelines".
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> The report will also include the biennial report on the implementation of the commitments made in the Rome Declaration on Nutrition, adopted at the Second International Conference on Nutrition (2014). The Board will be invited to note the report and its annexes, adopt the proposed updates to the appendices of WHO's comprehensive mental health action plan 2013–2030, and provide guidance on the continued relevance of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and the global coordination mechanism on the prevention and control of noncommunicable diseases. In this exercise, the Board will be able to take into account the outcomes of two evaluations, the executive summaries of which will be submitted by the Evaluation Office in separate reports (EB148/7 Add.1 and EB148/7 Add.2.
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> Oral health
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> At the recommendation of the Officers of the Executive Board, the Director-General will submit a report outlining the challenges to global public health posed by oral diseases, recent oral health activities of the Secretariat, and actions towards better oral health by 2030 as part of the work on noncommunicable diseases and universal health coverage.

The Board will be invited to note the report (in EB148/8) and provide guidance on the way forward.

Background

Recent governing body discussions of NCDs

Previous reports on implementation of ICN2

Secretariat topic page on NCDs

Secretariat topic page on oral health

PHM Comment

Oral health

PHM appreciates the analysis provided in EB148/8. We look forward to the Global Oral Health Report and we particularly support the inclusion of health taxes or bans on the sale and advertisement of unhealthy products and counteracting the underlying commercial interests that drive key risks. However, PHM is perplexed by the faith being shown in the 'integration strategy' and the common risk factor approach. It is unlikely that somehow oral health will magically benefit from being mentioned whenever NCDs are mentioned. The current approach fails to address the real reasons for neglect and we strongly urge the WHO to highlight the specific policy challenges associated with oral health.

PHM regrets the unproblematic identification of oral health as part of universal health cover, including the references to 'benefit packages' suggesting that a subset of services will be purchased by the State from private providers and families will face user charges for the rest. This reliance on the private sector for oral health services will reproduce dentist-centered health care models, ignore prevention, and exacerbate existing inequalities in access to decent oral health care. PHM urges the Secretariat to rethink this extremely backward policy and instead present a clear positioning of oral health care within a primary health care model, supported by publicly funded and administered specialist services.

PHM regrets the inadequate inclusion of workforce issues in the listing of oral health priorities. The reference in para 12 is weak and there is no emphasis on workforce issues in the listing of WHO priorities in para 22 or policy opportunities in para 23.

PHM cautions WHO against the dependence upon digital health technologies for surveillance and service provision under the Global Oral Health Programme (para 22). These technologies remain unfeasible in many parts of the world, and continued reliance on these will exacerbate oral health inequities between and within countries, resulting in worse oral health among marginalized and underserved communities. Instead, PHM urges the Secretariat to support the

demonstration of community-based oral health models that depend upon community health workers and integration with existing programs that cover the most vulnerable populations.

Within the realm of oral health, diseases such as fluorosis garner little attention, despite the considerable burden in parts of the world. In addition to sugar consumption, tobacco usage, and poor hygiene, it is worth noting that malnutrition and inadequate access to clean, potable water are significant social determinants of oral health. These determinants provide a valuable avenue for action on multisectoral and systemic action for oral health. PHM urges the Secretariat to explicitly recognise these determinants and direct concerted actions on these fronts.

In para 9, the report speaks of the 'continued low priority accorded to oral health'. In fact, it is not oral health that is neglected; it is low income and marginalized people who are neglected. PHM urges Board members to recognize how the culture and economics of neoliberal globalization are driving increased political and economic inequality and loss of solidarity. We note the references to social and commercial determinants but these references appear focused solely on behavioral risk factors and their 'underlying social and commercial determinants' (para 6). It is time WHO addressed directly the geopolitical and macroeconomic determinants of political and economic inequality and marginalization, including neoliberal globalization.

1. Oral health services, whatever exist, have been drastically affected during the Covid-19 pandemic due to travel restrictions and lockdowns
2. Note that the general recommendation for availability of dentists is 1:7500, which is a distant dream for practically all of the low and middle income countries, given some concentrations in urban higher-income areas.

Non-communicable Diseases

The data presented in EB148/7 confirm that the disease burden of NCDs is huge. The human cost in terms of morbidity, disability and premature mortality is likewise huge. The economic balance sheet is more complicated. For the industries driving the NCDs epidemic (tobacco, alcohol, junk food, passive transport, etc), the morbidity upon which their profits depend is dismissed as personal choice. However, health care, including the supply industries, provides employment to many and profits to a few. Whether health care expenditure on NCDs is a cost or a market opportunity depends on perspective. PHM takes the view that the human burden and the opportunity costs of the NCD industries (precluding better uses of resources) demand action.

The burden of mal(under)nutrition is likewise huge although for the economic forces whose security depends on widening inequality and deepening poverty and for the industries whose practices drive hunger, the human costs of malnutrition are simply collateral damage.

Important though NCDs are, they need to be seen in context, alongside global warming, biodiversity loss, and the human suffering associated with widening inequality and alienation. Fortunately there are powerful synergies which could be leveraged from strategies directed to

addressing these existential challenges facing humanity and also overcoming the drivers of NCDs and malnutrition.

These synergies include:

- transport planning and investment directed to reducing carbon pollution and encouraging active transport and physical activity;
- radical reduction in meat consumption in the rich world and rich classes with impacts on global warming, biodiversity conservation and fresh water conservation as well as impacting on obesity and cardiovascular disease;
- reform of food systems, globally and nationally, to wrest control from the transnational food and supermarket corporations so that farming can move to national and local food sovereignty based on wider spread but smaller scale agroecology - while also reducing the pressures of cheap junk food on people's diets.

These synergies have been recognised in WHO resolutions and in high level political declarations at the UN General Assembly (although there is little in the reports before the Board which reports action on the synergies). The world needs a much more proactive approach from WHO through vigorous intersectoral advocacy and inspirational leadership. It is exactly such leadership that the donor chokehold is designed to preempt.

It is most unfortunate that WHO has retreated from the radical principles of the original Alma-Ata Declaration on Primary Health Care which highlighted the role of primary health care practitioners in working with their communities to address the structural causes of illness as well as providing health care.

Instead WHO has been forced to adopt the World Bank's model of 'universal health cover' through a mixed service delivery model supported by competitive health insurance markets offering 'benefit packages' for essential services (and out of pocket payment for the rest). This health system model precludes community engagement as part of primary health care and precludes community action around the structural causes of illness.

The tools and guidelines being promoted by WHO (see Table 4 in EB148/7) are important resources for addressing NCDs, prevention and care. However, there is no emphasis in this package on looking for the synergies between the existential challenges (global warming, biodiversity and inequality) and addressing the more immediate commercial, political and economic determinants of health.

Even so the number of WHO staff, in particular in country offices and working on NCDs, is far too few to have the impact which is needed. The gross underfunding of WHO is a major constraint on global aspirations to reduce the burdens of NCDs (see EB148/7 Add.1). Perhaps this is also intentional.

Further, para 34 of EB148/7 advises that,

> *Bilateral donors have not shown increased appetite for funding activities specifically earmarked as addressing NCDs to establish even the minimal critical capacity,*

mechanisms and mandates needed in low- and middle-income countries to pursue change. In the absence of such funding, groups with economic, market and commercial interests stepped up their efforts to lobby against implementation of interventions by WHO, discrediting WHO's scientific knowledge, available evidence and reviews of international experience, and bringing legal challenges against countries to oppose progress.

Building stronger community engagement around NCDs and the existential synergies noted above is critical to achieve both and comprehensive PHC is a critical step towards this. Stronger community engagement also has the potential to increase the political pressure on governments and donors to properly fund WHO (adequate in total, lift the freeze on ACs, untie donor funds) so it can do its job.

PHM appreciates the work done through the Inter Agency Taskforce on multisectoral action but it needs to be matched by community engagement directed to building a political constituency to drive such reforms.

The individual behaviourist focus of the 'concrete guidance to strengthen health literacy' provided in Annex 6 is a lost opportunity. As argued above, any such initiatives must ensure that literacy regarding individual risk and behaviour is matched with literacy regarding the structural reforms needed to address the commercial, political and economic determination of health.

PHM appreciates the recognition in Annex 7 (to EB148/7) of the need for multisectoral action for the prevention and control of NCDs. However, the commitment to analyse possible approaches is now over ten years old and still has not been fulfilled; owing, we are told in para 2 to lack of resources. This is truly an indictment of the donor chokehold.

Notes of discussion

EB148/CONF./3 - Oral health (Draft resolution proposed by Bangladesh, Bhutan, Botswana, Eswatini, Indonesia, Israel, Japan, Jamaica, Kenya, Peru, Qatar, Sri Lanka, Thailand and Member States of the European Union)