

# WHCA ACTION GUIDE

World Health Communication Associates



The "Unofficial" WHCA Action Guide to the:

# WHO-62<sup>nd</sup>

## World Health Assembly

MAY 2009, GENEVA



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## INTRODUCTION

This “unofficial” WHCA Action Guide is a compilation of information from the WHO website regarding the 62<sup>nd</sup> World Health Assembly. It is presented for use by World Health Communication Associates and World Health Editors Network (WHEN) members only and is not intended for sale or general circulation. It includes useful information regarding the Assembly, including texts of key discussion papers and resolutions. It serves as a background document to the WHEN workshop entitled “Making Global Health News – 2009” being held in Geneva, 17-18 May 2009. The proceedings of this workshop will be published on the WHCA/WHEN website at [www.whcaonline.org](http://www.whcaonline.org).

A big thank you to WHCA Associates *Carinne Allinson* and *Tuuli Sauren* for the compilation, editing and design of this document. We would also like to thank the British Medical Journal, The Lancet and the World Health Professions Alliance for editorials and comments included with permission in this Guide.

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The **World Health Communication Associates** (WHCA) works to improve health by helping public health advocates and organisations acquire the knowledge, savvy and resources to enable their messages to stand out and positively shape health choices, behaviours and perceptions in local, national and global information marketplaces. WHCA focuses exclusively on health and environmental issues and does no product promotion. The Associates are an independent network of active, strategically-placed communicators, with practical experience in health and environment reporting, investigative journalism, policy advocacy, intergovernmental and non-governmental public and press relations, international conference organisation and cross-border campaigning.

The **World Health Editors Network** (WHEN) is an international, inter-professional exchange and action platform dedicated to exploring and strengthening communications as a positive determinant of health. Through participation in events, editors get early access to global health news and experts and importantly, key international health agency agenda-setting intelligence. WHEN development is being facilitated by the World Health Professional Alliance and its constituent association members, including the International Council of Nurses (ICN), the International Pharmaceutical Federation (FIP), the FDI World Dental Federation, and the World Medical Association (WMA). WHCA serve as Secretariat to WHEN.

The **World Health Professions Alliance** (WHPA), speaking for more than 23 million health care professionals worldwide, assembles essential knowledge and experience from the key health care professions. The WHPA aims to facilitate collaboration between key health professionals and major international stakeholders such as governments, policy makers and the World Health Organization. By working in collaboration, instead of along parallel tracks, the patient and health care system benefit.

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## SECTION I : INTRODUCTION TO THE WHO WORLD HEALTH ASSEMBLY

(Adapted from WHO website, [www.who.int](http://www.who.int), accessed April 2008)

The World Health Organization (WHO) is the directing and coordinating authority on international health within the United Nations' system. WHO experts produce health guidelines and standards, and help countries to address public health issues. WHO also supports and promotes health research. Through WHO, governments can jointly tackle global health problems and improve people's well-being. WHO's Constitution came into force on 7 April 1948—a date now celebrated every year as World Health Day.

### **World Health Assembly**

The World Health Assembly is the supreme decision-making body for WHO. It generally meets in Geneva in May each year and is attended by delegations from all 193 Member States. Its main function is to determine the policies of the Organization. The Health Assembly appoints the Director-General, supervises the financial policies of the Organization, and reviews and approves the Proposed programme budget. It similarly considers reports of the Executive Board, which it instructs in regard to matters upon which further action, study, investigation or report may be required.

### **Executive Board**

The Executive Board is composed of 34 members technically qualified in the field of health. Members are elected for three-year terms. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions for forwarding to the Health Assembly are adopted, is held in January each year, with a second shorter meeting in May, immediately after the Health Assembly, for more administrative matters. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work.

### **WHO Staff**

Over 8000 public health experts including doctors, epidemiologists, scientists, managers, administrators and other professionals from all over the world work for WHO in 147 country offices, six regional offices (see Annex 1) and at the headquarters in Geneva, Switzerland.

## **Regional Committees**

The six WHO Regional Committees meet separately once every year to set policy and approve budgets and programmes of work for their respective regions. Each meeting addresses the specific public health needs of the area represented by the region.

## SECTION II : PRACTICAL INFORMATION : 62<sup>ND</sup> WORLD HEALTH ASSEMBLY

(adapted from A62/DIV/2- accessed 2/5/09)

### DATE AND PLACE OF THE HEALTH ASSEMBLY

The Sixty-second World Health Assembly will open in Geneva on Monday, 18 May 2009, at 10:00; it will close on Wednesday, 27 May 2009. The Health Assembly will be held in the Palais des Nations, located near Place des Nations and Avenue de la Paix, and is most easily reached by the entrance gate on Route de Pregny.

### ACCESS TO THE PALAIS DES NATIONS FOR THE HEALTH ASSEMBLY

Visitors day passes can be obtained at WHO Headquarters on Appia Way on a daily first come first serve basis.

The Health Assembly will meet in the Assembly block of the Palais des Nations. The Assembly block is conveniently reached by Doors (Portes) 13 or 15. The plenary meetings will be held in the Assembly Hall (Salle des Assemblées) which can be reached by stairway or elevator from Doors 13 or 15. The two main committees of the Health Assembly will meet in separate conference rooms, Committee A in Conference Room XVIII and Committee B in Conference Room XVII. Both rooms are located on the first floor of E Building ("Bâtiment E"). **Smoking is not allowed at the Health Assembly.**

### LIST OF DELEGATES

A provisional list of delegates and other participants (document A62/DIV/1) will be distributed at the beginning of the Health Assembly. This list will be issued on the basis of the credentials received by the Secretariat up to 14:00 on Sunday, 17 May. A revised list will be issued later as part of the normal document distribution. In the event of any official change in delegation membership, delegations are kindly requested to notify the Inquiry Office in writing on form WHO23 WHA which is distributed with the list. The form should be signed by the chief delegate.

## DOCUMENTATION

### Meeting information

The *Journal* of the Health Assembly, published each day, gives the time, place and programme of meetings, the agenda items for discussion and the corresponding documents, and other relevant information.

### Internet access

The WHO web site (<http://www.who.int>) provides easy electronic access to documentation, including the various basic documents such as Rules of Procedure. The Governance page, accessed from the WHO home page (right-hand navigation column, under Key WHO Information/Governance of WHO), offers options to download documents for the current sessions of the governing bodies and to search documents of previous sessions and other relevant documentation (direct address: <http://www.who.int/gb>).

Since documentation is available on the Internet, and as an economy measure, there will be no provision for dispatch or transport of any documentation made available during the Health Assembly.

## DISTRIBUTION OF DOCUMENTS

A document distribution service operates at the counter in the hall between Doors 13 and 15 of the Palais des Nations. Each day delegates, representatives and other participants will receive their documents under the name of their country or organization in the pigeon-holes situated on both sides of this counter. Documents will be distributed in the languages indicated by delegates on the form that they will be invited to complete. Pigeon-holes are used exclusively for official WHO documents produced and distributed through the WHO document distribution system. The only distribution of documents considered official is the distribution to these pigeon-holes. Participants are requested to collect their documents before the meetings each day.

## PUBLIC TRANSPORT AND TAXIS

From Monday to Friday WHO can be reached by bus "8" which runs from Veyrier to Avenue Appia, passing through Rive (town centre), Place Cornavin (railway station) and Place des Nations (Palais des Nations); at weekends this bus runs only as far as Avenue Appia. WHO can also be reached by bus "F" which runs daily from Place Cornavin to Ferney-Voltaire, France, with stops at Place des Nations and

Vy-des-Champs, next to the headquarters building. In addition, bus “5” runs daily from Hôpital to Grand-Saconnex, with stops at Place Cornavin and Place des Nations, and bus “28” runs from Jardin Botanique with stops at Appia and Vy-des-Champs for headquarters.

Two tram services, tram “13” and “15”, are also available. They both run from Palettes to the Place des Nations, passing by Cornavin station, including at weekends.

Tickets must be purchased and validated **before** entering buses. Individual tickets are available from vending machines at main bus stops. Electronic cards for multiple trips may be purchased from the Naville kiosks in WHO headquarters and at the Palais des Nations, any newsagent in town bearing the “TPG” sign, and at the main railway station (Cornavin).

With effect from January 2008, Geneva International Airport is offering a free ticket for public transport in Geneva. This Unireso ticket, which can be obtained from the machine in the baggage collection area at the “Arrivals” level, allows 80 minutes’ free use of public transport, including the train service from the airport to the main railway station.

In addition, a “Geneva Transport Card”, can be obtained by delegates from the establishment at which they are staying, enabling them to use public transport free of charge during their visit. Further information about this card is available from the Geneva Tourism & Convention Bureau (accessible online at <http://www.geneve-tourisme.ch>).

Geneva taxi drivers know the headquarters building as “OMS” (Avenue Appia).

There are taxi ranks in almost all main squares in Geneva and outside the Palais des Nations. Taxis can be called by telephone by dialling the following numbers: 022 320 20 20, 022 320 22 02 and 022 331 41 33. Taxis can also be ordered through the usher on duty at the nearest door in the Assembly block.

## RESTAURANT, CAFETERIA AND BAR

The restaurant on the eighth floor of the Assembly block is open from 12:00 to 14:30 from Monday to Friday (ext. 73588 for reservations). The restaurant can organize private receptions (cocktail parties) and luncheons for a minimum of 25 participants. These services can also be provided on Saturdays or Sundays. Arrangements for dinners should be discussed with DSR/UN (ext. 73588).

The cafeteria, which is on the ground floor of the Assembly block, and to which there is direct access by Lift 29, is open from 08:15 to 16:45, Monday to Friday (on Thursday, 21 May, it will open from 12.00 until 14.00); hot meals are served from 11:30 to 14:00 or 14.30 (grill only).

The snack bar in the hall between Doors 13 and 15 is open from 07:30 to 19:00 or until the close of meetings, and on Saturday mornings. It should be noted that this area has been reserved for non-smokers.

The Delegates' Bar, adjacent to Conference Room VII on the third floor, is open from 08:30 to 16:45, Monday to Friday, and also serves snacks. (This bar will be closed on Thursday, 21 May.)

The Bar du Serpent, located on the first floor of E Building, is open from 09:00 to 17:30, Monday to Friday and on Saturday until 12:30 or until the close of meetings; it also serves sandwiches.

Delegates and other participants in the Health Assembly may also use the restaurant and cafeteria at WHO.

## **PERSONAL SECURITY**

Geneva can generally be regarded as a safe city with a low rate of violent crime. However, pickpocketing and purse or cell-phone snatching do occur in the vicinity of, or within, the train and bus stations, the airport and in some public parks.

Geneva emergency numbers are:

- police 117
- ambulance service 144
- fire 118
- roadside assistance 140

## **WHO PUBLICATIONS**

WHO Publications can be purchased at the WHO Press sales counter located between Doors 13 and 15 at the Palais des Nations and also at the WHO Bookshop located at headquarters. A 50% discount is granted to delegates. WHO souvenirs are also available at the WHO Press sales counter or at the WHO Bookshop.

Delegates wishing to discuss free dissemination of WHO publications in their country can contact Mrs Maryvonne Grisetti, WHO Press, headquarters building, office 4157, ext. 12481.

## **LIBRARY**

The Library at WHO is situated on the ground floor near the Executive Board room. The Reference desk is staffed from 09:00 to 12:00 and 14:00 to 16:00 from Monday to Friday. The reference area (Library computers and printer) is accessible 24 hours (ext. 12062).

## **THE "CYBERCAFE"**

Delegates are invited to visit the WHO Cybercafé, located at the Bar du Serpent in "E" Building. Workstations will be available, giving full access to the Internet and in particular to the WHO web site (<http://www.who.int>). The Cybercafé will also be equipped with a wireless hotspot allowing visitors to connect to the Internet with their own wireless-enabled notebooks (laptops).

Another Cybercafé will also be available on the 8th floor of the "A" Building catering exclusively for Health Assembly delegates.

## SECTION III : OVERVIEW OF THE 62<sup>ND</sup> WORLD HEALTH ASSEMBLY AGENDA AND RESOLUTIONS

### Provisional Agenda

#### PLENARY

1. Opening of the Assembly
  - 1.1 Appointment of the Committee on Credentials
  - 1.2 Election of the President
  - 1.3 Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
  - 1.4 Adoption of the agenda and allocation of items to the main committees
2. Reports of the Executive Board on its 123rd and 124th sessions
3. Address by Dr Margaret Chan, Director-General
4. Invited speaker
5. Admission of new Members and Associate Members [if any]
6. Executive Board: election
7. Awards
8. Reports of the main committees
9. Closure of the Assembly

#### COMMITTEE A

10. Opening of the Committee
11. Medium-term strategic plan, including Proposed programme budget 2010–2011
12. Technical and health matters
  - 12.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
  - 12.2 Implementation of the International Health Regulations (2005)
  - 12.3 Prevention of avoidable blindness and visual impairment
  - 12.4 Primary health care, including health system strengthening

- 12.5 Commission on Social Determinants of Health
- 12.6 Monitoring of the achievement of the health-related Millennium Development Goals
- 12.7 Climate change and health
- 12.8 WHO's role and responsibilities in health research
- 12.9 Counterfeit medical products
- 12.10 Human organ and tissue transplantation
- 12.11 Public health, innovation and intellectual property: global strategy and plan of action
- 12.12 Chagas disease: control and elimination
- 12.13 Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services
- 12.14 Strategic Approach to International Chemicals Management
- 12.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis
- 12.16 Food safety
- 12.17 Viral hepatitis
- 12.18 Progress reports on technical and health matters
  - A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)
  - B. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)
  - C. Malaria, including proposal for establishment of World Malaria Day (resolution WHA60.18)
  - D. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)
  - E. Prevention and control of sexually transmitted infections (resolution WHA59.19)
  - F. Strengthening of health information systems (resolution WHA60.27)
  - G. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)

- H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)
- I. Rational use of medicines (resolution WHA60.16)
- J. Better medicines for children (resolution WHA60.20)
- K. Health technologies (resolution WHA60.29)
- L. Multilingualism (resolution WHA61.12)

## COMMITTEE B

- 13. Opening of the Committee
- 14. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
- 15. Programme and budget matters
  - 15.1 Programme budget 2006–2007: performance assessment
  - 15.2 Implementation of Programme budget 2008–2009: interim report
- 16. Audit and oversight matters : Report of the Internal Auditor
- 17. Financial matters
  - 17.1 Unaudited interim financial report on the accounts of WHO for 2008 and comments thereon made by the Programme, Budget and Administration Committee of the Executive Board
  - 17.2 Interim report of the External Auditor
  - 17.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
  - 17.4 Special arrangements for settlement of arrears [if any]
  - 17.5 Scale of assessments 2010–2011
  - 17.6 Assessment of new Members and Associate Members [if any]
  - 17.7 Amendments to the Financial Regulations and Financial Rules
- 18. Staffing matters
  - 18.1 The election of the Director-General of the World Health Organization
  - 18.2 Human resources: annual report
  - 18.3 Report of the International Civil Service Commission

- 18.4 Amendments to the Staff Regulations and Staff Rules
- 18.5 Report of the United Nations Joint Staff Pension Board
- 18.6 Appointment of representatives to the WHO Staff Pension Committee
- 19. Management matters : Partnerships
- 20. Collaboration within the United Nations system and with other intergovernmental organizations

## SECTION IV : AGENDA DISCUSSION TOPICS AND RESOLUTIONS (\*)

### 12.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

#### Extracts from Document A62/5 (Report by the Secretariat):

1. In May 2007, the Sixtieth World Health Assembly adopted resolution WHA60.28 on Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits which, inter alia, requested the Director-General to report to the Sixty-first World Health Assembly, through the Executive Board, on progress made in implementing the resolution, including the work of the Intergovernmental Meeting. In May 2008, the Health Assembly noted the report submitted by the Secretariat,<sup>1</sup> and in January 2009 the Executive Board noted a further report.<sup>2</sup>
2. In the period since the Intergovernmental Meeting held in November 2007, several activities have been undertaken to implement resolution WHA60.28.

#### INTERGOVERNMENTAL PROCESS

3. At the Intergovernmental Meeting session in November 2007, Member States adopted an Interim Statement<sup>3</sup> calling for urgent implementation of two measures and requesting the Chair to convene an open-ended working group to carry work forward. The working group met in Geneva in April 2008 and focused on five issues, calling on the Chair to prepare a text, through the Bureau and in close consultation with Member States, for discussion at the resumption of the group's meeting and the resumed Intergovernmental Meeting (Geneva, 8–13 December 2008).
4. The resumed open-ended working group considered the draft Chair's text, and agreed that it be submitted to the resumed Intergovernmental Meeting as the basis for its work, before adjourning. Progress was made at the resumed Intergovernmental Meeting, notably through adoption of two texts: Guiding Principles for the development of terms of reference for WHO Network

<sup>1</sup> Document WHA61/2008/REC/3, summary records of the first and second meetings of Committee A.

<sup>2</sup> Document EB124/2009/REC/2, summary record of the first meeting, section 7.

<sup>3</sup> Document EB122/5, Annex 5.

laboratories, and Terms of Reference for the Advisory Group.<sup>4</sup> Nonetheless, consensus on the Chair's text was not reached before the meeting was suspended. Before the Intergovernmental Meeting resumes on 15 and 16 May 2009, the Chair and officers will facilitate informal consultations among Member States in order to find ways to resolve the remaining issues.

## TRACEABILITY MECHANISM

5. In the Interim Statement the Intergovernmental Meeting invited the Director-General to establish "a technical and feasible system as soon as possible within WHO to track all shared H5N1 and other potentially pandemic human viruses and the parts thereof". During the two months between the suspension of the Intergovernmental Meeting in November 2007 and the opening of the 122nd session of the Executive Board (21–26 January 2008), the Secretariat devised and launched an interim influenza virus traceability system. The system was well received by the technical influenza community; in 2008 there were, on average, 10 000 page views a month on the virus tracking system web site.
6. The interim influenza virus traceability mechanism provides many of the features and information requested by Member States, notably information on all influenza A (H5N1) viruses and clinical specimens shared by Member States with WHO's Global Influenza Surveillance Network since 24 November 2007, and tracking of all influenza A (H5N1) viruses that have been selected and developed under WHO's aegis into candidate vaccine viruses using reverse genetics. The system also provides information on analysis results and progeny materials, if any, that have been generated. However, given the rapidity with which the interim system was developed, it suffers from certain deficiencies such as lack of linkages with other databases and redundant or cumbersome data-entry requirements.
7. In order to define the scope and identify critical technical parameters of an improved system, WHO convened a technical consultation (Ottawa, 24–26 September 2008), which brought together participants, with diverse backgrounds, to discuss the technical parameters and required features of the improved system with due reference to the mandate of the Intergovernmental Meeting. Two members of the Advisory Mechanism attended the meeting as observers and submitted a report of the proceedings directly to the Advisory Mechanism.

<sup>4</sup> Document EB124/4 Add.1, Annex 1, Appendix 1 and 2.

8. On the recommendation of the technical consultation in Ottawa, a small subgroup of participants and some additional experts formed a technical working group of experts and convened in Geneva to finalize the technical specifications of the system.
9. Based on the detailed specifications developed through these two consultative processes, the Secretariat issued a detailed Invitation for Contributions inviting interested parties to contribute complete software systems or discrete components that could enhance the Influenza Virus Traceability Mechanism. The terms and conditions for responding and those governing the acceptance of contributions by the Secretariat are contained in the Invitation for Contributions.

### **ADVISORY GROUP**

10. The Director-General, in close consultation with Member States, appointed an Advisory Group of 18 members comprising internationally recognized policy makers, public health experts and technical experts in the field of influenza, and based on equitable representation of WHO regions and affected countries.
11. This Advisory Group advises the Director-General on strengthening the trust-based system needed to protect public health and undertake necessary monitoring and assessment of the system. The Advisory Group has met twice. At its first meeting (Geneva, 21 October 2008), it drafted provisional terms of reference and considered progress made on the development of the Influenza Virus Traceability Mechanism, notably through the report of the two members of the Advisory Group who attended the Ottawa technical consultation (see paragraph 7). In its second meeting (5 March 2009), the Advisory Group discussed the four preparatory documents to be submitted to the Intergovernmental Meeting at its resumed session in May and provided comments on them to the Secretariat.

### **INTERNATIONAL STOCKPILE OF H5N1 INFLUENZA VACCINES**

12. Pursuant to resolution WHA60.28, the Secretariat undertook work towards establishing an international stockpile of vaccines for H5N1 or other influenza viruses of pandemic potential. In collaboration with a consulting group funded by the Bill & Melinda Gates Foundation, WHO developed several options for the stockpile, including the associated costs and possible financing mechanisms. A detailed report on the findings was released in February 2009.<sup>5</sup>

<sup>5</sup> [http://www.who.int/csr/disease/influenza/H5N1\\_Stockpile\\_Design\\_Feb2009.pdf](http://www.who.int/csr/disease/influenza/H5N1_Stockpile_Design_Feb2009.pdf).

13. During a meeting of experts and Member State representatives (Geneva, 4 March 2009), technical options for the design and financing of the international stockpile were discussed. Based on expert guidance, as well as the evidence and findings contained in the report,<sup>5</sup> the Director-General considers that the optimal configuration for the international stockpile of H5N1 vaccines is as follows:
- a short-term (three-to-five years) physical stockpile of donated vaccines that does not require replenishment
  - vaccine to be held in filled doses with ancillary supplies
  - the stockpile to be located in up to three cities, selected according to cost implications and other criteria which include, but are not limited to:
    - international air and cargo hubs (reliability of airport facilities and services in times of crisis)
    - geographical/regional balance
    - commitment of host country to ensure access and facilitate international deployment
    - demonstrated logistics infrastructure capacity (e.g. storage, handling and maintenance).

The estimated present value cost of this option is US\$ 70 million. The Director-General will consult with potential donors to secure in-kind and other donations to meet this estimated cost.

14. WHO will look to the guidance of the WHO Strategic Advisory Group of Experts on immunization and the specialized working group on H5N1 vaccines in order to consider and provide further recommendations on the use of H5N1 influenza vaccines in high-risk and priority groups (as defined in country plans) and the use of H5N1 vaccine that has been stockpiled but is reaching the end of its shelf-life. Meetings of the Strategic Advisory Group of Experts on immunization and its working group are scheduled for April 2009.

## **STRENGTHENING SURVEILLANCE AT THE ANIMAL–HUMAN INTERFACE**

15. Collaboration between FAO, WHO, UNICEF and OIE is continuing, as exemplified by the Global Early Warning System for Major Animal Diseases, the Global Framework for Transboundary Animal Diseases, discussion related to the Mediterranean Zoonoses Control Programme, a recent jointly sponsored scientific meeting that brought together animal and human influenza scientists, and the Canadian International Development Agency-funded tripartite

programmes on avian influenza. This collaboration has been strengthened as a result of joint responses to H5N1 disease in poultry and humans. There is now an acceptance that, in order to maintain the momentum in the response to H5N1 infection and increased preparedness for a pandemic of influenza, there should be a framework to enable a response to diseases at the human–animal interface, which includes human public health, and domestic and wildlife animal health using the concept of “One World, One Health” from the Wildlife Conservation Society 2004. A strategic framework for “One World, One Health” was presented to the Ministerial Meeting on Avian and Pandemic Influenza (Sharm-el-Sheikh, Egypt, 25–26 October 2008) by FAO, WHO, UNICEF, OIE, the World Bank and the United Nations System Influenza Coordinator. The success of the current response to avian influenza will help to promote a sustained response to avian influenza and other diseases which have a profound effect on human and animal health and the health of communities and economies.

16. The Executive Board at its 124th session noted an earlier version of this report.<sup>6</sup>

#### **ACTION BY THE HEALTH ASSEMBLY**

17. The Health Assembly is invited to note this report.

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<sup>6</sup> See document EB124/2009/REC/3, summary record of the first meeting, section 7.

## For more information:

### WHO Websites:

- Avian 'Flu: [http://www.who.int/csr/disease/avian\\_influenza/en/index.html](http://www.who.int/csr/disease/avian_influenza/en/index.html)
- Influenza, generally: <http://www.who.int/topics/influenza/en/>
- FluNet: <http://gamapserver.who.int/GlobalAtlas/home.asp>
- GOARN: <http://www.who.int/csr/outbreaknetwork/en/>
- WHO EURO, Avian Influenza: [http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=avian\\_influenza](http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=avian_influenza)
- WHO EURO, Influenza (generally): <http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=influenza>
- Influenza Virus Tracking System: [http://www.who.int/fluvirus\\_tracker](http://www.who.int/fluvirus_tracker)

### Non-WHO Websites:

- ECDC, Avian Influenza: [http://ecdc.europa.eu/Health\\_topics/Avian\\_Influenza/Avian\\_Influenza.html](http://ecdc.europa.eu/Health_topics/Avian_Influenza/Avian_Influenza.html)
- ECDC, Influenza (generally): [http://ecdc.europa.eu/Health\\_topics/influenza/Index.html](http://ecdc.europa.eu/Health_topics/influenza/Index.html)
- ECDC, Pandemic Influenza: [http://ecdc.europa.eu/Health\\_topics/Pandemic\\_Influenza/Pandemic\\_Influenza.html](http://ecdc.europa.eu/Health_topics/Pandemic_Influenza/Pandemic_Influenza.html)

## 12.2 Implementation of the International Health Regulations (2005)

### Extracts from Document A62/6 (Report by the Secretariat):

1. In resolution WHA61.2, the Health Assembly decided that States Parties to the International Health Regulations (2005) and the Director-General would report annually to the Health Assembly on the implementation of the Regulations. It further decided that the first review and evaluation of the functioning of the decision instrument described in Annex 2 of the Regulations would be submitted to the Sixty-second World Health Assembly.
2. This report describes activities undertaken since the report submitted to the Health Assembly in May 2008,<sup>7</sup> and is structured in line with the “areas of work for implementation” established in 2007.<sup>8</sup> It also summarizes information received by WHO regarding implementation activities carried out by States Parties for the period 15 June 2007 to March 2009. The Executive Board took note of an earlier version of this report at its 124<sup>th</sup> session in January 2009.<sup>9</sup>
3. In order to facilitate States Parties’ reporting to the Health Assembly, in accordance with Article 54.1 of the Regulations, the Secretariat prepared a questionnaire, which was circulated in February 2008, requesting information on progress achieved in implementation of the Regulations since their entry into force on 15 June 2007. The Secretariat summarized the information received from the 144 States Parties that responded and sent that report to National IHR Focal Points in October 2008. Nearly all respondents (97%) provided full contact details of the national focal point, and most (89%) reported establishment of a means to provide continuous coverage for urgent communications with WHO. The responses indicated that communication channels between the national focal points and other relevant national authorities had been established by 83% of reporting Parties, with the agriculture ministry being the most frequently cited as collaborators. The competent authorities for the application of health measures at points of entry had been identified by 80% of respondents. Nearly three quarters (73%) of Parties reported having taken action to promote the awareness and understanding of the Regulations. At the time of reporting, 21% of Parties’ countries indicated that they had examined the possible need for

<sup>7</sup> Document A61/7.

<sup>8</sup> Document WHO/CDS/EPR/IHR/2007.1.

<sup>9</sup> Document EB123/2009/REC/2, summary record of the first meeting, section 7.

additional financial resources in order to implement adequately the requirements of the Regulations. Some 68% of respondents expressed an intention to adapt existing national legislation to meet their obligations, and 58% reported their participation in regional arrangements that explicitly covered implementation of the Regulations.

4. In order to update this information for the Sixty-second World Health Assembly a further questionnaire was sent to National IHR Focal Points in early February 2009 for completion online, by e-mail or in hard copy. Preliminary analysis based on the responses from 82 States Parties in all WHO regions that were received by the submission deadline shows that National IHR Focal Points continue to establish cross-sectoral links (100%) and that, in addition to the health sector, the food safety (91%) and agriculture, fisheries and animal health (82%) sectors are the most frequently cited collaborators. All 82 States Parties indicated that activities had been undertaken to promote awareness of the requirements of the Regulations with policy- and decision-makers being the most frequently identified target of such activity (83%) after health sector personnel (91%). Other primary targets for these activities are personnel in the food safety sector (80%) and those involved in emergency preparedness (76%). The limited number of responses available at the time of submitting this report, however, renders any detailed comparison between the 2008 results and this latest update uncertain. The Secretariat will continue to solicit additional responses and provide a fuller analysis on that basis. In 2009 the Secretariat plans to establish a new web-based system for States Parties to report progress in implementation. Such a system will also facilitate the Secretariat's annual reporting to the Health Assembly by allowing the extraction of key indicators status in a timely way, without having to rely on repeated completion of questionnaires.

## GLOBAL PARTNERSHIP

5. The Secretariat continues to produce multilingual online training packages for all staff and national health authorities. These packages contain, inter alia, general knowledge about the Regulations and a more specific training module on event assessment and notification using the decision instrument. Another is being developed on adjustments of national legislation appropriate for full and efficient implementation. The second edition of the Regulations, published in English in 2008, includes Annex 9 as revised by ICAO<sup>10</sup> in 2007, and appendices containing

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<sup>10</sup> Document A61/7.

a list of States Parties and their reservations and other communications to WHO. The other five language versions were published in January 2009 and all are available on the WHO web site.

6. WHO maintains close working relationships with other organizations of the United Nations system and international agencies and other entities, including the Cruise Lines International Association, the International Association of Independent Tanker Owners and European Centre for Disease Prevention and Control. WHO also continues to rely heavily on its technical partners<sup>6</sup> including those in the Global Outbreak Alert and Response Network. Efforts to encourage the donor community and development agencies to support implementation are being made with regard to the strengthening of national surveillance and response capacities, as set out in Annex 1 of the Regulations. Regional organizations such as the Asian Development Bank, the European Union and MERCOSUR (the Common Market of the South) have been powerful allies in this endeavour. Roles for finance and commerce ministries and for central banks in support of implementation continue to be explored.

## **STRENGTHENING NATIONAL CAPACITY**

7. Regarding national capacities in disease surveillance and response, the Secretariat, through its regional and country offices, continues to adapt WHO's regional strategies for national disease surveillance and response systems to the requirements of the Regulations. The WHO Lyon Office for National Epidemic Preparedness and Response continues to provide technical assistance for the assessment of existing national structure and resources, the development of regional surveillance networks, and the promotion of laboratory quality systems. It also supports training in field epidemiology and risk communications.
8. Special attention has been given to the importance of good laboratory practices and quality management for the most vulnerable health systems. Microbiology External Quality Assessment programmes for epidemic-prone diseases were continued for 76 reference laboratories in 46 countries in the African Region and 21 countries in the Eastern Mediterranean Region. Thirteen twinning projects were established between resource-limited laboratories and specialized institutions throughout WHO's six regions. Laboratory biosafety training programmes and laboratory certification for transport of infectious substances also form part of WHO's efforts to bring the laboratory back to the core of national surveillance

systems. Programmes in this area have been set up in the African, South-East Asia and Western Pacific Regions.

9. For further improvement of global influenza preparedness, WHO has continued to strengthen national and regional capacities in influenza laboratory diagnosis, surveillance, preparedness and response by working with three countries on the formal designation of three new WHO Influenza Collaborating Centres, by supporting the designation and setting-up of seven new national influenza centres since November 2007, and by supporting stronger quality assurance and training activities. The continuation of the WHO External Quality Assessment project for the detection of influenza subtype A viruses using the polymerase chain reaction was followed by distribution of two proficiency testing panels every year to all National Influenza Centres and other national influenza laboratories with capacity to use the polymerase chain reaction test. Tailored training as follow-up to the WHO External Quality Assessment project was organized for national influenza centres in Asia, Africa and the Middle East. In addition, further training sessions to increase influenza laboratory capacity will be organized for African countries later in 2009. In the past two years, training workshops for safe handling of infectious substances under ICAO regulations were held in all six WHO regions. For the past several years, WHO Collaborating Centres for reference and research on influenza have been updating and distributing influenza diagnostic reagents for surveillance to national influenza centres at no cost.
10. The Secretariat has supported States Parties in assessing and strengthening capacities at designated international airports, ports and ground crossings, in accordance with Annex 1 of the Regulations, and has also been supporting the implementation of the requirements of the Regulations concerning ship inspection and the issuance of Ship Sanitation Certificates. As of 1 March 2009, more than 1640 ports have been listed as authorized to issue Ship Sanitation Certificates by 69 countries in all WHO regions. Joint initiatives were prepared as part of the Cooperative Agreement for Preventing the Spread of Communicable Diseases through Air Travel, under the leadership of ICAO. Following a series of expert consultations and workshops, with over 500 participants from 87 countries in all WHO regions, several technical documents were developed, existing guidelines were updated, and new technical guidelines are in preparation for the certification of ports, airports and ground crossings. The workshops provided

the opportunity to validate and introduce new tools for implementation of the Regulations at global level.

## **PREVENTION AND RESPONSE TO INTERNATIONAL PUBLIC HEALTH EMERGENCIES**

11. The networks of National IHR Focal Points and WHO IHR Contact Points continue to be used effectively for rapid communication of public health information between WHO and States Parties. WHO has maintained and tested the accessibility and effectiveness of its Regulations Contact Points in all six regional offices. The number of users with access to the IHR Event Information Site has continued to grow; the current number of accounts is 638, representing 157 States Parties.
12. On 11 and 12 June 2008, WHO tested its alert and response procedures worldwide through the Public Health Security Exercise, which helped to identify opportunities for improvement in detecting and responding to potential or real international public health emergencies. Although the processing and consolidation of information proved to be challenging, a flow of crucial public health information was quickly established and sustained between the Secretariat (headquarters, regional offices and country offices) and participating Member States. Case definitions for the four notifiable diseases in the Regulations were posted on the WHO web site together with the WHO Interim Guidance for the use of the decision instrument. This guidance document builds on input from experts and WHO staff members experienced in the development and application of the decision instrument in Annex 2 of the Regulations. The document is designed primarily for National IHR Focal Points and for others responsible for assessing the need to notify WHO of events under the Regulations and includes case scenarios illustrating the application of the assessment criteria. An expert consultation (Geneva, 20–22 October 2008), which was attended by experts from 13 States Parties and all six regional offices, provided advice on further refining the interim guidance (which is due to be made available later in 2009) and recommended methodologies for the review and evaluation of the functioning of Annex 2. In addition to two quantitative and one qualitative analyses, a study of WHO databases was recommended as a first step.
13. In line with a recommendation from the expert consultation, the Secretariat reviewed communications, assessments and outcomes of public health

events that were reported to, or identified for follow-up by, the Organization. The main source of data used was the Event Management System which has been implemented at WHO headquarters for several years and more recently introduced into some regional offices. All events entered into the System between the entry into force of Regulations on 15 June 2007 and 31 December 2008 were reviewed and the regional offices validated the data, through for example identification of additional events and filling in gaps where information in the System was missing. Of the 684 events included in the study the National IHR Focal Point was positively identified as the initial information source in 133 (19%) and official government sources in a further 64 (9%). Of the 133 events whose initial report was from a National IHR Focal Point there was evidence that Annex 2 of the Regulations had been used in the assessment of the event on 44 occasions (33%). In 95 of the reports from National IHR Focal Points (71%) the nature of the report under the Regulations (i.e. notification, information-sharing, consultation or other report) was not specified, and only 14 (11%) were identified specifically as notifications under the Regulations. These results indicate that the National IHR Focal Points are not yet a major source of early information to WHO on events and there is no evidence to confirm that Annex 2 of the Regulations is being frequently or routinely used in the assessment of events. This analysis throws a limited amount of light on the use being made of Annex 2 by States Parties; the Event Management System is an operational tool and not intended to collect information of the type needed to understand the extent of current use, and any barriers to more extensive use, of the decision instrument. The findings emphasize the importance of the further studies recommended by the expert consultation, so that actions to improve the use of Annex 2 can be designed and targeted appropriately and the early flow of information to WHO on events facilitated.

14. The application of the Regulations to the management of specific health risks continues to be analysed in relation to the undiminished threat posed by current outbreaks of avian influenza in poultry, human infections with avian influenza viruses and the preparations for a possible influenza pandemic. WHO has convened a series of global consultations to update guidance on pandemic influenza preparedness and response. This new advice will be disseminated to Member States and other stakeholders shortly.
15. During the period under review, WHO has responded to significant public health events in accordance with the Regulations, including cases of lead intoxication

in children and the new and widespread global resistance to the antiviral agent oseltamivir among seasonal influenza viruses A (H1N1). In the related area of chemical and radiological public health risks, WHO has ensured that its threat-specific networks, such as the Radiation Emergency Medical Preparedness and Assistance Network, ChemiNet (WHO Global Chemical Incident Alert and Response Network), the poisons centre network and BioDoseNet (the Global Biodosimetry Network), are fully aware of both the requirements of the Regulations and their roles in improving national surveillance capacities and in assisting in international alert, assessment and response. WHO has conducted surveillance and assessment of chemical-related outbreaks, provided technical support to countries facing chemical emergencies, and organized emergency response missions, for example to deal with an outbreak of illness of unknown etiology (later identified as due to ingestion of sodium bromide) and mass lead poisoning in children. WHO has used its recently developed common platform for alert and response to potential public health emergencies to participate in the international nuclear emergency exercise held in 2008 (one of several such exercises periodically organized and coordinated by IAEA), named “ConvEx-3”. An expert consultation on yellow fever and international travel was organized (Geneva, 4 and 5 September 2008) to review the criteria for inclusion of countries and/or areas in, or their removal from, the list of those with yellow fever transmission, in accordance with Annex 7 of the Regulations. Participants also reviewed the criteria for determining the list of countries or areas with yellow fever transmission for which WHO might recommend vector-control measures for departing conveyances, as set out in Annex 5 of the Regulations. On the recommendation of the consultation, an informal working group of experts on country-specific mapping of yellow fever risk has been set up. Finally, a separate report on food safety has been submitted to the Health Assembly.<sup>11</sup>

## LEGAL ISSUES AND MONITORING

16. In accordance with requirements of the Regulations, the Director-General has appointed 56 experts nominated by States Parties to serve on the Roster of Experts in 21 subject areas, and she has proposed an additional 117 experts. Administrative procedures have been developed so that the Secretariat can meet requirements during a public health emergency of international concern.

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<sup>11</sup> Document A62/21.

Advice and information on the Regulations and other implementation issues are continuously provided within WHO, to States Parties and to competent intergovernmental organizations or international bodies.

17. The Secretariat monitors the progress of States Parties in establishing National IHR Focal Points, their communications and their access to the Event Information Site. The preparation of specific indicators to monitor national progress in strengthening core capacities set out in Annex 1 of the Regulations has reached its final stages.

## **REGIONAL ACTIVITIES**

18. Provision of support to States Parties by WHO's regional and country offices has increased. Activities to raise awareness in health and other governmental sectors in countries have been carried out. Relying heavily on existing regional strategies and technical partners, workshops on the Regulations, meetings and field visits, including in the area of capacity strengthening at points of entry (international ports, airports and ground crossings), have been organized in all WHO regions.
19. In addition to WHO's IHR Contact Points being available on a continuous basis at regional level for urgent communications with National IHR Focal Points, all WHO regional offices have set up emergency operation rooms with greatly improved communication facilities. All were tested during the Public Health Security Exercise.
20. Key issues in implementation include the need to continue to increase awareness by national and regional stakeholders. Regional offices have identified a need for greater focus in the mobilization of resources and the role of disease-specific programmes in contributing to generic capacity strengthening.

## **ACTION BY THE HEALTH ASSEMBLY**

21. The Health Assembly is invited to take note of this report.

## For more information:

### WHO Websites:

- IHR (2005): [http://www.who.int/topics/international\\_health\\_regulations/en/](http://www.who.int/topics/international_health_regulations/en/)
- Globalization, trade and health: <http://www.who.int/trade/en/>
- International travel and health: <http://www.who.int/ith/en/>
- Full text of IHR (2005): [http://www.who.int/csr/ihr/IHRWHA58\\_3-en.pdf](http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf)
- Public health passenger locator card: [http://www.who.int/csr/ihr/locator\\_card/en/index.html](http://www.who.int/csr/ihr/locator_card/en/index.html)

### Non-WHO Websites:

- UK Health Protection Agency: <http://www.hpa.org.uk/hpa/international/IHR.htm>
- US Centers for Disease Control & Prevention: <http://www.cdc.gov/cogh/ihrregulations.htm>
- US Dept of Health & Human Services: <http://www.globalhealth.gov/ihr/>

## \*12.3 Prevention of avoidable blindness and visual impairment

### Extracts from Document A62/7 (Report by the Secretariat):

1. The Fifty-ninth World Health Assembly, in resolution WHA59.25 on elimination of avoidable blindness, requested the Director-General “to monitor progress in the Global Initiative for the Elimination of Avoidable Blindness in collaboration with international partners, and to report to the Executive Board every three years”. During the Sixty-first World Health Assembly, the Secretariat was asked to prepare an action plan for the prevention of avoidable blindness, in the context of the action plan for the global strategy for the prevention and control of noncommunicable disease, for submission to the Executive Board.<sup>12</sup>
2. The Secretariat drafted the action plan after consultation with Member States and international partners. It was published on the WHO web site on 19 September 2008 for public review and comment. Representatives of Permanent Missions to the United Nations Office and other International Organizations in Geneva, also invited to review and comment, gave positive and constructive feedback at an informal consultation (Geneva, 3 October 2008).
3. The Executive Board, at its 124th session in January 2009, considered an earlier version of this report and the draft action plan. The Board endorsed the draft action plan subject to the amendments proposed by members. The Board also asked that the draft action plan be forwarded to the Health Assembly for its consideration.<sup>13</sup>
4. The draft action plan (see Annex) sets out current experience, draws on the recognized achievements and deals with gaps in implementing activities over the past decades. It was designed to provide ways of achieving the Organization-wide expected results for prevention of blindness set out in the Medium-term strategic plan 2008–2013 by expanding the work of Member States, the Secretariat and international partners through development of comprehensive eye-health programmes at national and subnational levels. It has five objectives, with three sets of recommendations for action under each objective for Member States, the Secretariat and international partners. Its time span covers the remaining period of the Medium-term strategic plan, i.e. 2009–2013. Since blinding conditions are chronic and mostly due to noncommunicable causes,

<sup>12</sup> Document WHA61/2008/REC/3, summary record of the eighth meeting of Committee A.

<sup>13</sup> Document EB124/2009/REC/2, summary record of the third and fourth meetings.

this plan complements the action plan for the global strategy for the prevention and control of noncommunicable diseases, endorsed by the Health Assembly in resolution WHA61.14.

## **ACTION BY THE HEALTH ASSEMBLY**

5. The Health Assembly is invited to consider the following draft resolution:

The Sixty-second World Health Assembly,

Having considered the report and draft action plan on the prevention of avoidable blindness and visual impairment;<sup>14</sup>

Recalling resolutions WHA56.26 on elimination of avoidable blindness and WHA59.25 on prevention of avoidable blindness and visual impairment;

Recognizing that the action plan for the prevention of avoidable blindness and visual impairment complements the action plan for the global strategy for the prevention and control of noncommunicable diseases endorsed by the Health Assembly in resolution WHA61.14,

1. ENDORSES the action plan for the prevention of avoidable blindness and visual impairment;
2. URGES Member States to implement the action plan for the prevention of avoidable blindness and visual impairment, in accordance with national priorities;
3. REQUESTS the Director-General:
  - (1) to provide support to Member States in implementing the proposed actions for the prevention of blindness and visual impairment action plan, in accordance with national priorities;
  - (2) to continue to give priority to the prevention of avoidable blindness and visual impairment, within the framework of the Medium-term strategic plan 2008–2013 and the programme budgets in order to strengthen capacity of the Member States and increase technical capacity of the Secretariat;
  - (3) to report to the Sixty-fifth and Sixty-seventh World Health Assemblies, through the Executive Board, on progress in implementing the action plan for the prevention of avoidable blindness and visual impairment.

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<sup>14</sup> Document A62/7.

## For more information:

### WHO Websites:

- Health topics – blindness: <http://www.who.int/topics/blindness/en/>
- Chronic diseases and health promotion: <http://www.who.int/chp/en/index.html>
- African Programme for Onchocerciasis Control: <http://www.who.int/apoc/en/>
- Diabetes: <http://www.who.int/diabetes/en/>
- Prevention of Avoidable Blindness and Visual Impairment: <http://www.who.int/blindness/en/index.html>

### Non-WHO websites:

- Vision 2020: <http://www.v2020.org/>
- CBM International: [http://www.cbm.org/en/tree/CBM\\_EV\\_EN\\_baumbart\\_18450.html](http://www.cbm.org/en/tree/CBM_EV_EN_baumbart_18450.html)

## \*12.4 Primary Health care, including health system strengthening

### Extract from Document A62/8 (Report by the Secretariat):

1. There have been many calls for a renewal of primary health care at several international, regional, and national conferences organized by, or in collaboration with, WHO,<sup>15</sup> and at 2008 regional committee meetings, coinciding with the 30th anniversary of the Declaration of Alma-Ata, which articulated the values of Health for All through primary health care, addressing both priority health needs and the fundamental determinants of health, so as to enable people to lead socially and economically productive lives, and thus drive overall development.
2. Member States, in their calls for a renewal of primary health care, have reaffirmed their commitment to the values of equity, solidarity and social justice, and the principles of multi-sectoral action and community participation. The calls represent the ambition to deal effectively with current and future challenges to health, mobilizing health professionals and lay people, government institutions and civil society around an agenda of transformation of health-system inequalities, service delivery organization, public policies, and development.
3. The health of the world's population has improved over the last 30 years and can be partly attributed to better nutrition, water supply, sanitation, housing, and education. Although some countries have shown sustained improvement in health outcomes, others have lagged behind or even experienced reversals. In part these differences can be attributed to socioeconomic, political and ecological constraints. However, low-income countries have found it difficult to cope with rising commodity prices, recession, structural adjustments programmes, political instability, civil strife, the emergence of HIV/AIDS, and others. But differences in health outcomes are also related to investment in health and financing, decentralization, human resource and other major health-sector policies.
4. There are important lessons in the successes and failures of the last 30 years: health systems do not automatically yield the optimal and most effective balance of promotion, prevention, cure and palliation; and they do not naturally move towards the production of enhanced and more equitable health outcomes, greater solidarity and social justice. Leadership and a sense of direction require

<sup>15</sup> Ottawa 1986, Ljubljana 1996, Jakarta 1997, Mexico 2004, Bangkok 2005, Buenos Aires 2007, Beijing 2007, Bangkok 2008, Jakarta 2008, Tallinn 2008, Ouagadougou 2008, Doha 2008.

sustained commitment and an approach embedded in, and a driver of, overall development.

5. Health authorities in many countries are aware that progress towards improved health outcomes, including, but not limited to, the Millennium Development Goals, is too slow and unequal, that performance does not meet expectations, and that they are ill-prepared to respond to challenges and demands. Many recognize the potential of primary health care for providing a stronger sense of direction and unity in segmented and fragmented health systems, and for providing the framework that integrates health into all policies.
6. This dissatisfaction is echoed by international agencies, global health initiatives, donors, and civil society organizations. Consequently, global stakeholders are increasingly recognizing the need for improved health-systems performance based on the values of primary health care.
7. Further support has come from two reports published in 2008. The report of the Commission on Social Determinants of Health<sup>16</sup> documented widening gaps in health outcomes, both within and between countries, and challenged governments to make equity an explicit policy objective in all government sectors. The Commission's analysis of underlying social, economic, and political causes of ill health, and of the methods most likely to provide solutions, makes a convincing case for, and endorses, a renewed focus on primary health care.
8. In addition, The world health report 2008<sup>17</sup> noted that, in rich and in poor countries alike, a health sector organized according to the tenets of primary health care had the greatest potential for producing better health outcomes, improving health equity and responding to social expectations. The report identifies the key areas where policy change is required in order to ensure that health systems are based on the values and principles of primary health care.

## THE HEALTH CHALLENGES

9. There are differences not only in health outcomes between countries, but also national inequalities in access, coverage and expenditure.

<sup>16</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

<sup>17</sup> World Health Organization. *The world health report 2008: Primary health care, now more than ever*. Geneva, World Health Organization, 2008.

10. Rising social expectations regarding health and health care, fuelled by modernization, greater access to information and improved health literacy, are driving demand for more people-centred access, better community health protection and more effective participation in decisions that affect health. There is pressure on policy makers and political leaders to steer their health systems towards health equity, social justice and solidarity.
11. There are unprecedented opportunities to do so. In recent years, countries have gained experience and knowledge; there is the mutually reinforcing demand for change from populations, policy makers and the global health community; and, as indicated by the Report of the Secretariat regarding monitoring of the achievement of the health-related Millennium Development Goals,<sup>18</sup> there is a growing consensus that health will not improve without functioning health systems, that health systems function best when they are based on primary health care, and that there is an opportunity to align more fully the agenda for responding to specific diseases with the agenda for strengthening health systems. The rapid expansion and growing economic and social weight of the health sector – a long-term trend across the world, with the exception of fragile States – provides leverage to obtain the policy changes that primary health care requires.

## AN AGENDA FOR ACTION

12. There are four broad policy areas for essential changes: dealing with health inequalities by moving towards universal coverage; putting people at the centre of service delivery; integrating health into public policies across sectors; and providing inclusive leadership for health governance.
13. The changes rely on the alignment of the different components or building blocks of health systems, i.e. the health workforce; the health information system; the systems to provide access to medical products, vaccines, and technologies; the financing system; and leadership and governance, and on the way they jointly translate health-sector inputs into overall outcomes.<sup>19</sup>
14. The policies must be shaped by the Member States themselves, and tailored to the specificities of each country. The global health community must also use its power of mobilization and influence to facilitate the renewal.

<sup>18</sup> Document EB124/10.

<sup>19</sup> World Health Organization. *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva, World Health Organization, 2007.

15. **Dealing with health inequalities by moving towards universal coverage.** This means moving towards a sufficient supply of service networks (inclusive of the human resources, infrastructure, resources, management and steering required), where financial and other barriers to access are removed, and where families are protected against the financial consequences and impoverishment that may result from seeking care. Moving towards universal coverage constitutes the core strategy to ensure that health systems contribute to health equity, social justice, and the elimination of exclusion. It does not, however, eliminate the need for tackling the social determinants of health inequalities, through a whole-of-society approach as recommended by the Commission on Social Determinants, nor does it preclude the need for efforts at reaching the unreached or for systematic monitoring and documentation of health inequalities and exclusion.
16. Depending on the national context, a step-by-step progression towards universal coverage requires a combination of (i) the extension of health-care networks where they are not available; (ii) the shift from reliance on user fees levied on the sick to the solidarity and protection provided by pooling and prepayment; and (iii) the development of mechanisms of social health protection. In high- as well as in low-income countries, present levels and trends of domestic expenditure on health could allow for a greater degree of universality.
17. In many countries, purchase of an essential set of health interventions for all is beyond national capacity. Increased external financial assistance for health will be required for some years to come, including through innovative mechanisms. Scepticism about aid effectiveness has been replaced by recognition of the need for donors to direct financial flows towards country-led priorities and initiatives in ways that strengthen existing infrastructures, reduce fragmentation and duplication, and minimize transaction costs. Channelling aid in ways that build up the institutional capacity to manage the financing of the system can accelerate the extension of service networks together with the development of social health protection. This would improve synergies between external and domestic funding: the visibility and strategic importance of external funding should not obscure the fact that more than 75% of health expenditure in the average low-income country comes from domestic sources.
18. The move towards universal coverage also remains an unfinished agenda in high-income countries, where cost containment is having a serious effect on equity of treatment.

19. **Putting people at the centre of service delivery.** Health services must pay far more attention to putting the patient first, and to continuity and integration of care. The organization of a comprehensive continuum of care along the life-cycle is particularly important, encompassing the full range of health actions, from prevention and promotion to curative and palliative care. The public, private-for-profit, or private-not-for-profit nature of health care delivery is far less critical than the degree to which services, in each context, can be organized so as to present these actions.
20. To ensure that services deliver appropriate care, they have to be designed and organized around close-to-client networks of primary care teams, with the responsibility for the health of a defined population, and with the capacities to coordinate the inputs of hospitals, specialists, and other services (including supplies and logistics) that can contribute to the health of that population. In many countries, health districts are an appropriate planning unit for organizing service delivery in line with these principles.
21. The health-care delivery landscape has become far more complex over the last decades. Along with governmental services, the offer of care now generally includes a range of providers, governmental and nongovernmental, for-profit and not-for-profit, and a range of services, including traditional medicine. This variety can add value to service delivery, provided its responsiveness to the variety of problems and expectations and its entrepreneurial dynamism is harnessed to contribute to improved health and health equity, and mechanisms are in place to ensure safety and consumer protection.
22. There are currently new opportunities for countries to take advantage of recent reviews of experience with different, context-sensitive approaches to the integration of traditional and conventional medicine, building on that accumulated knowledge to contribute to the necessary reorientation of health care delivery towards people-centred primary care.
23. Putting people at the centre of service delivery is not merely a question of designing the appropriate service delivery models. The improvement of basic health infrastructures, services and the workforce requires long-term commitment and investment. Given the critical shortage of health workers and the immediate impact on health, investment in the health workforce, including through professional associations and training institutions, is decisive, in high- as well as in low-income countries.

24. **Multisectoral action and health in all policies.** The deliberations of the regional committees, the Report of the Commission on Social Determinants of Health and *The world health report 2008* have reiterated the need to step up efforts to improve health by acting on wider social, economic, and environmental causes of ill health and health inequalities.
25. Better public policies, within and beyond the health sector, represent a huge untapped potential to improve health. Public health interventions, from public hygiene and disease prevention to health promotion and the establishment of a rapid response capacity are of critical importance for health outcomes and for securing and sustaining public trust in the health system.
26. Public authorities, across all government sectors, must also assume their responsibilities for ensuring that health considerations are given their rightful place in the deliberations on other policy domains, such as gender equality, consumer protection or labour policies. Health authorities must create the conditions under which other sectors can incorporate health considerations within their policies and outcomes. Health impact assessments offer promising avenues for more concrete multisectoral policy dialogue.
27. **Inclusive leadership and effective government for health.** In many countries there is a need for substantial reinvestment in country capacity to govern the health sector. The enhanced responsibilities must be accompanied by new forms of leadership for health, particularly in a context where political and administrative decentralization offers both challenges and opportunities.
28. While each Member State has its own way of governing its health system, health ministries have the ultimate responsibility for health-system development. However, given the complexity of the health sector, the responsibility has to be exercised through collaborative models of policy dialogue with multiple stakeholders, from professional organizations to United Nations agencies, from development banks to civil society, from women's and youth groups to networks of patients.
29. These new ways of operating will require reinvestment commensurate with the growth and weight of the health sector in society, in leadership capacities, in the gathering and use of information, and in knowledge and research. There is a clear need for building more effective, more proactive and more collaborative ways of governing the health sector.

30. An earlier version of this report was considered by the Executive Board at its 124<sup>th</sup> session in January 2009.

#### **ACTION BY THE HEALTH ASSEMBLY**

31. The Health Assembly is invited to consider the draft resolutions contained in resolutions EB124.R8 and EB124.R9.



## **WHPA intervention on EB 124, agenda item 4.5 Primary Health Care, including health system strengthening**

Thank you for the opportunity to speak on behalf of the World Medical Association, the International Council of Nurses, the International Pharmaceutical Federation and the World Dental Federation, which form together the World Health Professional Alliance - WHPA. The Alliance represents national associations in more than 150 countries, and the collective views of more than 25 million health professionals, working together to achieve the highest possible standards of care, ethics, education and health-related human rights for all people.

We welcome the report by the secretariat on primary health care, including health system strengthening and support the agenda for action addressing health inequalities through non-universal coverage and the demand for people-centred care approach. While the report stresses the importance of the comprehensive development of health care systems for the provision of health care to people, we would like to call your attention to the importance of well functioning health care systems for economic development. Not only is the promotion and protection of the health of the people essential to sustained economic and social development and contributes to a better quality of life and to world peace, additionally have the health care sectors meanwhile developed to major if not largest sectors of national economies.

Beyond the humanitarian dimension and beyond the importance for the productivity of the people in many successful economies, health care systems are the dynamic pillars of the economic system.

Building health care systems around primary care and considering that as the core of a comprehensive health system approach is a meaningful and rational strategy. We welcome the new strategy: it will help to deliver proper treatment to severely ill patients, it will also provide new perspectives for health care professionals in their home countries and it will strengthen economic and social development.

Primary health care forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. Primary care brings health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Therefore we welcome that WHO now sees primary health care as sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need. We see primary health care as a policy direction for all countries at all levels of development.

In conclusion, the Alliance would like to emphasise the need to broaden the strategic directions and priorities of the report. Providing universal care will truly only be possible when health care systems are built up as comprehensive system founded on strong primary care structures but not limited to it. This will give all severely ill patients a chance for treatment; it will retain and attract health professionals and is the basis for a sustainable economic development.

## RESOLUTION 12.4: Primary health care, including health system strengthening

### Extract from Executive Board Resolution, EB124.R8:

The Executive Board, having considered the report on primary health care, including health system strengthening, RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Welcoming the efforts of the Director-General, and recognizing the central role that WHO plays, in promoting primary health care globally;

Having considered the report on primary health care, including health system strengthening;

Recalling the Declaration of Alma-Ata (1978), the Ottawa Charter for Health Promotion (1986), the United Nations Millennium Declaration (2000) and subsequent relevant resolutions of WHO's regional committees and Health Assemblies;<sup>20</sup>

Recalling also the discussions at the series of summits and global, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;<sup>21</sup>

Noting the growing consensus in the global health community that vertical approaches, such as disease-specific programmes, and integrated health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

Recognizing the need to draw on the experiences, both positive and negative, of primary health care in the years since the Declaration of Alma-Ata and the Millennium Declaration;

<sup>20</sup> Resolutions WHA54.13, WHA56.6, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.24, WHA60.27, WHA61.17 and WHA61.18.

<sup>21</sup> Including summits on health system strengthening, such as the G8 Hokkaido Toyako Summit (2008), International Conference on Global Action for Health System Strengthening (Tokyo, 2008), International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration of WHO/UNICEF on primary health care (Almaty, 2008), Latin American Social Summit (2006) and G15 Summit (2004); WHO regional meetings on primary health care, such as those at Buenos Aires (2007), Beijing (2007), Bangkok (2008), Tallinn (2008), Ouagadougou (2008), Jakarta (2008) and Doha (2008); and conferences on health promotion, such as Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and the MERCOSUR Task Force on Health (since 1995).

Welcoming *The world health report 2008*,<sup>22</sup> published on the thirtieth anniversary of the international conference of Alma-Ata, that identifies four broad policy directions for reducing health inequalities and improving health for all: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health and also welcoming the Commission on Social Determinants of Health's final report;<sup>23</sup>

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and fully honour financing commitments made by national governments and their development partners, as appropriate, in order to better fill the resource gaps in the health sector;

Reaffirming also the need to take concrete, effective and timely action, in implementing all agreed commitments on aid effectiveness and to increase the predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening, more so given the potential effects on health and health systems of the current international financial and food crises and of climate change;

Strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action and community participation as the basis for strengthening health systems;

1. URGES Member States:

- (1) to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the Millennium Development Goals;
- (2) to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable and sustainable financing mechanisms, mindful of the need

<sup>22</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

<sup>23</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

to ensure social protection and protect health budgets in the context of the current international financial crisis;

- (3) to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health-care services, including health promotion, disease prevention, curative care and end-of-life services, that are integrated and coordinated according to need;
  - (4) to promote active participation by all people, in the processes of developing policy and improving health and health care, in order to support the renewal of primary health care;
  - (5) to train adequate numbers of health workers, able to work in a multidisciplinary context, in order to respond effectively to people's health needs;
  - (6) to ensure that vertical programmes, including disease-specific programmes, are developed and implemented in the context of integrated primary health care;
  - (7) to improve access to appropriate medicines, health products and technologies, all of which are required to support primary health care;
  - (8) to develop and strengthen health information and surveillance systems relating to primary health care in order to facilitate evidence-based policies and programmes and their evaluation;
  - (9) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to facilitate multisectoral action as part of primary health care;
2. REQUESTS the Director-General:
- (1) to ensure that WHO reflects the values and principles of the Declaration of Alma-Ata in its work and that the overall organizational efforts across all levels contribute to the renewal of primary health care;
  - (2) to strengthen the Secretariat's capacities to support Member States in their efforts to deliver on the four broad policy directions for renewal of primary health care identified in The world health report 2008;
  - (3) to collate and analyse past and current experiences of Member States in implementing primary health care and facilitate the exchange of experience, evidence and information on good practice;

- (4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;
- (5) to report to the Sixty-third World Health Assembly, and subsequently every two years to the World Health Assembly, through the Executive Board, on progress regarding this resolution, including reporting on the effectiveness of WHO in its support to countries in the implementation of primary health care.

## For more information:

### WHO Websites:

- Primary health care: [http://www.who.int/topics/primary\\_health\\_care/en](http://www.who.int/topics/primary_health_care/en)
- Health systems strengthening: <http://www.who.int/healthsystems/en/>
- World Health Report 2008: <http://www.who.int/whr/2008/en/index.html>
- AFRO Division of Health Systems and Services: <http://www.afro.who.int/dsd/index.html>
- PAHO Primary health care: <http://www.paho.org/english/dd/pin/almaata25.htm>
- SEARO Health System strengthening: <http://www.searo.who.int/en/Section1243/Section1255.htm>
- EURO Primary health care: [http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=primary\\_health\\_care](http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=primary_health_care)
- EMRO Health System Observatory: <http://gis.emro.who.int/healthsystemobservatory/main/Forms/main.aspx>
- EMRO Human Resources for Health: <http://www.emro.who.int/hrh-obs/>
- WPRO Primary health care: [http://www.wpro.who.int/health\\_topics/primary\\_health\\_care/](http://www.wpro.who.int/health_topics/primary_health_care/)
- Traditional medicine: [http://www.who.int/topics/traditional\\_medicine/en/](http://www.who.int/topics/traditional_medicine/en/)

### Non-WHO Websites:

- 5 by 2015: <http://www.15by2015.org/>

## \*12.5 Commission on Social Determinants of Health

### Extract from Document A62/9 (Report by Secretariat):

1. In his address to the Fifty-seventh World Health Assembly,<sup>24</sup> the late Director-General, Dr Lee Jong-wook, announced the creation of the Commission on Social Determinants of Health. The Commission, launched in March 2005, aimed to provide guidance to Member States and WHO's programmes by gathering evidence on social determinants and ways to overcome health inequities. This report outlines the recommendations of the Commission in its final report.<sup>25</sup>
2. The social determinants of health are defined as the structural determinants and conditions of daily life responsible for a major part of health inequities between and within countries. They include the distribution of power, income, goods and services, and the circumstances of people's lives, such as their access to health care, schools and education; their conditions of work and leisure; and the state of their housing and environment. The term "social determinants" is thus shorthand for the social, political, economic, environmental and cultural factors that greatly affect health status.
3. The Commission consisted of 19 members, chaired by Professor Sir Michael Marmot of University College, London.<sup>26</sup> Supported by the Secretariat, it convened four working groups on: work with Member States, work with civil society, global knowledge networks and work within WHO. Many Member States contributed to the work of the Commission with the aim of learning from and sharing experiences.
4. The Commission consulted with numerous civil society bodies in all regions, which contributed case studies and evidence for all the Commission's areas of work. A separate civil society report was also produced.<sup>27</sup> The Commission

<sup>24</sup> Document A57/3.

<sup>25</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

<sup>26</sup> The other members were: Professor Frances Baum (Australia), Dr Monique Bégin (Canada), Dr Giovanni Berlinguer (Italy), Ms Mirai Chatterjee (India), Dr William Foege (United States of America), Professor Yan Guo (China), Professor Kiyoshi Kurokawa (Japan), Dr Ricardo Lagos (Chile), Professor Alireza Marandi (Islamic Republic of Iran), Dr Pascoal Mocumbi (Mozambique), Dr Ndioro Ndiaye (Senegal), Ms Charity Ngilu (Kenya), Professor Hoda Rashad (Egypt), Professor Amartya Sen (India), Dr David Satcher (United States of America), Dr Anna Tibaijuka (United Republic of Tanzania), Professor Denny Vågerö (Sweden), Dr Gail Wilensky (United States of America).

<sup>27</sup> Civil Society Report to the Commission on Social Determinants of Health. Submitted to the Commission on Social Determinants of Health at its Ninth Meeting, Beijing, October 2007.

convened international experts on early child development, employment conditions, globalization, health systems, measurement and evidence, priority public health conditions, social exclusion, urban settings, and women and gender equity in nine global knowledge networks. The Secretariat was more directly involved in two of these knowledge networks. The WHO Kobe Centre hosted the Urban Settings Knowledge Network. The Secretariat also hosted the Priority Public Health Conditions Knowledge Network, which coordinated analyses of social determinants of major public health conditions.

5. The Commission met 10 times, in Brazil, Canada, Chile, China, Egypt, India, Islamic Republic of Iran, Japan, Kenya and Switzerland. Regional consultations also took place in each of the WHO regions. In addition, each working group convened numerous meetings and consultations.
6. The Executive Board was briefed at its 115<sup>th</sup> and 120<sup>th</sup> sessions,<sup>28</sup> and at its 124<sup>th</sup> session considered the matter in the light of the Commission's final report.<sup>29</sup>

## KEY FINDINGS AND RECOMMENDATIONS

7. Health inequities are increasing both within and between countries. A gap in life expectancy of more than 40 years exists between the richest and poorest countries. Moreover, gross inequities in health status divide different groups of people within all countries, regardless of income. In high-income countries, life expectancy gaps of more than a decade exist between different groups according to such factors as ethnicity, gender, socioeconomic status and geographical area. Low-income countries in all regions show marked differences in child mortality according to level of household wealth.
8. Such health inequities are not inevitable. Instead, they mostly point to policy failure, reflecting inequities in daily living conditions and in access to power, resources, and participation in society.
9. Social determinants must be addressed in order to achieve many disease-specific targets, including the health-related Millennium Development Goals, and to control and eliminate epidemics endangering entire populations. Most priority public health conditions share key social determinants, including determinants of exposure to risks, disease vulnerability, access to care, and the consequences of disease. Ample opportunities exist to deal with these determinants collectively,

<sup>28</sup> Documents EB115/35 and EB120/35, section B.

<sup>29</sup> Document EB124/2009/REC/2, summary record of the fifth meeting.

both within and outside the health system. Coordinated action on public health conditions within strong systems based on primary health care is therefore needed to achieve the Millennium Development Goals and reduce health inequities, in addition to improving the population's overall health.

10. The Commission makes three main recommendations:

- (a) improve daily living conditions
- (b) tackle the inequitable distribution of power, money and resources
- (c) measure and understand the problem and assess the impact of action.

Under these main recommendations, the Commission presents action areas and specific recommendations aimed at all parties, including WHO, other multilateral agencies, national and local governments, civil society, the private sector and research institutions.

11. For the first recommendation, the Commission identifies the following action areas:

- (a) a comprehensive approach to early child development, building on existing child-survival programmes and extending interventions in early life to include social/emotional and language/cognitive development;
- (b) sustained investment in rural development, addressing policies of exclusion that lead to rural poverty, landlessness and displacement of people from their homes; urban governance and planning;
- (c) economic and social policy responses to climate change and other environmental degradation take into account health equity;
- (d) full and fair employment and decent work as a central aim of national and international social and economic policy-making; safe, secure and fairly-paid work, year-round work opportunities, and a healthy work–life balance for all; and improved working conditions for all workers in order to reduce exposure to material hazards, work-related stress, and health-damaging behaviours;
- (e) comprehensive social-protection policies that support an income level conducive to healthy living for all;
- (f) specifically with regard to the health sector, the Commission calls for the building of universal health-care systems oriented around primary health care.

12. For the second recommendation, the Commission identifies the following action areas:
  - (a) place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration in all policies;
  - (b) adjust the health sector as appropriate – include social determinants in the policy and programmatic functions of health ministries and strengthen such ministries’ stewardship role in supporting a social determinants approach throughout government;
  - (c) strengthen public financing for action on social determinants; increase international financing for health equity, and coordinate increased finance by means of a framework for acting on social determinants;
  - (d) reinforce the primary role of the State in providing basic services essential to health (such as water and sanitation) and regulating goods and services with a major impact on health (such as tobacco, alcohol and food);
  - (e) address gender bias in the structures of society – in laws and their enforcement, in the way organizations are run and interventions designed, and in how a country’s economic performance is measured;
  - (f) reaffirm commitment to addressing sexual and reproductive health and rights universally;
  - (g) empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy-making;
  - (h) enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.
13. For the third recommendation, the Commission identifies the following actions:
  - (a) ensure that routine monitoring systems for health equity and social determinants are in place locally, nationally and internationally;
  - (b) invest in generating and sharing new evidence on how social determinants influence population health and health equity, and on the effectiveness or otherwise of measures to reduce health inequities through action on social determinants;
  - (c) provide information about social determinants to policy actors, stakeholders and practitioners, and invest in raising public awareness.

## ANALYSIS AND FUTURE ACTION

14. The concern for equity central to the Commission's call to address social determinants is in keeping with the values of primary health care. The Commission's recommendations complement the call for action in *The world health report 2008*.<sup>30</sup> Both reports emphasize the need for action beyond the health sector by considering "health in all policies". The Commission's report can be seen as an exhaustive review of the range of policies that require consideration in implementing multisectoral action for health, as part of a revitalization of primary health care.
15. Similarly, within the health sector, the Commission aligns itself with *The world health report's* call for health systems to be based on the principles of primary health care and in particular to provide universal coverage. The Commission also identifies how addressing social determinants within the health sector can make health systems more inclusive, accessible and sensitive to disadvantaged communities, and make health promotion more effective.
16. Making progress towards all the Millennium Development Goals requires, among other measures, addressing health inequities – particularly within countries, strengthening health systems based on primary health care, and action on social determinants. The Commission's recommendations thus represent important areas where concerted action could speed p
17. The continuing financial, food, fuel and environmental crises reinforce the importance of addressing social determinants since poorer people are more likely to suffer disproportionately. Minimizing such inequities during these crises requires preserving levels of health and social expenditure, in addition to using it better. Revitalizing primary health care and addressing social determinants become more important than ever if progress is to be hastened towards reducing health inequities and achieving health targets such as the Millennium Development Goals.
18. Significant work on rectifying health inequities and addressing social determinants is already under way within the Secretariat and in Member States, as agreed in the Eleventh General Programme of Work and the Medium-term strategic plan 2008–2013 under strategic objective 7.

30 World Health Organization. *The world health report 2008: primary health care – now more than ever*. Geneva, World Health Organization, 2008.

19. The Commission asks WHO to build on this work. For the Secretariat, the Commission recommends work in three specific domains. First, the Secretariat should strengthen global and national capacities in order to address social determinants by (a) providing support to Member States in implementing a “health in all policies” approach throughout government and to reorient their health sectors to work on social determinants; (b) making Member States better able to consider the impacts of global policies on health inequities in their countries; and (c) working with partner agencies in the multilateral system to build capacity for considering responses to social determinants and health inequities.
20. Secondly, the Secretariat should strengthen existing efforts on measurement and evaluation of the social determinants and health inequities by (a) facilitating target-setting and monitoring progress towards health equity between and within countries; (b) supporting the establishment of national health-equity surveillance systems in Member States; and (c) supporting Member States in development and use of tools for assessing impact on health-equity.
21. Thirdly, the Secretariat should build internal capacity for addressing social determinants in all areas of its work by (a) enhancing staff competencies and setting standards for mainstreaming work on social determinants; and (b) evaluating programmes against these benchmarks.
22. The Executive Board considered the above report at its 124<sup>th</sup> session and adopted resolution EB124.R6 which had been proposed by several Member States.

#### **ACTION BY THE HEALTH ASSEMBLY**

23. The Health Assembly is invited to consider the draft resolution contained in resolution EB124.R6.



## WHPA intervention on EB 124, agenda item 4.6 Social Determinants of Health

Thank you for the opportunity to speak on behalf of the World Medical Association, the International Council of Nurses, the International Pharmaceutical Federation and the World Dental Federation, which together form the World Health Professions Alliance -WHPA. The Alliance represents national associations in more than 150 countries, and the collective views of more than 25 million health professionals, working together to achieve the highest possible standards of care, ethics, education and health-related human rights for all people.

Our organisations welcome the report by the secretariat on the Commission on Social Determinants of Health acknowledging the report of the Commission itself entitled “Closing the gap in generation – health equity through action on social determinants of health”.

We support the holistic approach to social determinants of health taken in the report, placing health equity at the core of the matter, calling for global and coherent principles of action in order to achieve the health related Millennium Development Goals (MDGs) and ultimately social justice worldwide.

Our organisations welcome the **recommendation to build health care services based on the principle of universal coverage of quality services (9.1)**. We agree that a focus on primary health care is an important element in that perspective. We also believe that primary health care needs the support of other levels of care, including secondary and tertiary care. We believe that primary health care without backup and referral to secondary and tertiary levels of care will be seen as second-class care affordable only to the poorest population. The Alliance advocates that primary health care should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need. Access to the appropriate level of health care should not be the privilege of a few, but the fundamental right of all.

Regarding the **health workforce**, we welcome in particular the recommendation directed at national governments and donors to “increase investment in medical and health personnel” (9.3). We support the need for sex-disaggregated data on the care economy allowing for recognition and a better understanding of women’s contribution to formal and informal health care systems. We regret however that the report in general does not give more attention to health professionals as key players in addressing the social determinants of health and inequalities they face in their daily work. Their knowledge and grass-root experiences are unique and should be fully taken into consideration in the follow-up process of the report through a planned and comprehensive consultation with civil society.

Concerning more specifically the recommendation to address the health human resources brain-drain (9.4), we would like to draw your attention on the following key considerations from the Joint Health Professions Statement on Task Shifting:

- Health professionals struggle with the dilemma of resource restrictions and meeting the needs of everyone - and the evidence shows that better health outcomes occur when higher numbers of professionals are engaged in direct care.
- There needs to be sufficient health professionals to provide the required selection, training, direction, supervision, and continuing education of assistive personnel.
- While we recognise the potential benefits of community health workers in helping to sustain and develop health human resources, we are concerned that adding new cadres of workers, and correlative task shifting, result in fragmented and inefficient service through reductionist and vertical approaches.

In conclusion, we would like to emphasize the urgent need to develop **positive practice environments in the health care sector**. It is now well documented that health professionals worldwide work in unhealthy and unproductive work environments which have a negative impact on the recruitment and retention of health professionals, the performance and cost-effectiveness of health facilities, and ultimately on patient outcomes. It is for this reason that the members of the Alliance together with the International Hospital Federation, the World Confederation for Physical Therapy and the Global Health Workforce Alliance are conducting a **campaign for positive practice environments, focused on positive change in the health care workplace** so as to advance the quality of health services.

We are calling on Member State parties to support our campaign, to mobilise all relevant health actors to take part in this campaign with the common goal to make a positive change and progress towards health equity worldwide.

## **BMJ Editorial: In search of equity**

**Fiona Godlee, *editor, BMJ***  
**(BMJ 2008;337:a1554. Published 3 September 2008)**

It's almost 30 years since the Black report on inequalities in health in England and Wales, commissioned in 1977 by a Labour government but given a cold reception in 1980 by their Conservative successors. In contrast, we have good reason to hope that WHO will embrace Michael Marmot's far more ambitious report, commissioned by its former director general, Lee Jong-wook, and delivered to his successor Margaret Chan in Geneva last week.

George Davey Smith has been critical in the past of such reports. His BMJ editorial, with colleagues, about the 1998 Acheson report on health inequalities was less than favourable ([www.bmj.com/cgi/content/full/317/7171/1465](http://www.bmj.com/cgi/content/full/317/7171/1465)). This time around his, and Nancy Krieger's, praise is fulsome (doi:[10.1136/bmj.a1526](https://doi.org/10.1136/bmj.a1526)). At last, he writes, an official report has the honesty and courage to say that social injustice is killing people on a grand scale. The real test, though, will be in what happens next. The report's scope is enormous, covering a wide range of social determinants of health and diverse local circumstances around the world. Each country will need its own strategy for implementation, and any success will depend on government departments—health, education, employment, urban planning—working across their entrenched silos.

Bids for equity appear elsewhere in this week's BMJ. Direct to consumer advertising of prescription drugs turns out to cause disproportionate harm to women, says Barbara Mintzes in her editorial (doi:[10.1136/bmj.a985](https://doi.org/10.1136/bmj.a985)). Campaigners in Canada are using this inequity—partly explained by women's greater use of prescription drugs—to bolster the country's consumer advertising ban, which is under assault from media groups as well as cross border advertising from the United States. In their longitudinal study, Michael Law and colleagues found that US television advertisements viewed in Canada caused a rise in prescriptions for tegaserod, a treatment for irritable bowel syndrome that was later withdrawn because of safety concerns (doi:[10.1136/bmj.a1055](https://doi.org/10.1136/bmj.a1055)).

Another call for equity comes in this week's head to head debate, which asks whether a national qualifying exam would be a fair way to rank medical students. Chris Ricketts and Julian Archer (doi:[10.1136/bmj.a1282](https://doi.org/10.1136/bmj.a1282)) argue that the UK's current system of leaving it to individual medical schools is unfair. They call for more standardisation and a national curriculum to allow comparisons between medical schools. They also think this will improve patient care. Ian Noble (doi:[10.1136/bmj.a1279](https://doi.org/10.1136/bmj.a1279)) is not convinced. A national exam would, he says, damage diversity and innovation in medical education, would be hard to implement, and would emphasise knowledge over performance.

Knowledge alone is clearly not sufficient in making good doctors, but it is necessary. You can test your knowledge in our new educational clinical quiz, Endgames (doi:[10.1136/bmj.a107](https://doi.org/10.1136/bmj.a107), doi:[10.1136/bmj.a196](https://doi.org/10.1136/bmj.a196), doi:[10.1136/bmj.a207](https://doi.org/10.1136/bmj.a207), doi:[10.1136/bmj.a1482](https://doi.org/10.1136/bmj.a1482)). Compiled from peer reviewed contributions from readers, it will cover clinical medicine and statistics. Short and long answers are available on [bmj.com](http://bmj.com). There's also a prize quiz, chosen from the BMJ's sister product, OnExamination ([www.onexamination.com](http://www.onexamination.com)). We hope you'll find it educational and entertaining.

## BMJ Editorial: Tackling health inequities

### WHO report calls for global action to ensure health equity within and between countries

(BMJ 2008;337:a1526. Published 3 September 2008)

Finally, an official report on health inequity has been published that has the honesty and courage to say that "social injustice is killing people on a grand scale."<sup>a</sup> The report of the World Health Organization's Commission on Social Determinants of Health synthesises evidence from a large and disparate range of sources, while recognising that what constitutes evidence is itself contested and not value free.<sup>b</sup> It presents a wealth of data to show the unquestionable link between economic, social, and bodily wellbeing—within and across countries. In the case of life expectancy, these embodied facts of social inequity<sup>c</sup> can span the equivalent of a lifetime: women born in Botswana can anticipate living an average of 43 years, half that of the 86 years for women in Japan; between the poorest and most affluent parts of Glasgow life expectancy in men ranges from 54 to 82 years.

Many official reports have documented social inequalities in health over the past 170 years, from Chadwick<sup>d</sup> to Sachs.<sup>e</sup> Yet, in contrast to these reports, which

subtly (and not so subtly) emphasised the detrimental effects of poor health induced by poverty on economic performance,<sup>f</sup> the commission firmly draws the arrow of causality from impoverished environments to ill health, something that is clear to most of the world's population (if not to some economists).

The ability of this report to make these conclusions rests on its unprecedented broad scope—unlike many other reports that have focused on one country or on groups of countries at similar economic levels, the commission has produced a global picture of economic and social deprivation that makes it impossible not to recognise the importance of economic redistribution, health care, and the direct material consequences of poverty and social inequality across the life course on health.

Once it is acknowledged that poverty, exploitation, oppression, and injustice damage health, the question is clearly what should be done and by whom? The commission offers three overarching recommendations. Firstly, improving the conditions of daily living from before birth to old age will alleviate the health consequences of inequality. Secondly, although the commission accepts that it “was beyond the[ir] remit, and competence . . . to design a new international economic order that balances the needs of social and economic development of the whole global population, health equity, and the urgency of dealing with global warming,” it appropriately identifies the inequitable distribution of power, money, and resources as underlying poor health. Finally, to galvanise action and ensure accountability, it recommends global, national, and local monitoring of health inequities; the assessment of the impact of policies aimed at the alleviation of these inequalities; and the training of all health professionals in the social determinants of health.

Wisely advocating a “both and” rather than a divisive “either or” approach, the commission calls for “bottom-up” and “top-down” action, both within and outside the health sector. Declaring that “health is not a tradable commodity,” it boldly asserts that “certain goods and services such as basic human and societal needs—access to clean water, for example—and health care” must be “made available universally regardless of ability to pay.”

The report's inclusion of both social and health system policies as social determinants of health follows others<sup>g</sup> in moving on from debates that narrowly pit one against the other. Throughout, the report usefully provides diverse concrete examples showing how health equity can be advanced by intersectoral action from grassroots organisations, national and local government, multilateral agencies (including WHO itself), the private sector, and research and teaching institutions.

Observing that governments obviously are “not always benign,” the commission underscores the “clear links between a ‘rights’ approach to health and the social determinants approach to health equity.” Highlighting the harmful effects of gender inequity, discrimination, and social exclusion on health (including the health of indigenous populations), it calls for democratic and participatory approaches as the essential glue for integrating multisectoral multiagency activity and making sure this work has an effect. Indeed, as advocated 65 years ago by Morris, the leading health inequalities researcher of the 20th century,<sup>h</sup> the need to include community based, participatory approaches to evaluation and monitoring—often seen to be the domain of “experts”—is as crucial as grassroots involvement.

Equally telling, the commission eviscerates the platitude that economic growth and reliance on markets are sufficient for improving health.<sup>l</sup> Pointing to the harmful health consequences of the “market oriented economic policies” pursued since the 1980s that have led to a “significant reduction in the role of the state and levels of public spending and investment,” the report provides evidence that equity oriented growth can produce the health gains of development without the adverse effects of growth that favours the “interests of a rich and powerful minority over the interests of a disempowered majority.” As the report clearly notes, although markets can “bring health benefits in the form of new technologies, goods and services, and improved standard of living,” this is not the full story, because “the marketplace can also generate negative conditions for health, in the form of economic inequalities, resource depletion, environmental pollution, unhealthy working conditions, and the circulation of dangerous and unhealthy goods,” such as tobacco.

The commission accordingly forcefully argues that work on health inequities is blocked not by a lack of resources, but by a lack of political will. Noting that the budget of the Gates foundation has at times exceeded WHO’s core budget; that the annual cost of bringing the 40% of the world’s population currently living below \$2 (£0.55; €0.68) a day up to this level would be \$300 billion—less than 1% of the gross national income of the high income countries; and that many countries spend more on the military than on health, the report makes it clear the problem is not money itself but rather how “money is used for fair distribution of goods and services and building institutions within low income countries.”

To return to the question of what is to be done the report clarifies that just as cynicism and inaction are not an option, neither is there one master plan to be dictated from above. Instead, health professionals have clear and plentiful work to do within

the many systems in which we work, together with every other sector of society. By placing health equity as a crucial goal and as the standard for accountability, and by recognising that social justice is the foundation of public health,<sup>k</sup> we stand a better chance at rectifying current inequities and playing our part in establishing a more just and sustainable world.

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## **RESOLUTION 12.5: Reducing health inequities through action on the social determinants of health**

### **Extract from Executive Board Resolution, EB124.R6:**

The Executive Board, having considered the Secretariat's report on the final report of the Commission on Social Determinants of Health, RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Having considered the Secretariat's report on the final report of the Commission on Social Determinants of Health;

Noting the 60th anniversary of the establishment of WHO in 1948, and its Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the United Nations Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Welcoming in this regard resolution WHA61.18, which initiates annual monitoring by the World Health Assembly of the achievement of health-related Millennium Development Goals;

Noting *The world health report 2008* on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;
2. CALLS UPON the international community, including United Nations agencies, intergovernmental bodies, civil society and the private sector:
  - (1) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;
  - (2) to take action in collaboration with WHO's Member States and the WHO Secretariat on assessing the impacts of policies and programmes on health inequities and on addressing the social determinants of health;
  - (3) to work closely with WHO's Member States and the WHO Secretariat on measures to enhance health equity in all policies in order to improve health for the entire population and reduce inequities;
3. URGES Member States:
  - (1) to develop and implement goals and strategies to improve public health with a focus on health inequities;

- (2) to take into account health equity in all national policies that address social determinants of health and to ensure equitable access to health promotion, disease prevention and health care;
  - (3) to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies;
  - (4) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;
  - (5) to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;
  - (6) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;
  - (7) to generate new, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;
  - (8) to develop, make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social determinants in each context (such as age, gender, ethnicity, education, employment and socioeconomic status) so that health inequities can be detected and the impact of policies monitored in order to devise appropriate policy interventions to minimize health inequities;
4. REQUESTS the Director-General:
- (1) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence to minimize health inequities; and to advocate for this topic to be high on global development and research agendas;
  - (2) to strengthen the capacity within the Organization with the purpose to give sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequities;

- (3) to implement measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes;
- (4) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;
- (5) to support Member States in implementing a health-in-all-policies approach to tackling inequities in health;
- (6) to support Member States, upon request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and to design, or if necessary redesign, their health sectors to address this appropriately;
- (7) to support Member States, upon request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequities and to develop and monitor targets on health equity;
- (8) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;
- (9) to support the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
- (10) to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to highlight the developments, progress and renewed plans for addressing the alarming trends of health inequities and to increase global awareness on social determinants of health, including health equity;
- (11) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly through the Executive Board.

## For more information:

### WHO Websites:

- Social Determinants of Health: [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)
- Commission on Social Determinants of Health: [http://www.who.int/social\\_determinants/thecommission/en/](http://www.who.int/social_determinants/thecommission/en/)
- EURO Office for Investment for Health and Development: <http://www.euro.who.int/ihd>
- Poverty: <http://www.who.int/topics/poverty/en/>
- Human Rights: [http://www.who.int/topics/human\\_rights/en/](http://www.who.int/topics/human_rights/en/)

### Non-WHO Websites:

- UK Department of Health, Health inequalities: <http://www.dh.gov.uk/en/Publichealth/Healthinequalities/index.htm>
- Canada's response to WHO Commission on Social Determinants of Health: <http://www.phac-aspc.gc.ca/sdh-dss/crg-grc-eng.php>
- People's Health Movement: <http://www.phmovement.org/cms/>
- National Social Marketing Centre, Social Determinants of Health programme: <http://www.nsms.org.uk/public/default.aspx?pageID=67&MenuID=0>
- European Public Health Alliance: <http://www.epha.org/a/1737>
- Action for Global Health: [http://www.actionforglobalhealth.eu/news/who\\_commission\\_on\\_social\\_determinants\\_of\\_health\\_final\\_report](http://www.actionforglobalhealth.eu/news/who_commission_on_social_determinants_of_health_final_report)

## Can health equity become a reality?

A global movement to address the social determinants of health has been gathering pace. This week's issue of *The Lancet* contributes to this campaign by publishing evidence on actions that can reduce the startling health inequalities that persist within and between countries.

The catalyst for this special issue has been our close work with the Commission on Social Determinants of Health. Set up in 2005 by WHO, the Commission—an independent group of scientists and politicians, chaired by Michael Marmot—has gathered evidence for policies that address the social conditions in which people live and work to improve health. Its final report, published in August, is summarised today in a Public Health article.

The Commission identified three overarching principles to reduce health inequalities nationally and globally: improve daily living conditions; tackle the unequal distribution of power, money, and resources; and measure and understand the problem and assess the results of action. Under the three themes, the Commission's final report provides a vast array of recommendations, including the governmental provision of programmes for early child development, the expansion of the Multilateral Debt Relief Initiative, and the registration of all children at birth without financial cost to households.

Critics have stated that the Commission's recommendations are too lofty and ambitious. Some are sceptical about the possibility of change on such a grand scale. Others have called for pragmatic solutions—quick fixes that are more politically acceptable. But the essence of the campaign for health equity is that root and branch reform is needed to fundamentally change the way governments and UN agencies are doing things. Putting fairness and social justice on the global agenda will not be an easy task. It will take time. But now that the Commission's final report has been published and evidence is being gathered for action, it would be a terrible mistake to stall this movement with negativity and pessimism.

So what needs to happen now to move forward? The challenge is to convert the Commission's comprehensive set of conclusions into action. Although the principles behind achieving health equity are universal, individual countries will need to work on practical policies for their populations, since solutions for India will be very

different to those for the USA. The ball is already rolling. On Nov 6, Alan Johnson, the UK's Secretary of State for Health, announced that a group, led by Michael Marmot, would be set up to translate the Commission's principles into concrete policies for the UK. Other nations must follow suit and establish similar bodies.

Global leadership is essential to push this agenda forward. WHO is the obvious candidate for this role and Margaret Chan, the Director-General, can use her position to advocate for equity in health. WHO's six Regional Directors should be active in organising meetings to translate the Commission's findings into country-specific policies. The agency is also best placed to set up the necessary monitoring and evaluation system for improvements in health equity.

Other relevant UN agencies should be included in discussions about achieving health equity. For example, UN-HABITAT—the UN agency for human settlements—will be key in addressing inequalities in urban settings. Its recently published *State of the World's Cities 2008/9* showed that major US cities are as unequal in terms of income as are African and Latin American cities, and that one in three people in developing countries lives in a slum.

As well as leadership and advocacy, there is clearly a need for more research on the magnitude of the problem in low-to-middle-income nations, and on how inequalities can be tackled. But gaps in information should not be an excuse for inaction. As several papers in today's issue show, much is possible now. For example, Olle Lundberg and colleagues report that increased generosity in social policies that support dual-earner families is linked with lower rates of infant mortality.

Civil society must continue to play a strong part in holding governments to account over health inequalities. And, as countries begin to implement evidence-based policies, they will need to convene to share their developments at a regular international meeting, similar to the *Countdown to 2015* conferences that track progress on child survival. The Commission calls for such a meeting to take place in 2010. We strongly support the need for this conference. It will give countries the impetus to act.

All societies must strive to close their gaps in health equity in a generation. Too much is at stake not to do so. ■ *The Lancet*



State of the World's Cities

See *Perspectives* page 1625

See *Articles* page 1633

See *Public Health* page 1661

For more on the Commission on Social Determinants of Health see [http://www.who.int/social\\_determinants/](http://www.who.int/social_determinants/)

For the UN-HABITAT report see <http://www.unhabitat.org/press/getPage.asp?page=book/1/ewb/book-2562>

## 12.6 Monitoring of the achievement of the health-related Millennium Development Goals

### Extract from Document A62/10 (Report by Secretariat):

1. Health is at the heart of the Millennium Development Goals. Goals 4, 5 and 6 specifically focus on health, but all the others have health-related aspects; achieving them will not be possible without progress on food security, gender equality, the empowerment of women, wider access to education, and better stewardship of the environment. Looking to 2015 and beyond, the challenges presented by weak health systems, the epidemiological transition and emerging health threats will become increasingly prominent.

### CURRENT STATUS AND TRENDS

2. Overall, the proportion of children under five years of age suffering from undernutrition (according to the WHO Child Growth Standards) declined from 27% in 1990 to 20% in 2005. However, progress has been uneven and an estimated 112 million children are underweight. Undernutrition is an underlying cause in more than one third of child deaths.
3. In 2007, there were an estimated 9 million child deaths, significantly fewer than the 12.5 million estimated in 1990, with a 27% decline in the under-five mortality rate over that period to 67 per 1000 live births in 2007. Reducing child mortality increasingly depends on tackling neonatal mortality; globally, an estimated 37% of deaths among children under five occurs in the first month of life, most in the first week. Countries making the least progress are generally those affected by high levels of HIV/AIDS, economic hardship or conflict.
4. Much of the progress in reducing child mortality can be attributed to increased immunization coverage, use of oral rehydration therapy during episodes of diarrhoea, use of insecticide-treated bednets, access to artemisinin-based combination therapies, and efforts to eliminate disease due to *Haemophilus influenzae* type b infection, and reductions in disease incidence due to improved water and sanitation. However, because the availability and use of proven interventions at community level remain low, pneumonia and diarrhoea still kill 3.8 million children under five each year.
5. Every year some 536 000 women die of complications during pregnancy or childbirth, 99% of them in developing countries. The global maternal mortality

ratio of 400 maternal deaths per 100 000 live births in 2005 has barely changed since 1990. Most maternal deaths occur in the African Region, where the maternal mortality ratio is 900 per 100 000 live births, with no measureable improvement between 1990 and 2005.

6. Progress in reducing maternal mortality and morbidity depends on better access to, and use of, good maternal and reproductive health services. The proportion of pregnant women in the developing world who had at least one antenatal care visit increased from slightly more than half at the beginning of the 1990s to almost three quarters a decade later. Over the period 2000–2006, 65% of births globally were attended by skilled health personnel, 4% more than in 1990–1999.
7. Globally, the contraceptive prevalence rate increased from 59% in 1990–1995 to 63% in 2000–2006. Nonetheless, in some regions it remains very difficult to reduce the considerable unmet need for family planning and the high rates of adolescent fertility. Globally, there were 48 births for every 1000 women aged 15–19 years in 2006, only a small decline from 51 per 1000 in 2000.
8. In 2006, an estimated 3300 million people were at risk of malaria. Of these, some 1200 million were in the high-risk category (living in areas with more than one reported case of malaria per 1000 population per year). Although it is still too early to register global changes in impact, 27 countries (including five in Africa) have reduced reported cases of the disease and/or deaths resulting from it by up to 50% between 1990 and 2006. Coverage of interventions for the prevention and treatment of malaria has increased. There has been a significant growth in the production and use of insecticide-treated mosquito nets, although global targets are still not being met. By June 2008, all but four countries and territories with a high burden of the disease had adopted artemisinin-based combination therapy as the first-line treatment for falciparum malaria, and use of combination therapies is being scaled up.
9. The Millennium Development Goal target in respect of halting and reversing the incidence of tuberculosis was met globally in 2004. Since then the rate has been falling slowly.<sup>31</sup> Tuberculosis prevalence and death rates per 100 000 population declined from 296 in 1990 to 206 in 2007 for the former, and from 28 in 1990 to 25 in 2006 for the latter. Globally, the tuberculosis case-detection rate under

<sup>31</sup> *Global tuberculosis control: surveillance, planning, financing*: WHO report 2008. Geneva, World Health Organization, 2008.

the DOTS approach increased from an estimated 11% in 1995 to 63% in 2007. The rate of improvement in case detection slowed after 2004, largely as a result of earlier successes in the countries with the largest number of cases. Data on treatment success rates under the DOTS approach indicate consistent improvement, with rates rising from 79% in 1990 to 85% in 2006. Multidrug-resistant tuberculosis and HIV-associated tuberculosis pose particular challenges in some regions.

10. New estimates indicate that 2.7 million people were newly infected with HIV during 2007 and that there were two million deaths related to AIDS, bringing the total number of people living with HIV to 33 million. The percentage of adults living with HIV globally has remained stable since 2000. Use of antiretroviral therapy has increased; in the course of 2007, about one million more people living with HIV received antiretroviral therapy. However, despite this, of the estimated 9.7 million people in developing countries who need treatment, only three million were receiving the medicines. Progress has been made in prevention, but at the end of 2007 only 33% of HIV-infected women had received antiretroviral medicines to reduce the risk of mother-to-child transmission.
11. An estimated 1.2 billion people are affected by neglected tropical diseases, chronic disabling infections that thrive in conditions of impoverishment and weak health systems. In 2007, 546 million people were treated to prevent transmission of lymphatic filariasis. Only 9585 cases of dracunculiasis were reported in the five countries in which the disease is endemic, compared with an estimated 3.5 million reported in 20 such countries in 1985. The global prevalence of leprosy at the beginning of 2008 stood at 212 802 reported cases, down from 5.2 million cases in 1985.
12. Lack of safe water and poor sanitation are important risk factors for mortality and morbidity, including diarrhoeal diseases, cholera, worm infestations, and hepatitis. Globally, the proportion of the population with access to improved drinking-water sources increased from 76% to 86% between 1990 and 2006. Since 1990, the number of people in developing regions using improved sanitation facilities has increased by 1100 million. Nevertheless, in 2006, there were 54 countries in which information was available where less than half the population used an improved sanitation facility.
13. Although nearly all developing countries publish an essential medicines list, the availability of medicines at public health facilities is often poor. Surveys in about 30 developing countries indicate that availability of selected medicines at health facilities was only 35% in the public sector and 63% in the private sector. Lack of

medicines in the public sector forces patients to purchase medicines privately. In the private sector, however, generic medicines are often sold at several times their international reference price, while originator brands are generally even more expensive.

## ACCELERATING PROGRESS

14. At the midpoint between 2000 and 2015, the analysis reveals encouraging signs of progress, particularly in child health; it points to areas where current gains need to be sustained, particularly in relation to HIV/AIDS, tuberculosis and malaria; and indicates areas where there has been little or no movement, notably maternal and newborn health. More detailed data, not reported here, show that major differences in progress exist between and within countries and regions.
15. Strategies to accelerate achievement of the Millennium Development Goals have received attention from the MDG Africa Steering Group, chaired by the United Nations Secretary-General; in the Toyako Framework for Action on Global Health (welcomed at the G8 Summit held in Hokkaido, Japan, from 7 to 9 July 2008); and at the United Nations High-Level Event on the Millennium Development Goals (New York, 25 September 2008).
16. **Based on the Millennium Declaration, the Millennium Development Goals** are a way of ensuring that the benefits of globalization are evenly and fairly shared. The values they support echo those in the Declaration of Alma-Ata (1978). In this context, the renewed commitment to primary health care provides a framework and direction for future work on the Millennium Development Goals through its focus on the following: equity, health as an outcome of policy across all sectors, and health systems that advance universal access and respond to people's needs.
17. **A greater focus on equity, solidarity and gender.** Detailed analysis of trends reveals that regional and national averages mask important inequities within countries, within regions and between sexes. For example, the greatest reductions in child mortality have been recorded among the richest households and in urban areas; such improvements have been the slowest to achieve among the poor and in rural populations. Similarly, greater reductions in undernutrition have been achieved among boys than among girls. Moreover, the high burden of maternal mortality is a result of many factors including poor access to care, failure

to prevent unwanted pregnancies and women's low status in many societies. Within regions in which performance is generally poor, certain countries are nevertheless making rapid progress; five countries in Africa, for example, have succeeded in reducing child mortality by 40% or more. It is estimated that one third of people living in absolute poverty reside in so-called fragile states that receive up to 40% less aid per capita than other low-income countries.

18. **Promoting health as an outcome of all policies.** By 2030, eight out of the 10 leading causes of death will be linked to noncommunicable diseases and conditions such as mental disorders, injuries and violence.<sup>32</sup> Success in tackling risk factors such as tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol, and the socioeconomic impact of cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, depends not only on effective health-care services but also on actions taken in a wide variety of policy domains. Although noncommunicable diseases are often seen as the main target of intersectoral action, many other health outcomes are determined by policy interventions beyond the health sector – whether it be import duties on essential medicines and technologies, employment and housing policy affecting early childhood development, laws that discriminate against people living with HIV/AIDS, or restrictions on the movement of people or livestock in order to prevent the spread of epidemics.
19. **Building stronger health systems based on primary health care.** All the health-related Millennium Development Goals depend for their achievement on stronger health systems. As indicated in WHO's framework for action in this area,<sup>33</sup> in order for progress to be made, work is needed on all the main prerequisites for effective health systems, namely: fair systems of finance that protect against impoverishment; a well-trained and adequately remunerated workforce; the application of information systems to support policy and management; reliable systems for procuring and distributing essential medicines and technologies; effective referral systems and service delivery; and the capacity to frame and implement policies that guide all major stakeholders. The core values of primary health care give direction to the following activities for reforming health systems: promoting universal access in support of equity; ensuring a people-centred approach to service delivery; extending the reach of health into other

<sup>32</sup> *The global burden of disease: 2004 update.* Geneva, World Health Organization, 2008.

<sup>33</sup> *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.* Geneva, World Health Organization, 2007.

policy areas; establishing a system of governance for steering these reforms. Although it is important to measure the effectiveness of investment made for strengthening health systems, the creation of strong health systems remains a means to an end; the principal aim is to reduce maternal mortality and achieve other key health outcomes.

20. These policy directions have implications for the many stakeholders supporting the achievement of the Millennium Development Goals. Three such directions that are of particular concern to WHO are highlighted below.
21. **Monitoring trends.** At the global level, monitoring progress towards the Millennium Development Goals is a well-established process coordinated by the United Nations Statistics Division. WHO participates in the Inter-Agency and Expert Group on MDG Indicators. In addition, WHO will report on the most recent estimates for statistics related to the Goals in its annual publication, *World health statistics*, which appears in May each year. WHO is strengthening its core function of monitoring the global health situation and trends therein by establishing a global health observatory. The observatory will increase access to health data across the Organization, and enhance the quality of the information concerned.
22. **Increasing the quantity and quality of resources for health.** Although significant and sustained increases in domestic financing and external development aid are needed, there is also an urgent need to improve alignment between the growing numbers of international initiatives seeking to accelerate progress towards the Millennium Development Goals. In this regard, WHO will promote the implementation of the Paris Declaration on Aid Effectiveness: ownership, harmonisation, alignment, results and mutual accountability (2005) and the Accra Agenda for Action. WHO's support for the international commitments to health system strengthening – the International Health Partnership and Providing for Health – will promote, in respect of the former, the elaboration and use of national health strategies and plans as a means of increasing alignment with national priorities, and in the case of the latter, the provision of more consistent advice on domestic financing policies. In order to increase and safeguard aid for health, the Director-General will join a high-level task force on innovative international financing.
23. **Working in partnership.** WHO will continue to work in partnership with all actors concerned with improving people's health. The Organization's involvement in this area includes pursuing a growing network of relationships with civil

society and the private sector. WHO is an active supporter of United Nations reforms to increase the effectiveness of support provided through the United Nations system for development at country level. Global Health Partnerships have established their place as providers of aid – particularly those partnerships that offer significant financing to countries, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. In addition to fighting HIV/AIDS, tuberculosis and malaria and increasing immunization coverage, both partnerships now play a major role in providing financing in support of stronger health systems.

24. The renewal of commitment to primary health care offers a framework for making more rapid and equitable progress towards the Millennium Development Goals. The strategies for accelerating achievement of the health-related Goals in this report are consistent with the conclusions of *The world health report 2008*<sup>34</sup> and the report of the Commission on Social Determinants of Health.<sup>35</sup>
25. The Executive Board at its 124<sup>th</sup> session in January 2009 noted an earlier version of this report.<sup>36</sup>

#### **ACTION BY THE HEALTH ASSEMBLY**

26. The Health Assembly is invited to note the report.

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<sup>34</sup> *The world health report 2008: primary health care now more than ever*. Geneva, World Health Organization, 2008.

<sup>35</sup> "Closing the gap in a generation: health equity through action on the social determinants of health" (document WHO/IER/CSDH/08.1).

<sup>36</sup> See document EB124/2009/REC/2, summary record of the sixth meeting, section 2, and the seventh meeting.

## For more information:

### WHO Websites:

- Health and the Millennium Development Goals: <http://www.who.int/mdg/en/>
- Millennium Development Goals: [http://www.who.int/topics/millennium\\_development\\_goals/en/](http://www.who.int/topics/millennium_development_goals/en/)

### Non-WHO Websites:

- Global Fund: <http://www.theglobalfund.org/en/>
- UN Millennium Development Goals: <http://www.un.org/millenniumgoals/>
- United Nations Development Programme (UNDP): <http://www.undp.org/mdg/>
- UN Millennium Project: <http://www.unmillenniumproject.org/goals/index.htm>
- UN Statistics Division, MDG Indicators: <http://unstats.un.org/unsd/mdg/default.aspx>
- MDG Monitor: [http://www.mdgmonitor.org/browse\\_goal.cfm](http://www.mdgmonitor.org/browse_goal.cfm)

## **\*12.7 Climate change and health**

### **Extract from Document A62/11 (Report by Secretariat):**

1. There is a strong and growing, global, scientific consensus that warming of the climate system is a fact and is affecting human health. In view of the evidence, the Sixty-first World Health Assembly, in its resolution WHA61.19 requested the Director-General, inter alia, to consult Member States on the preparation of “a workplan for scaling up WHO’s technical support to Member States for assessing and addressing the implications of climate change for health and health systems”.
2. Accordingly, a workplan was prepared through a consultative process, building on regional committee resolutions and regional frameworks for action, and further incorporating suggestions from Member States submitted electronically and in a meeting attended by 22 countries<sup>37</sup> nominated by the WHO Regional Directors (Geneva, 9–10 October 2008). The resulting, proposed workplan<sup>38</sup> was reviewed and amended by the Executive Board at its 124<sup>th</sup> session in January 2009.<sup>39</sup>
3. The workplan is a framework for action by the Secretariat, taking into account the climates, cultures, socioeconomic development, health systems, health status and vulnerability across Member States. It is organized around four objectives. The central focus is on environmental risks to health (i.e. under strategic objective 8), but several actions require the incorporation of climate-change considerations into other strategic objectives, work on which is in hand. It will be implemented within the time frame of WHO’s Medium-term strategic plan 2008–2013.

### **OVERALL AIM**

4. The workplan aims to:
  - support health systems in all countries, in particular low- and middle-income States and small island States, in order to enhance capacity for

<sup>37</sup> Bangladesh, Barbados, Brazil, China, Costa Rica, Denmark, El Salvador, Germany, India, Italy, Jordan, Madagascar, Maldives, Norway, Oman, Poland, Republic of Korea, Russian Federation, Samoa, Serbia, Spain, United Kingdom of Great Britain and Northern Ireland.

<sup>38</sup> Document EB124/11.

<sup>39</sup> See document EB124/2009/REC/1, Annex 4.

assessing and monitoring health vulnerability, risks and impacts due to climate change;

- identify strategies and actions to protect human health, particularly of the most vulnerable groups; and
- share knowledge and good practices.

## OBJECTIVES AND ACTION

### Objective 1. Awareness raising

5. Raising awareness of the effects of climate change on health, in order to prompt action for public health measures. A better understanding of the risks and effects of climate change on health will motivate and facilitate both behavioural change and societal support for actions taken to reduce greenhouse gas emissions. Improved awareness will help health-sector professionals to provide leadership in supporting rapid and comprehensive strategies for mitigation<sup>40</sup> and adaptation<sup>41</sup> that will both improve health and reduce vulnerability.

### Action

6. The Secretariat will undertake two actions, set out below.

*Action 1.1 Development of tools, guidance, information and training packages to support awareness and advocacy campaigns to protect health from climate change at national and regional levels.*

7. This action will target different population groups, especially health professionals. Education packages for the general public, particularly vulnerable groups such as children and the elderly, will be produced in collaboration with national authorities and nongovernmental organizations.

*Action 1.2 Develop and run a global awareness-raising and advocacy campaign aiming to put health at the centre of the climate change mitigation and adaptation agenda at the international level.*

8. This campaign aims to ensure that health is fully considered in the negotiations being carried out towards the 15th Conference of the Parties to the United Nations Framework Convention on Climate Change, scheduled to be held in Copenhagen,

<sup>40</sup> In this context, mitigation means action to reduce human effects on the climate system, principally strategies to reduce emissions of greenhouse gases, or enhance their removal from the atmosphere.

<sup>41</sup> Adaptation means adjustment that moderates harm or exploits beneficial opportunities in natural or human systems in response to actual or expected climatic stimuli or their effects.

in December 2009. The campaign will also aim to clarify the role and necessary actions of the population, policy-makers and others for implementing health-related measures to enhance adaptation and reduce greenhouse gases. In this regard, the benefits for health of different choices in areas such as energy production and transport, will be clarified and quantified. The campaign will use standard methods and will also use innovative approaches on multimedia platforms. Relevant youth groups and nongovernmental organizations will be actively involved.

**Objective 2. Engage in partnerships with other United Nations organizations and sectors other than the health sector at national, regional and international levels, in order to ensure that health protection and health promotion are central to climate change adaptation and mitigation policies**

9. Partnerships will be sought at all levels. This requires the public health sector to play a stewardship role in fostering policy coherence across sectors, and to influence policies and actions that can benefit health.

**Action**

10. The Secretariat will undertake three actions.

*Action 2.1 Participate in the relevant mechanisms and coordination activities within the United Nations system.*

11. Particular attention will be given to the United Nations Framework Convention on Climate Change, Nairobi Work Programme on impacts, vulnerability and adaptation to climate change. The Secretariat will work to ensure that health concerns are fully taken into account in decision-making, resource allocation and outreach activities.

*Action 2.2 Exercise WHO stewardship role with other sectors and related United Nations organizations.*

12. Interaction with other sectors will be enhanced through the production of specific tools and information material to clarify the impact that different development choices (e.g. in the transport and energy sectors) could have in promoting and protecting health. Joint projects with other sectors (e.g. agriculture and emergency management) will address the need for intersectoral collaboration in order to improve effectiveness of adaptation responses.

*Action 2.3 Provide the health sector with information, tools and advice so it can actively participate in national, regional and international mechanisms.*

13. Health representatives need to ensure that health concerns are adequately integrated into national committees, National Adaptation Programmes of Action and regional and international adaptation and mitigation strategies. The Secretariat will provide Member States with information and data as well as advocacy instruments in order to support the preparation of the necessary documentation at country level, to facilitate access to resources and strategically position health into current and future national and international policies.

### **Objective 3. Promote and support the generation of scientific evidence**

14. There are some important gaps in our knowledge, in particular about the current and potential future impacts of climate-related risks, the degree of population vulnerability, characteristics of vulnerable groups, the type of surveillance and alert and emergency management systems, the most useful indicators for monitoring and evaluation of the criteria for action, as well as the comparative effectiveness of different adaptation and mitigation policies for health promotion and protection.

### **Action**

15. The Secretariat will undertake seven actions.

*Action 3.1 Assess the burden of disease attributable to climate change and project it to future years using existing and new approaches.*

16. The Secretariat will work closely with other relevant scientific bodies to update earlier estimates and include new indirect outcomes not considered in previous calculations. Existing tools to facilitate the application of the outcomes to regional, national and local levels will be revised and enhanced.

*Action 3.2 Review and develop methodologies and guidelines on how to evaluate vulnerability to climate change-related health effects at local, national and regional levels.*

17. Vulnerability assessments provide a better understanding of current and future risks to health, along with associated uncertainties. They also facilitate the identification of the interventions that can reduce pressure on climate-sensitive health determinants, increase population resilience to climate change, and enhance capacity for preparedness and response to emergencies.

*Action 3.3* Develop a clearinghouse of existing health protection strategies in Member States and make the information widely available. Assess comparative effectiveness, including cost-effectiveness.

18. Some countries and regions are undertaking or planning strategies and actions. There is a need to document and disseminate these developments, and share and assess their effectiveness.

*Action 3.4* Support and monitor research to improve public health knowledge on the health risks of climate change and on the most effective interventions to manage those risks.

19. WHO has held a formal consultation process with leading researchers, bodies in the United Nations system, nongovernmental organizations and donors, and has defined priority areas for future research under the headings defined in resolution WHA61.19. It will work with these and other relevant partners to establish the financial and coordination mechanisms necessary to address the identified knowledge gaps and build the necessary research capacity, particularly in developing countries.

*Action 3.5* Assess the health impact of adaptation and mitigation policies in other sectors and identify the most effective actions which have the potential to benefit health.

20. The choices made by other sectors, such as energy, agriculture and transport, have a direct impact on human health. A clarification of the health implications of mitigation and adaptation decisions in these sectors and the development of tools for their evaluation at regional, national and local level will support achievement of health benefits, and avoidance of health risks.

*Action 3.6* Identify and develop indicators to monitor climate change-related health outcomes within surveillance systems.

21. Existing surveillance systems will be reviewed to identify indicators that could be used for identifying and assessing climate-related health risks and the effectiveness of actions. New indicators will be proposed if necessary.

*Action 3.7* Work with other relevant scientific organizations to develop a comprehensive international assessment of the economic costs associated with the health effects of climate change under different scenarios of adaptation and mitigation action and/or inaction. Provide Member States with means for conducting such assessments at the national level.

22. The Intergovernmental Panel on Climate Change, Fourth Assessment Report (2001) and the Stern Review on the Economics of Climate Change (2006) have clarified the economic impact of climate change in society as a whole and in specific economic sectors. A similar assessment for the health effects would benefit policy development and strengthen the argument for appropriate action to mitigate and adapt to climate change.

**Objective 4. Strengthen health systems to cope with the health threats posed by climate change, including emergencies related to extreme weather events and sea-level rise**

23. Health-system action to protect populations from the impacts of climate change will need to encompass public health interventions within the formal health sector, such as control of neglected tropical diseases and provision of primary health care, and actions to improve the environmental and social determinants of health, ranging from access to clean water and sanitation to enhancing the welfare of women. A common theme must be ensuring equity and giving priority to protecting the health security of particularly vulnerable groups.
24. In addition, there is a particular need to control and reduce health risks, and strengthen coordinated preparedness and response in respect of the health effects of acute emergencies and other crises that may be exacerbated by climate variability and change.

**Action**

25. The Secretariat will undertake six actions.

*Action 4.1 Provide technical support for building capacity to assess and monitor vulnerability to climate change-related health risks.*

26. The Secretariat will collaborate with countries to develop national capacity for hazard, vulnerability, risk and capacity assessments with a particular focus on low- and middle-income countries and on small-island developing States. This will include training in the use of specific tools prepared in the different relevant technical areas.

*Action 4.2 Advocate for the strengthening of primary health care (including primary prevention) services to support capacity of local communities to become resilient to climate-related health risks.*

27. Many of the responses to the health challenges posed by climate change will require primary health care, including primary prevention, interventions in

areas such as vector management, environmental health protection, and disease surveillance.

*Action 4.3 Mobilize and guide international support for the urgent strengthening and financing of public health systems at the national level.*

28. The Secretariat will support the health sector in Member States to engage in international climate change-related mechanisms, in order to access the necessary financial and political support to implement effective health adaptation responses to climate change. The development of health infrastructure must take account of the risks of climate change to ensure that it is safe and can function in emergencies.

*Action 4.4 Support the preparation, implementation and evaluation of regional and national mitigation and adaptation plans requiring health-system action.*

29. The Secretariat will work with countries to establish and evaluate action plans both in the area of specific responsibility of the health sector and in other sectors where actions have an impact on health and on health-sector resources. The need for incorporating climate change into existing health programmes and scaling-up of disaster risk reduction, emergency preparedness and response capacities in order to meet the increased risk of emergencies, will be strongly emphasized. In addition, support will be provided to Member States that want to reduce greenhouse gas emissions within their health sector.

*Action 4.5 Standardize and support the development of early warning systems related to the health consequences of climate change and climate variability.*

30. Several countries use warning systems to inform the population on how to prepare for, and cope with, health risks associated with weather-related events. WHO will work with other actors such as meteorological agencies, and participate in experience-sharing, standardization, and wider implementation of effective strategies.

*Action 4.6 Support the assessment of the effectiveness of health emergency management measures in reducing the impact of extreme events on health with the development of appropriate evaluation methods and pilot studies.*

31. The Secretariat will support more systematic evaluations of the accuracy of warnings, and the effectiveness of the social, preventive and clinical responses, in

protecting health in vulnerable population groups. The effects of climate change on health, the long-term risks stemming from drought and sea-level rise that could affect water and food security and safety, competition for resources, and displacement of populations with humanitarian needs, should all be integrated into early warning systems with appropriate evaluation schemes.

## **IMPLEMENTATION**

32. The activities described in this workplan will be implemented in support of countries through the WHO network at all levels as well as by making effective use of the relevant WHO collaborating centres and the expertise of other relevant bodies such as the Intergovernmental Panel on Climate Change. If necessary, new WHO collaborating centres will be designated to support implementation in some geographical areas and on specific issues. Collaboration with national and international centres of scientific excellence will be enhanced, with particular emphasis on working with institutions from those countries that are most vulnerable to the effects of climate change on health. Monitoring and evaluation will be carried out through the mechanisms and indicators included within WHO's Medium-term strategic plan 2008–2013 as well as the programme budget of each relevant biennium. It is estimated that, despite the sharp increase in activities, the budget for the bienniums 2008–2009 and 2010–2011 will cover the needs. However, the planned budget for the biennium 2012–2013 should be re-assessed on the basis of the actions being developed over the present and next bienniums, and the requirements of Member States for collaboration and support.
33. At its 124<sup>th</sup> session the Executive Board discussed an earlier version of this report. It adopted resolution EB124.R5, in which it endorsed the workplan on climate change.

## **ACTION BY THE HEALTH ASSEMBLY**

34. The Health Assembly is invited to consider resolution EB124.R5.

## RESOLUTION 12.7: Climate change and health

### Extract from Executive Board Resolution, EB124.R5:

The Executive Board, recalling resolution WHA61.19 on Climate change and health;

Noting the proposed workplan on climate change and health,

1. ENDORSES the proposed workplan on climate change and health;
2. REQUESTS the Director-General:
  - (1) to implement the actions contained in the workplan on climate change and health;
  - (2) to report annually, beginning in 2010, through the Executive Board, to the Health Assembly on progress in implementing resolution WHA61.19 and the workplan.

### BMJ Editorial: The NHS carbon reduction strategy

#### **The battle plan is written, but will the NHS go to war with its emissions?**

**(BMJ 2009;338:b326. Published 28 January 2009)**

Climate change kills at least 150 000 people each year, and the suffering it causes will increase as we continue to pollute the atmosphere.<sup>A</sup> The effects of climate change on health will continue to be concentrated in the poorest parts of the world and will mainly affect children.<sup>B</sup> The NHS is responsible for 25% of England's public sector emissions—more than 18 million tonnes of carbon dioxide a year. The NHS carbon reduction strategy for England, "Saving Carbon, Improving Health," was published this week; it sets out how the NHS aims to lead the way to a low carbon world.<sup>C</sup>

The strategy builds on a strong evidence base—the groundbreaking NHS carbon footprinting exercise published in 2008.<sup>D</sup> However, the strategy quickly runs into its first obstacle. The largest part (60%) of the NHS carbon footprint is from procurement—the manufacture and transport of goods and services purchased by the NHS from other organisations. Pharmaceuticals contribute most to procurement emissions, being responsible for 4 million tonnes of carbon dioxide a year. The strategy is weak in this area, saying that "research will be undertaken into the carbon footprint of pharmaceuticals within the NHS to better understand this and to inform actions to produce significant reductions." This sounds like a dodge.

The NHS could reduce drug related carbon emissions either by reducing the carbon intensity of drug production or by reducing drug use. The NHS already pays a high price for drugs—much of the basic research that underpins drug development is funded by the public, which enables the drug industry to cream off the profitable part.<sup>E,F</sup> Because the global atmosphere also bears some of the costs, the real cost of drugs is even higher than the monetary cost. The NHS can and should use its purchasing power to press the drug industry to decarbonise.

The Department of Health should also give the prevention of disease the priority that it deserves but currently lacks. For example, the United Kingdom is predicted to be a predominantly obese society by 2050.<sup>G</sup> If we want to avoid a situation where more than half of the population is taking carbon intensive drugs to suppress their appetite or to prevent their bodies from absorbing fat, then we will need to do much better than Change4Life, the new “lifestyle revolution” recently launched by the Department of Health to stem rising obesity.<sup>H</sup>

The government would have us believe that obesity is a personal failing by weak willed people who make the wrong selections from a wealth of lifestyle and diet choices. However, a decade of research into obesity shows that fatness is an environmental problem not a personal foible.<sup>I</sup> People in the UK are getting fatter firstly because they are surrounded by low priced, heavily marketed, energy dense food, and secondly because fossil fuel powered transport means they move their bodies less than ever before. Serious government action to stem the oversupply of food and encourage sustainable transport (walking and cycling) would reduce the carbon footprint of the NHS and the whole of British society as well.

The strategy points out that the NHS is one of the largest purchasers of food in the UK, and that in future patients, visitors, and staff can look forward to healthy low carbon menus with much less meat, dairy produce, and eggs. Evidence shows that as far as the climate it concerned, meat is heat.<sup>J</sup> Providing land for cattle grazing results in deforestation, and the methane released from animal manure and enteric fermentation is a powerful greenhouse gas. Eating less meat would also have health benefits, such as reducing the risk of colon cancer.<sup>J</sup>

The strategy says that all trusts should have approved plans for tackling NHS related travel. The strategy recommends a flat reimbursement rate for NHS business mileage, regardless of the mode of transport (car, cycle, or foot), and it urges that travel related NHS emissions are monitored. The strategy also asserts that greater efforts should be made to reduce NHS related travel, and that the delivery of health

care will move closer to home. There are also important key actions on reducing water consumption and avoiding waste.

The enthusiasm of everyone in the NHS workforce will be enlisted to deliver the strategy through an ambitious low carbon workforce development programme. All NHS organisations “should” sign up to the NHS good corporate citizen assessment model, should produce a sustainable development management plan, and should embed carbon reduction in their financial mechanisms. The lack of any “musts” is concerning. The strategy is garnished with a rousing quotation from Prime Minister Gordon Brown about our “historic and world changing” mission to build a low carbon economy, a quotation worthy of any wartime Churchill. As a battle plan, the NHS carbon reduction strategy is an excellent start, and the NHS Sustainable Development Unit must be congratulated for its leadership. But only time will tell whether the NHS will actually go to war with its emissions and win.

**Ian Roberts**, *professor of epidemiology and public health, position*

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## BMJ Editorial: What's your carbon reduction strategy?

**Fiona Godlee, editor, BMJ**  
**(BMJ 2009;338:b1272. Published 26 March 2009)**

Back in 2006 I wrote an Editor's Choice called "What did you do about climate change Mum?" (*BMJ* 2006;332:10 June, doi:[10.1136/bmj.332.7554.0-f](https://doi.org/10.1136/bmj.332.7554.0-f)). It suggested that doctors might start measuring their carbon footprint. The most interesting thing about this short piece was the response it received on [bmj.com](http://bmj.com) ([www.bmj.com/cgi/eletters/332/7554/0-f](http://www.bmj.com/cgi/eletters/332/7554/0-f)). What was this stuff doing in a medical journal? What was I doing uncritically accepting the propaganda of the global warming lobby?

Things have changed since then. WHO's director general Margaret Chan has called climate change the biggest public health challenge of the 21st century. And last week the UN and Red Cross warned that a humanitarian crisis caused by droughts, floods, storms, and heatwaves could overwhelm relief agencies (doi:[10.1136/bmj.b1229](https://doi.org/10.1136/bmj.b1229)). Most chilling for me was a comment at a meeting at the Royal College of Physicians last year. When asked what people should do about climate change, Tom Burke of Rio Tinto said "Don't be under 40."

So although some will question the need for action, most are likely to say we're not doing nearly enough. This was the response from many to the new NHS carbon reduction strategy. But as Andrew Cole reports, its targets—to cut emissions by 10% by 2015 and 80% by 2050—are ambitious (doi:[10.1136/bmj.b933](https://doi.org/10.1136/bmj.b933)). A big chunk will have to come from NHS procurement, especially from drugs and equipment, using the NHS's purchasing power to get suppliers to adopt greener technology and getting us all to use less of everything. As David Hutchins and Stuart White explain (doi:[10.1136/bmj.b609](https://doi.org/10.1136/bmj.b609)), health services can reduce, reuse, and recycle just like everyone else. For its part, the *BMJ* is embarking on its own carbon reduction programme. As a small part of this, the journal is now printed on 100% recycled paper.

Meanwhile, there's a new guide to sustainable development from the Faculty of Public Health, NHS Kidney Care is funding the first ever "green nephrology fellowship" (doi:[10.1136/bmj.b1214](https://doi.org/10.1136/bmj.b1214)), and the people at [www.carbonaddict.org](http://www.carbonaddict.org) have identified "carbon dependency syndrome." As well as advice on sourcing food ("Seasonal and local (unless living next door to an intensive beef farm)") they give some startling facts. If everyone in the UK stopped eating meat on one day a week this would equate to taking five million cars off the road. And according to WHO, the 150 000 deaths so far attributed to climate change each year have been in "non-addicts"—children in the developing world.

Action by individuals and organisations is important. It will help to reduce carbon use and change our culture. But real progress will need action by governments. This doesn't mean we can sit back and do nothing. Governments need permission to take unpopular decisions, especially during an economic downturn. In December in Copenhagen the world's leaders will update their carbon commitments. The Climate and Health Council ([www.climateandhealth.org](http://www.climateandhealth.org)) wants to ensure that the health effects of climate change are fully acknowledged in these discussions. Nearly 2000 doctors and senior managers have already signed the council's pledge. We would like 10 000 signatures. If you do one thing today, go to the council website and sign the pledge.

## For more information:

### WHO Websites:

- Climate Change: <http://www.who.int/topics/climate/en/>
- Global environmental change: <http://www.who.int/globalchange/en/>
- Health and Environment Linkages Initiative: <http://www.who.int/heli/en/>
- Climate (EURO): <http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=climate>
- Global Environmental Changes (PAHO): <http://www.paho.org/Project.asp?SEL=TP&LNG=ENG&ID=88>
- Climate Change and Health (EMRO): <http://www.emro.who.int/ceha/climatechange.htm>
- cCASHh: [http://www.euro.who.int/globalchange/assessment/20070403\\_1](http://www.euro.who.int/globalchange/assessment/20070403_1)

### Non-WHO Websites:

- Health & Environment Alliance (HEAL): <http://www.env-health.org/>
- Intergovernmental Panel on Climate Change (IPCC): <http://www.ipcc.ch/>
- Centre on Global Change and Health, WHO Collaborating Centre (London School of Hygiene & Tropical Medicine, UK): <http://www.lshtm.ac.uk/cgch/climate.html>
- European Public Health Alliance (EPHA): <http://www.ephah.org/a/2840>
- UK Health Protection Agency press release (12/02/08): [http://www.hpa.org.uk/hpa/news/articles/press\\_releases/2008/080212\\_climateChange.htm](http://www.hpa.org.uk/hpa/news/articles/press_releases/2008/080212_climateChange.htm)
- World Development Movement climate change campaign: <http://www.wdm.org.uk/campaigns/climate/index.htm>
- Stop Climate Chaos: <http://www.stopclimatechaos.org/>

## \*12.8 WHO's role and responsibilities in health research

### Extract from Document A62/12 (Draft WHO strategy on research for health. Report by the Secretariat):

1. High-quality research and evidence are critical for improving global health and health equity, and for the achievement by WHO of its objective, namely, the attainment by all peoples of the highest possible level of health.
2. At a time when there are many competing demands on limited resources, it is especially important for policies and practices in support of health to be grounded in the best scientific knowledge.
3. Research is central to economic development and global health security and it is increasingly recognized that, in order to be effective, research has to be multidisciplinary and intersectoral in nature. In the face of current and emerging health threats – such as those posed by pandemics, chronic diseases, food insecurity, the impact on health of climate change, and fragile health systems – the Secretariat, Member States and the Organization's partners have a joint responsibility to ensure that research and evidence help to achieve health-related development goals and improve health outcomes. An approach that involves all government departments should therefore be adopted so that health is reflected in all government policies.
4. In response to resolution WHA58.34 on the Ministerial Summit on Health Research, the Secretariat prepared a position paper describing WHO's role and responsibilities in health research, which was discussed by ACHR at its forty-fifth session.<sup>42</sup> A report that contained the main points of the position paper was submitted to the Sixtieth World Health Assembly, in May 2007.<sup>43</sup> The Health Assembly subsequently adopted resolution WHA60.15, in which the Director-General was requested to submit to the Sixty-second World Health Assembly a strategy for the management and organization of research activities within WHO, and to convene a ministerial conference on health research in Bamako, in November 2008.
5. In response, a draft WHO strategy on research for health has been drawn up. In addition, WHO jointly convened, with five other partners,<sup>44</sup> the Global

<sup>42</sup> See document EB117/37.

<sup>43</sup> Document A60/23.

<sup>44</sup> Government of Mali, UNESCO, World Bank, Global Forum for Health Research, Council for Health Research for Development.

Ministerial Forum on Research for Health in Bamako (see paragraphs 32 and 33 below).

6. At its 124th session in January 2009, the Executive Board considered the draft strategy and adopted resolution EB124.R12.<sup>45</sup> The draft strategy, amended in the light of comments by members of the Board, is attached at Annex.

## THE CONSULTATION PROCESS

7. Informed by previous Health Assembly resolutions on research, a highly participatory and inclusive consultative process was conducted in order to formulate the strategy. The approach involved a historical review of research in WHO, together with a comprehensive survey and analysis both of current research activities within the Organization<sup>46</sup> and of WHO's role in the wider context of global health research.
8. During an 18-month period, from March 2007 to September 2008, the Secretariat solicited key stakeholders and partners (governments, nongovernmental organizations, funding agencies for research and development, research institutes, civil society and industry) for their views on research at WHO. The exercise sought to identify areas of success, changes that were needed and future priorities for research. Stakeholders' comments were posted on a dedicated web site and integrated into successive working versions of the strategy.
9. Consultative meetings and dialogue were organized with each of the six WHO regional offices, with technical departments at headquarters and with the advisory and governing bodies of WHO's research programmes. In total, more than 300 staff, including those based at country offices, provided inputs to the strategy.
10. The consultation process was guided by an independent external reference group, which was composed of representatives from governments, nongovernmental organizations, research funders, researchers, civil society and industry. ACHR provided further independent advice and support for the development of the strategy.
11. During the elaboration of the draft strategy account was taken of the following: the (then draft) global strategy and plan of action on public health, innovation

<sup>45</sup> Document EB124/2009/REC/2, summary record of the twelfth meeting.

<sup>46</sup> "Research at WHO today", document in preparation.

and intellectual property,<sup>47</sup> which was the outcome of the second session of the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property; the report of the Commission on Social Determinants of Health,<sup>48</sup> and the Global Ministerial Forum on Research for Health in Bamako.

12. Based on the consultation process, the draft strategy contains recommendations for the Secretariat, Member States and partners, including international partners, nongovernmental organizations and the private sector.

## DEFINITIONS

13. For the purposes of the strategy, research is defined as the development of knowledge with the aim of understanding health challenges and mounting an improved response to them. This definition covers the full spectrum of research, which spans five generic areas of activity: measuring the problem; understanding its cause(s); elaborating solutions; translating the solutions or evidence into policy, practice and products; and evaluating the effectiveness of solutions.
14. The term “research for health” reflects the fact that improving health outcomes requires the involvement of many sectors and disciplines. As identified in the work of the Global Forum for Health Research, it is research that seeks to understand the impact on health of policies, programmes, processes, actions or events originating in any sector; to assist in developing interventions that will help prevent or mitigate that impact; and to contribute to the achievement of the Millennium Development Goals, health equity and better health for all.

## THE DRAFT STRATEGY: VISION, MISSION, PRINCIPLES AND GOALS

15. The Annex to this document contains a comprehensive, Organization-wide draft strategy that sets out how to strengthen WHO’s role in research for health, and the consequent role of research in WHO.
16. The draft strategy builds on WHO’s core functions, adding value, where possible, to efforts in support of global research for health. WHO’s strengths in this area include the following: a neutral status and independence; a broad global membership; unparalleled experience in the field of international public health;

<sup>47</sup> Subsequently adopted in resolution WHA61.21.

<sup>48</sup> *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008.

a central role in global normative work; a commitment to evidence-based debate; an ability to convene numerous formal and informal networks around the world; and a regionalized structure, which provides the Organization with numerous opportunities for communicating and cooperating with countries.

17. Taking account of these unique advantages and recognizing the desirability of considering health research using a systems approach, the vision, mission, principles and goals of the draft strategy were defined. In order to facilitate this exercise, an analysis was conducted of trends in global health research and a synthesis made of shared, emergent themes from the consultation process.
18. The vision for the draft strategy is that decisions and actions to improve health and enhance health equity, are grounded in evidence from research.
19. The mission of the draft strategy is for the Secretariat, Member States and partners to work together to harness science, technology and broader knowledge in order to produce research-based evidence and tools for improving health.
20. A set of guiding principles has been defined for WHO's approach to research for health. The principles – quality, impact and inclusiveness – will guide decision-making in efforts to achieve the goals.
21. Five interrelated goals have been defined in order to enable WHO to realize the draft strategy's vision of the application of research-based evidence to inform decisions and actions in support of health and health equity.
22. The **Organization goal** involves the strengthening of the research culture across WHO; the **priorities goal** concerns the reinforcement of research that responds to priority health needs; the **capacity goal** relates to the provision of support to the strengthening of national health research systems; the **standards goal** concerns the promotion of good practice in research, drawing on WHO's core function of setting norms and standards; and the translation goal involves the strengthening of links between the policy, practice and products of research.
23. Each goal is framed according to the challenges that will need to be met, the actions that Member States, the Secretariat and partners will take in response to those challenges and a description of the results that achievement of the goals is expected to produce.
24. With the exception of the Organization goal, all the goals concern all Member States and all individuals, communities, institutions and organizations involved in the production and/or use of research, including WHO. The goals cut across national, regional and global levels, and across the Organization.

25. In resolution WHA60.15, the Health Assembly requested the Director-General to develop a strategy for the management and organization of research activities within WHO. This represents an opportunity for the Organization to: (1) review and revitalize the role of research within WHO; (2) improve provision of its support to Member States in building health research capacity; (3) strengthen its advocacy of the importance of research for health; and (4) better communicate its involvement in research for health.

## IMPLEMENTATION

26. It is envisaged that a plan will be drawn up for implementing the strategy in a phased manner at all levels of the Secretariat over a 10-year time frame. The plan will be incorporated into operational arrangements and workplans. The strategy will serve as a guiding framework for the formulation of workplans in the regional offices, which will then be in charge of their implementation. In discussion with Member States, implementation plans will also be integrated into country cooperation strategies.
27. The implementation plans will be realistic and will define clear roles and responsibilities; they will also specify the resources needed and identify the outcomes and impacts expected within a defined timetable, as indicated in the Annex. The plans will build on the research activities already in progress in more than 34 technical programmes within WHO, and on alliances and networks in support of the strategy's goals.
28. Several requirements have been identified as being critical for the successful implementation of the strategy, namely: effective governance within WHO, good collaboration with partners, and adequate staffing and funding.

## EVALUATION

29. An evaluation framework has been developed which provides an impact focused approach for assessing achievement of the strategy's vision, mission and goals.
30. The evaluation framework provides an approach for monitoring implementation of the elements of the strategy, as well as for evaluating the impact of the changes and initiatives resulting from implementation.
31. The framework also organizes the elements of the strategy into distinct components – including inputs/activities, outputs, outcomes and impacts – and defines various indicators to be tracked for each component.

## **GLOBAL MINISTERIAL FORUM ON RESEARCH FOR HEALTH**

32. Building on the achievements of the Mexico Ministerial Summit on Health Research in 2004, and responding to resolution WHA60.15, WHO and five partners convened the Global Ministerial Forum on Research for Health (Bamako, from 17-19 November 2008) with the theme “Strengthening research for health, development and equity”. The Forum provided an opportunity to review progress since the Mexico Ministerial Summit, to identify current health challenges that could be tackled through more research, and to look at future needs and challenges.
33. As with the strategy, the Forum placed research and innovation within the wider context of research for development. The Forum generated specific recommendations and commitments, culminating in a plan of action to strengthen research in support of health, development and equity.

## **ACTION BY THE HEALTH ASSEMBLY**

34. The Health Assembly is invited to consider the draft resolution contained in resolution EB124.R12.

## RESOLUTION 12.8: WHO's role and responsibilities in health research

### Extract from Executive Board Resolution EB124.R12:

The Executive Board, having considered the draft of the WHO strategy on research for health, RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Recalling resolution WHA58.34 on the Ministerial Summit on Health Research and resolution WHA60.15 on WHO's role and responsibilities in health research;

Recognizing the contribution of research to the development of solutions to health problems and the advancement of health worldwide;

Aware that, in a rapidly changing world facing significant environmental, demographic, social and economic challenges, research will be increasingly essential for clarifying the nature and scope of health problems, and for identifying effective life-saving interventions and strategies;

Realizing the increasingly multidisciplinary and intersectoral nature of research for health improvement;

Affirming the roles and responsibilities of WHO, as the leading global health organization, in health research;

Recognizing the need to strengthen the capacity of the public sector in health research;

Acknowledging that research activities in the private and public sectors can be mutually supportive and complementary in improving health globally;

Conscious of the need to strengthen the conduct, management and coordination of WHO's activities in health research;

Cognizant of the need to better communicate WHO's research activities and results, especially to its Member States and partners;

Noting the references to research for health in resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property and relevant conclusions and recommendations of the WHO Commission on Social Determinants for Health;

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008),

- 1 ENDORSES the WHO strategy on research for health annexed hereto;
2. URGES Member States:
  - (1) to recognize the importance of research for improving health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, that include the participation of all relevant sectors, public and private, that align external support around mutual priorities, and that strengthen key national institutions;
  - (2) to consider drawing on the strategy on research for health according to their own national circumstances and contexts, and as part of their overall policies on health and health research;
  - (3) to strengthen national health research systems by improving leadership and management of research for health, by focusing on national needs, by establishing effective institutional mechanisms for research, by using evidence in health policy development, and by harmonizing and coordinating national and external support (including that of WHO);
  - (4) to establish, as necessary and appropriate, governance mechanisms for research for health, to ensure rigorous application of good research norms and standards, including protection for human subjects involved in research, and to promote an open dialogue between policy-makers and researchers on national health needs, capacities and constraints;
  - (5) to improve the collection of reliable health information and data and to maximize, where appropriate, their free and unrestricted availability in the public domain;
  - (6) to promote intersectoral collaboration and high-quality research in order to produce the evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
  - (7) to initiate or strengthen intercountry collaboration with the aim of obtaining efficiencies of scale in research through the sharing of experiences, best practices and resources, the pooling of training and procurement mechanisms, and the use of common, standardized evaluation methods for research;
  - (8) to consider, where appropriate, establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States to the necessary research and expertise to meet health challenges;

- (9) to continue to pursue financing of research for health as articulated in resolution WHA58.34;
3. INVITES Member States, the health research community, international organizations, supporters of research, the private sector, civil society and other concerned stakeholders:
  - (1) to provide support to the Secretariat in implementing the research for health strategy and in monitoring and evaluating its effectiveness;
  - (2) to collaborate with the Secretariat, within the framework of the strategy, in identifying priorities for research for health, in developing guidelines relating to research for health and in the collection of health information and data;
  - (3) to assist the Secretariat and WHO's research partners in mobilizing enhanced resources for the identified global priorities for research for health;
  - (4) to pay particular attention to the research needs of low-income countries, notably in areas such as technology transfer, research workforce, and infrastructure development and the determinants of health particularly where this will contribute to the achievement of the Millennium Development Goals, health equity and better health for all and to collaborate with WHO Member States and the Secretariat to better align and coordinate the global health research architecture and its governance through the rationalization of existing global health research partnerships, to improve coherence and impact, and to increase efficiencies and equity;
  - (5) to support, where appropriate, technical cooperation among developing countries in research for health;
4. REQUESTS the Director-General:
  - (1) to provide leadership in identifying global priorities for research for health;
  - (2) to implement the strategy within the Organization at all levels and with partners, and in line with the references to research for health in the Global strategy and plan of action on public health, innovation and intellectual property;
  - (3) to improve the quality of research within the Organization;
  - (4) to provide adequate core resources in proposed programme budgets for the implementation of the research for health strategy;

- (5) to ensure that the highest norms and standards of good research are upheld within WHO, including technical, ethical and methodological aspects and the translation into practice, use and dissemination of results and to review and align the architecture and governance of the Organization's research activities and partnerships;
- (6) to provide support to Member States, upon request and as resources permit, in taking relevant actions to strengthen national health research systems and intersectoral collaborations;
- (7) to strengthen the role of WHO collaborating centres as a well-established, effective mechanism for cooperation between the Organization and countries in the field of research for health;
- (8) to report to the Sixty-fifth World Health Assembly on the implementation of this resolution, through the Executive Board, in 2012.

## **BMJ Editorial: It's time to change how Europe regulates research**

**Fiona Godlee**, *editor, BMJ*

**(BMJ 2008;337:a2986. Published 11 December 2008)**

So were they right, the UK academics who six weeks ago wrote that regulation was "the real threat to research"? (*BMJ* 2008;337:a1732, doi:[10.1136/bmj.a1732](https://doi.org/10.1136/bmj.a1732)). If the *BMJ's* rapid responses are a reliable guide, yes they were. This week's letters pages host a selection of these responses, each vying with the next to show, in the words of surgical trainee David Samuel, "how prohibitive, laborious, and bureaucratic attempting to conduct research has become" (doi:[10.1136/bmj.a2917](https://doi.org/10.1136/bmj.a2917)). Can anyone beat my delays? asks Martyn Parker, whose randomised trial was eventually approved after a delay of over two and a half years (doi:[10.1136/bmj.a2914](https://doi.org/10.1136/bmj.a2914)). Further responses are welcome if anyone wants to try.

It's not only researchers who suffer the consequences, says patient representative Christine Gratus. "The pursuit of patient confidentiality, often by patient representatives, is almost obsessive and can be in no one's interests, particularly patients," she writes (doi:[10.1136/bmj.a2915](https://doi.org/10.1136/bmj.a2915)). Bonnie Sibbald from the NHS research network in Manchester reports idiocies that would be funny if they weren't so costly in terms of researchers' and administrators' time (doi:[10.1136/bmj.a2916](https://doi.org/10.1136/bmj.a2916)). Richard Holt, a senior academic in Southampton, worries that young researchers are being

put off research as a career (doi:[10.1136/bmj.a2918](https://doi.org/10.1136/bmj.a2918)). “My last three grants have taken more than a year from award to full approval,” he writes, “leading to the embarrassing situation of the first year’s annual report in which our achievements are listed as ‘ethics and R&D approval obtained.’”

Hugh Davies from the UK’s National Research Ethics Service lists several initiatives that may or may not impress frustrated researchers and patients (doi:[10.1136/bmj.a2920](https://doi.org/10.1136/bmj.a2920)). The most substantial is the integrated research application system (IRAS), which when fully operational will be a one stop shop for applications to funders and regulatory bodies, including the Medicines and Healthcare Products Regulatory Agency. However, these bodies will need to raise their game if things are to improve substantially. At a gathering of UK research ethics committees last week, Iain Chalmers, one of the founders of the Cochrane Collaboration, said (not for the first time) that ethics committees and other regulators had failed patients on a massive scale by acquiescing in unnecessary research, obstructing necessary research, failing to require public registration of clinical trials, and not pressing for full publication of research results.

The EU Clinical Trials Directive must take some blame. Set up in 2004 to improve the quality and safety of trials and to harmonise and simplify application processes across Europe, it has been heavily criticised by industry and academics alike. In their letter, Cascorbi and colleagues report that, although long delays are mainly a UK phenomenon, approval times are generally longer in countries that follow the directive than in those that don’t.

The European Commission is listening, writes *BMJ* deputy editor Trish Groves in her blog from a meeting in Brussels earlier this month (<http://blogs.bmj.com/bmj>). One proposal is to simplify the directive and make it mandatory. As a first step, regulators have agreed to pilot a single Europe-wide application process. But things will need to move fast. While we dally, careers are being blighted, patients’ lives are being wasted, and important research that could be done in the UK and Europe is moving elsewhere.

## For more information:

### WHO websites:

- Research: <http://www.who.int/topics/research/en/>
- Research Policy: [http://www.who.int/topics/research\\_policy/en/](http://www.who.int/topics/research_policy/en/)
- Research Policy: <http://www.who.int/rpc/en/>
- Special Programme for Research and Training in Tropical Diseases: <http://www.who.int/tdr/index.html>
- The Alliance for Health Policy and Systems Research: <http://www.who.int/alliance-hpsr/en/>
- Health Systems Research (PAHO): <http://www.paho.org/Project.asp?SEL=TP&LNG=ENG&ID=167>
- Health Systems Research (AFRO): <http://www.afro.who.int/hsr/index.html>
- Health Research (Western Pacific): [http://www.wpro.who.int/health\\_topics/health\\_research/](http://www.wpro.who.int/health_topics/health_research/)
- Research Policy & Cooperation (SEARO): <http://www.searo.who.int/en/Section1243/Section2279.htm>
- Research Policy (EMRO): <http://www.emro.who.int/rpc/>

### Non-WHO websites:

- Global Forum for Health Research: [http://www.globalforumhealth.org/Site/000\\_Home.php](http://www.globalforumhealth.org/Site/000_Home.php)
- Council on Health Research for Development (COHRED): <http://www.cohred.org/main/>

## \*12.9 Counterfeit medical products

### Extract from Document A62/13 (Report by Secretariat):

1. In January 2009 the Executive Board at its 124th session considered a report from the Secretariat on counterfeit medical products and agreed to request the Director-General to revise the report in order to identify the public health concerns and focus on WHO's support to Member States in strengthening their medicines regulatory authorities and avoiding the negative impact of substandard and counterfeit medicines.<sup>49</sup>

### COUNTERFEIT MEDICINES

2. The occurrence of counterfeit medicines with their serious health repercussions, especially for the poor, is still increasing, although the exact magnitude of the problem is unknown; nonetheless, even a single case of counterfeiting is unacceptable.
3. Member States increasingly undertake studies to quantify the problem. An example was given by Nigeria during the Sixty-first World Health Assembly in 2008.<sup>50</sup> Other examples can be found on the web sites of national medicines regulatory authorities. In addition, WHO has carried out studies in Myanmar and Viet Nam.<sup>51</sup>
4. WHO has also been collecting counterfeit medicines-related data,<sup>52</sup> as no accurate data on the extent of the problem exist and any type of product can be counterfeited. In some countries occurrence of counterfeiting relates to expensive lifestyle medicines, hormones, steroids and anticancer medicines; in others it may relate to inexpensive generic medicines. In developing countries the most disturbing occurrence is the common availability of counterfeit medicines for the treatment of life-threatening conditions such as malaria, tuberculosis and HIV/AIDS. Experience has shown that vulnerable patient groups who pay for medicines out of their own pocket are often the most affected.
5. The basic investigational elements of studies aimed at identifying the magnitude of the problem of counterfeiting in a national market are sound

<sup>49</sup> Document EB124/2009/REC/2, summary record of the ninth meeting.

<sup>50</sup> Document WHA61/2008/REC/3, summary record of the tenth meeting of Committee A.

<sup>51</sup> Document WHO/EDM/QSM/99.3.

<sup>52</sup> For details see the WHO web site under Health Topics.

laboratory testing and verification of information available from national medicines regulatory authorities. Despite such measures, it is hard to trace the source. Close collaboration with the original manufacturers – who mostly use new technologies to identify their products unambiguously – as well as with enforcement agencies – using forensic means of analysis – has proved to be effective in tracing and fully identifying counterfeit medicines in recent years. Nevertheless, the full extent of the problem is unknown.

6. Counterfeiters are criminals, usually working within international networks and not easily traceable. The normal regulatory approach for legally manufactured but substandard medicines cannot, therefore, be used alone and there is a need for collaboration with governmental institutions, such as legislative bodies, enforcement agencies and courts.
7. Counterfeiting is primarily motivated by its potentially huge profits and criminals are adept at quickly adjusting to where the most money can be made. Factors that facilitate the production or circulation of counterfeit medical products include lack of appropriate legislation, absence or weakness of national medicines regulatory authorities, inadequate enforcement of existing legislation and weak penal sanctions.

## **WHO'S INVOLVEMENT IN COMBATING COUNTERFEIT MEDICINES**

8. In response to a recommendation by the Conference of Experts on the Rational Use of Drugs (Nairobi, 25–29 November 1985), at which the problem of counterfeit medicines was first discussed at the international level, WHO, together with other international and nongovernmental organizations, set up a clearing house to collect data and to inform governments about the nature and extent of counterfeiting.
9. As requested by resolution WHA41.16 in 1988, the Director-General initiated programmes for the prevention and detection of the export, import and smuggling of falsely labelled, counterfeited or substandard pharmaceutical preparations.
10. The first international meeting on counterfeit medicines, a workshop organized jointly by WHO and the International Federation of Pharmaceutical Manufacturers and Associations, was held from 1 to 3 April 1992 in Geneva in response to this resolution. The participants agreed on the following definition:

A counterfeit medicine is one which is deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient active ingredient or with fake packaging.

11. The workshop also adopted comprehensive recommendations which urged the commitment of all parties involved in medicines manufacture, distribution and use, including pharmacists and consumers, in solving the problem of counterfeit medicines.
12. Given the rapid spread of counterfeit medicines in many national distribution channels, and following the adoption by the Health Assembly of resolution WHA47.13 in 1994, the Secretariat has provided support to Member States in their efforts to ensure that available medicines were of good quality and in combating the use of counterfeit medicines.
13. In 1995, WHO, with financial assistance from the Government of Japan, launched the Project on Counterfeit Drugs. The objective was to support Member States in assessing the problem of counterfeit medicines and designing measures to combat counterfeiting. As one of the first outcomes of these efforts, WHO drafted guidelines for the development of measures to combat counterfeit medicines.
14. Increasing international trade of pharmaceuticals and sales through the Internet has further facilitated the entry of counterfeit products into the supply chain. In a meeting before the eleventh International Conference of Drug Regulatory Authorities (Madrid, 16–19 February 2004), combating of counterfeit medicines was reviewed. The main recommendations were taken up in the Conference and WHO was requested to develop a concept paper for an international convention on counterfeit medicines and to convene a regulators' meeting to discuss it. The regulators' meeting and further explanatory work revealed that there was no consensus among Member States for such an international convention; thus the idea to start a wide action-oriented international partnership led by WHO emerged.
15. In 2006 this led to WHO's launch of the International Medical Products Anti-Counterfeiting Taskforce, which has become the main conduit for WHO's work on counterfeits. Following discussions at the Sixty-first World Health Assembly and the 124th session of the Executive Board, the Secretariat has established a programme to coordinate its work to combat counterfeit medicines, including

coordination with the members of the Taskforce and providing it with secretariat functions.

## QUALITY

16. The tools and systems for quality assurance of medicines developed under the auspices of WHO's Expert Committee on Specifications for Pharmaceutical Preparations help many public health actors to work towards ensuring that all essential medicines, including those used in treating large populations, are safe, effective and of good quality. The norms, standards and guidelines reviewed by the Committee are prepared through a rigorous consultative process involving WHO's Member States, national authorities and international agencies such as UNICEF. They are submitted to WHO's governing bodies for information and subsequent implementation by Member States.
17. The comprehensive guidelines for quality assurance include recommendations that cover the development and production of medicines through to their distribution to patients.<sup>53</sup> Development of quality assurance standards is usually triggered by resolutions adopted by the Health Assembly and Executive Board and by the biennial International Conference of Drug Regulatory Authorities. These international guidelines have also contributed to the improvement of medicines regulation at country and global levels. Besides setting norms and standards, WHO supports countries in building national regulatory capacity. These activities have also been endorsed and supported by the Health Assembly through numerous resolutions.
18. The core functions of WHO's medicines regulatory support programmes include the provision of direct country and regional support for strengthening medicines regulation; developing and continuously improving tools to assist regulatory work; facilitating communication; and promoting harmonization among medicines regulatory authorities.
19. Country support involves assessing medicines regulatory systems to identify needs, prepare institutional plans, and provide financial support and capacity building, based on WHO's data collection tools and methodology. To date, 44 assessments have been performed on 40 regulatory systems with the involvement of regional offices and in close collaboration with the capacity-building teams from WHO's Secretariat. Technical assistance has also been

<sup>53</sup> The guidelines can be found on the WHO web site under Health Topics.

given to regional harmonization initiatives and for supporting the participation of bodies such as the Southern African Development Community, East African Community and the Caribbean Community.

20. WHO has organized the International Conference of Drug Regulatory Authorities every two years since 1980 with the objective of promoting harmonization, exchange of information, and finding collaborative approaches to problems of common concern to medicines and biological regulatory authorities worldwide.
21. In addition, the Prequalification of Medicines Programme forms part of WHO's activities in this area. This service aims to facilitate access to medicines that meet unified international standards of quality, safety and efficacy for HIV/AIDS, malaria, tuberculosis and reproductive health. Established in 2001, it was originally intended to promote consistency across United Nations procurement systems such as those of UNICEF and UNAIDS, and to present them with a choice of high-quality medicines. The Programme draws on the expertise of some of the leading national regulatory authorities to provide a list of prequalified products that comply with unified international standards.<sup>54</sup>

## REGIONAL ACTIVITIES ON COUNTERFEIT MEDICINES

22. Weak medicines regulatory authorities and proliferation of illicit medicine in many countries of the African Region are major challenges. An interregional meeting on combating counterfeit medical products (Abuja, 29 and 30 October 2008) was attended by medicines regulatory authorities, police and the customs authorities of 13 countries in the Region. It was proposed that WHO should continue to support countries to develop initiatives focused on the specific needs and problems related to counterfeit medical products; undertake country studies to quantify the magnitude of the problem; and draw up information, education and communication strategies on the dangers of counterfeit medical products for health workers and the general public.
23. Within the Pan American Network for Drug Regulatory Harmonization, the Working Group on Combating Drug Counterfeit was set up in 1999. A regional study was conducted to determine the situation of medicines counterfeiting in the countries of the Region of the Americas. It revealed that drug counterfeiting

<sup>54</sup> WHO gratefully acknowledges the assistance provided in 2008 by staff from the medicines regulatory authorities of Australia, Austria, Brazil, Canada, China, Estonia, Ethiopia, France, Germany, Ghana, Hungary, Italy, Kenya, the Netherlands, Poland, Singapore, South Africa, Spain, Sweden, Switzerland, Uganda, Ukraine, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and Zimbabwe.

was a problem that existed in varying degrees in most countries of the Region. To bring greater focus to the problem, the Working Group created a road map to evaluate the cycle of implementation by each country's focal point and to implement prevention and combating of medicines counterfeiting as part of their national health authorities.

24. The Eastern Mediterranean Region Office supports Member States in the Region by strengthening national medicines regulatory authorities; building the capacity of national quality control laboratories; encouraging medicines regulatory authorities to participate in meetings and the work of the International Medical Products Anti-Counterfeiting taskforce; and by sharing recommendations and outcomes of the Taskforce's meetings with medicines regulatory authorities. In addition, a review of different national situations concerning counterfeit medicines is under way.
25. In the European Region, combating counterfeit medicines is part of WHO's work on strengthening regulatory authorities, and special projects are currently being carried out in Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, The former Yugoslav Republic of Macedonia, Ukraine and Uzbekistan. In addition, close collaboration on counterfeit medical products is ongoing with the Council of Europe.
26. In the South-East Asia Region combating counterfeit medicines/medical products was discussed by the Regional Committee in 2008.<sup>55</sup> The Committee re-emphasized the importance of the public health focus in combating counterfeit medicines and separating them from intellectual property rights issues. The necessity for effective mechanisms of cooperation between medicines regulators, police, customs, prosecutors and, where applicable, health professionals, manufacturers, wholesalers, retailers and consumers' organizations was noted. These mechanisms should extend to cooperation between countries for effective combating of counterfeiting.
27. Combating counterfeit medicines is a high priority in the Western Pacific Region. Technical support for both intercountry activities and individual country-specific activities has been provided over the past 10 years. These activities have included, among others, intercountry workshops on combating counterfeit medicines (Cambodia, 2001; Thailand, 2002; Viet Nam, 2003; Philippines, 2005); national

<sup>55</sup> See document SEA/RC61/27 and Report of the Sixty-first session, Part 3, paragraphs 176–182.

training on improving inspection capacity (Lao People's Democratic Republic, Philippines, Viet Nam); intensified surveys (Cambodia, Lao People's Democratic Republic, Mongolia, Philippines); and public advocacy activities (Cambodia, Mongolia, Philippines). A regional rapid alert system was introduced in 2004 as an early warning mechanism, involving focal points from countries and partners in the Western Pacific and South-East Asia Regions. WHO has collaborated with the International Criminal Police Organization and other partners to investigate the distribution of fake artesunate in the Greater Mekong subregion in Operation Jupiter (2006), followed by the region-wide Operation Storm (2008) to undertake criminal investigation and legal enforcement.

### **ACTION BY THE HEALTH ASSEMBLY**

28. The Health Assembly is invited to note this report.



## **WHPA intervention on EB124, agenda item 4.11 Counterfeit Medical Products**

Thank you for the opportunity to speak on behalf of four health professions - dentists, nurses, physicians and pharmacists - which together represent national associations of health professions in more than 150 countries, and bring together more than 25 million health professionals.

Following debates arising from the 61st World Health Assembly, in order to address the negative impact of counterfeit medicines on health, a common comprehensive definition for counterfeit medical products needs to be in place in all Member States. We support fully the agreed working text by the WHO International Medical Product Anti-Counterfeiting Taskforce (IMPACT) Third General Meeting and urge all Member States and the international public health community to adopt its principles and to be consistent when establishing and enforcing appropriate legislation and regulations that will prevent counterfeit medical products from being manufactured, exported, imported or traded.

Since the Rome Declaration in 2006, non-governmental organisations such as health professions associations, together with other partners in civil society have called for the consolidation of the most relevant stakeholders in combating counterfeit medical products. We would like to commend the leadership at the WHO for initiating and supporting the work of the IMPACT Secretariat.

Over the past three years, IMPACT has developed a number of technical taskforce documents on legislation, regulatory infrastructure and implementation, enforcement, technology development trends and risk communication to combat counterfeit medical products. Some of these practical tools have been useful in the countries in which we work. The International Pharmaceutical Federation (FIP) in representing the World Dental Federation, World Medical Association and the International Council of Nurses, has taken a leadership role in the IMPACT Working Group on Communications and, therefore, strongly urges all Member States to support the draft resolution on counterfeit medical products as a reaffirmation of

the commitment to prevent and to take all necessary measures to ensure access to genuine quality medical products.

As health professional associations, we assign high priority to promoting awareness among all health professionals and patients of the dangers of counterfeit medical products. In today's world, digital technology and the Internet make information globally accessible. More and more patients are going online to not only research their own medical issues, but to self-diagnose and self-treat as well, based on what they read on the Internet. In some unfortunate cases, unsuspecting patients have died, become sick, or developed a resistance to a genuine antibiotic medicine through the ingestion of counterfeit medical products that contain the incorrect amount of appropriate dose of the drug, harmful additives and no active ingredients at all.

The economic injury of counterfeit goods such as handbags, music and software is significant to individuals, governments and economies; however, it will never compare to the serious public health risks that counterfeit medical products pose. This global and deadly phenomenon of counterfeit medical products will only be eradicated through an agreed framework of effective coordination, cooperation and action at the global level.

## For more information:

### WHO websites:

- Pharmaceutical Products: [http://www.who.int/topics/pharmaceutical\\_products/en/](http://www.who.int/topics/pharmaceutical_products/en/)
- Counterfeit Medicines Factsheet: <http://www.who.int/mediacentre/factsheets/fs275/en/>
- International Medical Products Anti-Counterfeiting Taskforce (IMPACT): <http://www.who.int/impact/en/>
- Essential Medicines and Pharmaceutical Policies: <http://www.who.int/medicines/en/>

### Non-WHO websites:

- US Food & Drug Administration (FDA): <http://www.fda.gov/counterfeit/>
- The Partnership for Safe Medicines: <http://www.safemedicines.org/>
- European Federation of Pharmaceutical Industries and Associations (efpia): <http://www.efpia.org/Content/Default.asp>

## \*12.10 Human organ and tissue transplantation

### Extract from Document A62/15 (Report by the Secretariat)<sup>56</sup>:

1. In 1991, the Forty-fourth World Health Assembly in resolution WHA44.25 endorsed the WHO Guiding Principles on Human Organ Transplantation. These Principles were the outcome of a process that began in 1987 when the Health Assembly first expressed concern, in resolution WHA40.13, about the commercial trade in human organs. Two years later, the Health Assembly called upon Member States to take appropriate measures to prevent the purchase and sale of human organs for transplantation (resolution WHA42.5). Over the past 18 years, the Guiding Principles have influenced legislation in more than 50 Member States as well as professional codes and practices.
2. In 2004, in the light of improvements in transplantation medicine and science as well as evolving practices and perceptions regarding organ and tissue transplantation, the Fifty-seventh World Health Assembly, in resolution WHA57.18, requested the Director-General to carry out several consultative, scientific and normative activities and report back to the Health Assembly. In response to the specific request “to continue examining and collecting global data on the practices, safety, quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues, including living donation,” the Secretariat has consulted extensively at national, regional and subregional levels with experts, representatives of health authorities and professional and scientific societies, lawyers and ethicists, and has created a global knowledge base on transplantation.<sup>57</sup> This resource includes a global observatory on donation and transplantation, which was developed in collaboration with the Spanish national transplantation organization and launched on the Internet in 2006 as a tool for monitoring transplantation activities and practices at a global level and for fostering transparency.<sup>58</sup> Kidney transplantations are now performed in 91 Member States in all WHO regions; however, these countries are at various stages of technical development and regulatory oversight. Although the number of transplantations each year has grown rapidly over the past two decades, the demand for transplantation using human cells, tissues and organs has also

<sup>56</sup> This report does not include progress in xenogeneic transplantation, also addressed by resolution WHA57.18, as it raises different and specific issues. The Secretariat will report on xenotransplantation at an appropriate time.

<sup>57</sup> Accessible at <http://www.who.int/transplantation/knowledgebase/en/>.

<sup>58</sup> Accessible at <http://www.transplant-observatory.org/default.aspx>.

increased significantly, resulting in a continuing shortage of human material, particularly organs. As few countries are near to being self-sufficient in the provision of cells, tissues and organs for transplantation, new ways have been sought to increase the donation of human material.

3. In response to the requests in resolution WHA57.18 for the Director-General to promote international cooperation and to support Member States' efforts to prevent "transplant tourism" and the trafficking of tissues and organs, the Secretariat has collaborated with scientific and professional bodies that are responding to the technical and ethical considerations raised by the various means of increasing transplantation. The growing reliance in many countries on organs donated by related and unrelated living persons was discussed at forums on kidney donation (Amsterdam, The Netherlands, 1–4 April 2004) and donation of other organs (Vancouver, British Columbia, Canada, 15–16 September 2005). These meetings were organized by The Transplantation Society, with which WHO has established official relations as a consultative body on technical matters pertaining to transplantation. Both meetings agreed minimum criteria for suitability of live donors and defined the obligations of transplant professionals to treat donors as patients, including that of providing appropriate follow-up and treatment for problems caused by the donation.
4. At a meeting in 2008 in Istanbul, Turkey, organized by The Transplantation Society and the International Society of Nephrology, more than 150 representatives of scientific and medical bodies from around the world, government officials, social scientists and ethicists defined the growing phenomena of "transplant tourism" and "organ trafficking" and declared that these practices "violate the principles of equity, justice and respect for human dignity and should be prohibited".<sup>59</sup> In certain countries, centres openly use the Internet and other means to invite patients to travel abroad in order to receive a transplant at "bargain" prices, with all donor costs included. Likewise, commercial trade in cells, tissues and organs – and even trafficking involving human beings who are kidnapped or lured into other countries where they are forced to be "donors" – continues to be a serious problem, particularly in countries with substantial transplant tourism. In order to gain easy access to organs, some wealthy countries now encourage transplantation outside their own borders, even though trade in organs may be prohibited in the wealthy countries concerned. This practice, which includes

<sup>59</sup> *The Lancet*, 2008. 372(5 July):5–6.

the provision of human material for transplantation (almost invariably obtained from poor people or victims of trafficking), should not be confused with the purchase abroad of medical care only.

## UPDATED GUIDING PRINCIPLES ON TRANSPLANTATION

5. Against this background, the Secretariat, in response to the explicit request in resolution WHA57.18, has revised the Guiding Principles,<sup>60</sup> reformulating them and their commentaries in order to cover practices that have been identified since 1991. As indicated in the Secretariat's report to the Executive Board in January 2009,<sup>61</sup> the revised Guiding Principles provide a framework to support progress in transplantation of cells, tissues and organs that will maximize the benefits of transplantation by meeting the needs of recipients, protecting donors and ensuring the dignity of all involved. Participants in the consultation process undertaken in preparing the revision confirmed the view that seeking financial gain from the human body or its parts undermines the benefits of transplantation, rather than enhancing them. Experience from all over the world demonstrates that commercial trade in this area evolves from being a market in organs to being a market in people, where – openly or under cover – the poor and vulnerable are exploited.
6. The revised Guiding Principles call for the prohibition of the giving or receiving of money in exchange for cells, tissues or organs for transplantation, as well as any other commercial dealings in this field. However, the Principles would not affect certain legitimate payments, including the following: the reimbursement of both expenses (such as those for medical care arising from donation) and losses (such as wages foregone), and the recovery of costs incurred in the procurement, processing, storage, distribution and implantation of cells, tissues and organs. In the process of revising the Guiding Principles, particular attention has been paid to the protection of minors and other vulnerable persons from coercion and improper inducement to donate cells, tissues or organs.
7. As a result of the consultations, two new Guiding Principles have been added: the first would strengthen commitment to the safety, quality and efficacy of both donation and transplantation procedures as well as of the human material used; and the second would request transparency in the organization and

<sup>60</sup> See Annex to Document A62/15 at [http://www.who.int/gb/ebwha/pdf\\_files/A62/A62\\_15-en.pdf](http://www.who.int/gb/ebwha/pdf_files/A62/A62_15-en.pdf).

<sup>61</sup> Document EB124/15.

performance of donation and transplantation activities in order to facilitate appropriate technical oversight and foster public trust. These new Principles encourage proper respect for human body parts and their donors, and for the patients receiving the donations.

## THE WAY FORWARD

8. The consultation process over the past five years has produced consensus on several ways of further improving access to, and increasing the safety, quality and efficacy of, the donation and transplantation of cells, tissues and organs. The following points summarize some of these suggestions.
9. Some participants in the consultation process have already requested support from WHO in formulating and enforcing legislation to stop commercial transplantation and increase access to transplantation. In many other countries, particularly where a weak, absent or ineffectively enforced legal framework enables profiteering from the sale of organs removed from vulnerable citizens, the Guiding Principles provide a template for national policies and laws that will promote transplantation while deterring commercial trade and trafficking.
10. Experience in countries with the most successful deceased-donor programmes has shown the advantage of having strong national organizations that can stimulate, coordinate and regulate donation and transplantation. Such organizations can inform the public about the importance of sustaining a community resource that is built on voluntary, unpaid donations of organs, tissues and cells (rather than on the exploitation inherent in organ purchases) and to which all have equitable access.
11. In order to achieve national or subregional self-sufficiency in organ transplantation, it will be necessary to increase donations from deceased donors. Currently, donors who are diagnosed dead on the basis of neurological criteria represent the major source of such donations. However, it is estimated that another source – so-called “non-heartbeating donors” – could potentially yield up to three times more donors. Furthermore, participants in the consultation process noted that, increasingly, the outcomes of transplantations with organs from non-heartbeating donors are good. With the permission of the next of kin (or, in rare cases, following the previously expressed wishes of the patient), the withdrawal of life support can be followed by a declaration of death based on the permanent cessation of circulation and respiration, and then by removal

of organs for transplantation. In certain circumstances, steps are taken to prolong the opportunity to obtain a donation while permission is sought from the relatives; this expedient is especially the case when death does not occur in an intensive care unit and withdrawal of respiratory support is unplanned. The techniques used to preserve organs need not involve complex technology, particularly where only kidneys are concerned; programmes that use non-heartbeating donors are therefore accessible to countries with limited resources.

12. The monitoring of donation and transplantation outcomes is essential in order to ensure high quality services and to identify problems. As with other medical products and devices, an effective surveillance system will provide early warning of adverse events and developments. The development of national (or subregional) monitoring and surveillance systems would enable information about important new technical developments as well as details of adverse events and reactions to be communicated quickly around the globe.
13. Success in increasing donations of cells, tissues and organs in order to meet global needs depends on public acceptance of safe, legal donation and transplantation, together with public awareness of the dangers of commercial trade and trafficking. The latter requirement particularly concerns poor and vulnerable people who are the most likely to be induced or coerced into becoming donors. Carefully designed and consistently implemented campaigns of advocacy that target all population groups, including schoolchildren, can help to increase public awareness that donation and transplantation are valuable and necessary, and that consent must be given within the limited period during which cells, tissues and organs can be kept viable.
14. With the growing global circulation of transplantable material, traceability is a major concern for transplant professionals and surveillance systems. There would be significant advantages in developing a common basis for a global system for coding transplantable material, especially cells and tissues. One outcome of the global consultation process was a recommendation that the development of such a global system should be fostered. The use of a global coding system could also offer benefits in combating commercial trade.
15. Some progress has been made in involving the community at national level for donation and transplantation services, but more remains to be done. The highest priority, however, should be given to initiatives aimed at the implementation of the primary-care approach, with strong components of prevention and health

promotion in order to reduce the diseases that lead to the need for transplants in the first place. Such initiatives require the high-quality public health programmes based on sound research and supported by tertiary care and medical education. One important stimulus to academic medicine and research is the emergence or strengthening of donation and transplantation services.

16. At its 124<sup>th</sup> session,<sup>62</sup> the Executive Board discussed an earlier version of this report and adopted resolution EB124.R13.

#### **ACTION BY THE HEALTH ASSEMBLY**

16. The Health Assembly is invited to consider the draft resolution contained in resolution EB124.R13.

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<sup>62</sup> See document EB124/2009/REC/2, summary records of the ninth and tenth meetings and the twelfth meeting, section 2.

## RESOLUTION 12.10: Human organ and tissue transplantation

### Extract from Executive Board Resolution, EB124.R13:

The Executive Board, having considered the report on human organ and tissue transplantation, RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Recalling resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation and WHA57.18 requesting an update of the Guiding Principles;

Having considered the report on human organ and tissue transplantation;

Aware of the growing magnitude and utility of human cell, tissue and organ transplantation for a wide range of conditions in low- as well as high-resource countries;

Committed to the principles of human dignity and solidarity which condemn the buying of human body parts for transplantation and the exploitation of the poorest and most vulnerable populations and the human trafficking that result from such practices;

Determined to prevent harm caused by the seeking of financial gain or comparable advantage in transactions involving human body parts, including organ trafficking and transplant tourism;

Convinced that the voluntary, non-remunerated donation of organs, cells and tissues from deceased and living donors helps to ensure a vital community resource;

Conscious of the extensive cross-boundary circulation of cells and tissues for transplantation;

Sensitive to the need for surveillance of adverse events and reactions associated with the donation, processing and transplantation of human cells, tissues and organs as such and for international exchange of such data to optimize the safety and efficacy of transplantation;

1. WELCOMES the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation;

2. URGES Member States:<sup>63</sup>

- (1) to implement the Guiding Principles on Human Cell, Tissue and Organ Transplantation in the formulation and enforcement of their own policies, laws and legislation regarding human cell, tissue and organ donation and transplantation where appropriate;
- (2) to foster public awareness and understanding of the benefits as a result of the voluntary non-remunerated provision of cells, tissues and organs as such from deceased and living donors, in contrast to the physical, psychological and social risks to individuals and communities caused by trafficking in material of human origin and transplant tourism;
- (3) to oppose the seeking of financial gain or comparable advantage in transactions involving human body parts, organ trafficking and transplant tourism, including by encouraging health-care professionals to notify relevant authorities when they become aware of such practices in accordance with national capacities and legislation;
- (4) to promote equitable access to transplantation services in accordance with national capacities, which provides the foundation for public support of voluntary donation;
- (5) to improve the safety and efficacy of donation and transplantation by promoting international best practices;
- (6) to strengthen national and multinational authorities and/or capacities to provide oversight, organization and coordination of donation and transplantation activities, with special attention to maximizing donation from deceased donors and to protecting the health and welfare of living donors;
- (7) to collaborate in collecting data including adverse events and reactions on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation;
- (8) to encourage the implementation of globally consistent coding systems for human cells, tissues and organs as such in order to facilitate national and international traceability of materials of human origin for transplantation;

3. REQUESTS the Director-General:

- (1) to disseminate the updated Guiding Principles on Human Cell, Tissue and Organ Transplantation as widely as possible to all interested parties;

<sup>63</sup> And regional economic international organizations where appropriate.

- (2) to support Member States and nongovernmental organizations to ban trafficking in material of human origin and transplant tourism;
- (3) to continue collecting and analysing global data on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation of human cells, tissues and organs;
- (4) to facilitate Member States' access to appropriate information on the donation, processing and transplantation of human cells, tissues and organs, including data on severe adverse events and reactions;
- (5) to provide, in response to requests from Member States, technical support for developing national legislation and regulation on, and suitable systems for, donation and transplantation of human cells, tissues or organs, in particular by facilitating international cooperation;
- (6) to review the Guiding Principles on Human Cell, Tissue and Organ Transplantation periodically in the light of national experience with their implementation and of developments in the field of transplantation of human cells, tissues and organs;
- (7) to report to the Health Assembly at least every four years on actions taken by the Secretariat, as well as by Member States, to implement this resolution.

## For more information:

### WHO websites:

- Department of Essential Health Technologies: <http://www.who.int/ehd/en/>
- Transplantation: <http://www.who.int/transplantation/en/>
- Human organ & tissue transplantation: [http://www.who.int/ethics/topics/human\\_transplant/en/](http://www.who.int/ethics/topics/human_transplant/en/)

### Non-WHO Websites:

- US Organ Donor site: <http://www.organdonor.gov/>
- World Medical Association policy statement: <http://www.wma.net/e/policy/wma.htm>
- US Medline Plus, Organ Donation: <http://www.nlm.nih.gov/medlineplus/organdonation.html>
- UK Dept of Health, Transplantation: [http://www.dh.gov.uk/en/Healthcare/Secondarycare/Transplantation/DH\\_355](http://www.dh.gov.uk/en/Healthcare/Secondarycare/Transplantation/DH_355)
- UK NHS Organ Donation: <http://www.organdonation.nhs.uk/ukt/default.jsp>
- Alberta Health Services (Canada), Organ & tissue donation: <http://www.capitalhealth.ca/YourHealth/Campaigns/HOPE/default.htm>
- Australian NHMRC, Ethical Guidelines for Organ and Tissue Donation by Living Donors: <http://www.nhmrc.gov.au/publications/synopses/files/e71.pdf>

## 12.11 Public health, innovation and intellectual property: global strategy and plan of action

### Extract from Document A62/16 (Report by the Secretariat):

1. In resolution WHA59.24 on Intellectual Property Rights, Innovation and Public Health, the Fifty-ninth Health Assembly decided to establish an Intergovernmental Working Group to draw up a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health and aimed, inter alia, at securing an enhanced and sustainable basis for needs-driven, essential health research and development on diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs.
2. Member States met in sessions of the Working Group in December 2006, November 2007 and April 2008. In addition, regional consultations were also held in all regions from August to October 2007 to discuss the draft global strategy and plan of action. The Group's work, which also involved experts, concerned entities and nongovernmental organizations, was submitted to the Sixty-first Health Assembly in May 2008.<sup>64</sup> The Health Assembly adopted the global strategy and the agreed parts of the plan of action on public health, innovation and intellectual property in resolution WHA61.21.
3. That resolution requested the Director-General, inter alia, to undertake a number of immediate and medium-term actions, including finalization of the outstanding components of the plan of action; preparation of a Quick Start Programme; establishment of a results-oriented and time-limited expert working group; and reporting on these actions. This report is an update on these activities.
4. The outstanding components of the plan of action, including time frames, progress indicators and estimated funding needs, have been finalized. Based on guidance provided by Member States to the Intergovernmental Working Group, the Secretariat has undertaken further work on a set of indicators that would allow the monitoring of overall progress in implementation of the global strategy and plan of action. Where appropriate, linkages to other existing monitoring mechanisms have been made. A proposed set of progress indicators

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<sup>64</sup> Document A61/9.

was reviewed by the Executive Board at its 124<sup>th</sup> session.<sup>65</sup> A revised document, incorporating suggestions from Member States will be provided to the Health Assembly. The Secretariat has also undertaken a costing exercise to estimate funding needs for the implementation of the plan of action. Where appropriate, this exercise has been guided by the work undertaken in costing other WHO plans of action. Proposed time frames and estimated funding needs can be found in another accompanying document.<sup>66</sup>

5. The Secretariat has initiated the Quick Start Programme to implement a number of specific actions of the global strategy and plan of action that fall under the responsibility of WHO. This work was preceded by an Organization-wide exercise to identify ongoing activities that contribute to implementation. Additional activities initiated in 2008 under the Quick Start Programme fall within the following broad areas: (i) mapping of global research and development activities, identification of research gaps and research priority setting; (ii) supporting research and development and promoting standard setting for traditional medicines in developing countries; (iii) developing and strengthening regulatory capacity in developing countries; and (iv) development of a monitoring and reporting framework. In addition, the Secretariat is collaborating with the Global Forum for Health Research to create a database of possible sources of financing for research and development.
6. The Director-General has established a results-oriented and time-bound expert working group. This regionally-representative group comprises internationally-recognized policy-makers and technical experts in the fields of public health, biomedical science, finance, and economics. In addition, a number of experts will be invited to provide expert advice and attend sessions of the expert working group to discuss specific issues. The expert working group held its first meeting from 12 to 14 January in Geneva. In its first meeting, the group reviewed current financing and coordination of research and development and decided on its method of work and follow-up activities. The second meeting of the group is planned for June 2009, and it is proposed to hold the third and final meeting in November 2009. Member States have been contacted so that they can submit proposals for new and innovative sources of funding to stimulate research and development; these proposals will be reviewed by the expert group in its second

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<sup>65</sup> Document EB124/2009/REC/2, summary record of the tenth meeting.

<sup>66</sup> Document A62/16 Add.1.

meeting. A web-based public hearing was held in support of this canvassing activity.

7. Key elements of the global strategy and plan of action, such as prioritizing research and development needs, promoting research and development, building and improving innovative capacity, transfer of technology, promoting sustainable financing mechanisms, and establishing monitoring and reporting systems, have clear links to the proposed WHO strategy on research for health.<sup>67</sup> The WHO strategy on research for health will be implemented throughout the Organization and with partners; implementation will also be in line with the references to research for health contained in the global strategy and plan of action. In addition, relevant actions of the global strategy have also been reflected in the draft WHO medicines strategy 2008–2013.
8. Activities in the areas of intellectual property and trade are coordinated with other relevant international intergovernmental organizations, including UNCTAD, WIPO and WTO, and aim at capacity building, information sharing, and technical and policy support to Member States. This ongoing work is guided by the global strategy and relevant Health Assembly resolutions. A report of the Secretariat's work was also presented to WTO's Council for Trade-Related Aspects of Intellectual Property Rights.<sup>68</sup> High-level meetings between the Directors-General of UNCTAD, WHO, WIPO and WTO have been held to discuss the global strategy and potential interagency collaboration to facilitate its implementation.
9. The global strategy and plan of action have also been presented and discussed at several high-level forums and meetings, including the WHO Congress on Traditional Medicine (Beijing, 7–9 November 2008) and the Global Ministerial Forum on Research for Health (Bamako, 17–20 November 2008).
10. The global strategy and plan of action were considered by all regional committees in 2008. The Regional Committee of the Americas adopted a resolution calling for Member States to promote action at regional level.<sup>69</sup>
11. The African Network for Drugs and Diagnostics Innovation was launched in October 2008 with support from the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and from several African institutions. It aims to promote and sustain African-led research and

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<sup>67</sup> See document A62/12.

<sup>68</sup> Document IP/C/W/516/Add.1.

<sup>69</sup> Resolution CD48/R.15.

development innovation, and support capacity and infrastructure development in Africa. Network activities to strengthen health innovation in Africa could be a critical regional contribution towards the implementation of the global strategy and plan of action. Similar initiatives are also being planned in other regions.

12. Informal consultations are taking place among Member States in order to reach agreement on the open paragraphs on stakeholders in the plan of action.

#### **ACTION BY THE HEALTH ASSEMBLY**

13. The Health Assembly is invited to note the report.

## For more information:

### WHO Websites:

- Intellectual property: [http://www.who.int/topics/intellectual\\_property/en/](http://www.who.int/topics/intellectual_property/en/)
- Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH): <http://www.who.int/intellectualproperty/en/>
- Public Health, Innovation and Intellectual Property: <http://www.who.int/phi/en/>



## **WHPA intervention on EB124, agenda item 4.13 Public Health Innovation and Intellectual Property**

Thank you for the opportunity to speak on behalf of four health professions - dentists, nurses, physicians and pharmacists - which together represent national associations of health professions in more than 150 countries, and bring together more than 25 million health professionals.

Having reviewed the secretariat report EB124/16 and addendum 1 on the proposed progress indicators, we would like to first express our appreciation for the important hard work that has been sustained since 2006 regarding the development of the global strategy on public health innovation and intellectual property. We support fully the fundamental objectives of the strategy in promoting incentives in R&D for diseases which predominantly affect developing countries; prioritizing where additional efforts are needed and ensuring sustainable financing mechanisms for promoting R&D for diseases which predominantly affect neglected populations in developing countries.

The future of pharmaceutical sciences is indeed at a crossroad. The issues and concerns about how equitable and affordable health care can be safeguarded for the future, while creating the right incentives to bring innovative therapies to the market is one that is on all our minds.

With this as a background, we would like to bring your attention to element 6: Improving delivery and access of the global strategy. In particular, we feel strongly that too many countries have desperate shortages of health care professionals, impacting negatively on patient outcomes and research capacities. The reasons are complex - but our understanding is the poor quality of most health care work environments that are undermining performance and driving health professionals away. Together with our national health professional associations in countries, we continue to assign high priority to supporting and increasing professional training opportunities and to provide incentives for the retention of health professionals.

We are also pleased to inform you that we have been working very closely with the WHO Global Health Workforce Alliance and the WHO department on Human Resources for Health, in providing technical assistance and advocacy where necessary on the need to support country level development of national strategic plans for the health workforce and related professionals, including policies and management practices on incentives, regulation and retention.

In conclusion, we would like to urge WHO and all Member States to give focused attention and targeted investment to strengthening of the pharmaceutical workforce. The lack of human resources in pharmaceutical research, manufacture, distribution and health care services delivery will be a critical barrier to any efforts to implement this global strategy.

## \*12.12 Chagas disease: control and elimination

### Extract from Document A62/17 (Report by the Secretariat):

1. Chagas disease, also called American trypanosomiasis and first discovered a century ago by Dr Carlos Chagas in 1909, results from infection by the parasite *Trypanosoma cruzi*. Latest available estimates indicate that around 8 million people are infected by the parasite worldwide, with, in 2008, about 11 000 deaths. Chagas disease is locally transmitted in countries and areas such as Argentina, Belize, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, French Guyana, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname and Venezuela (Bolivarian Republic of). The number of diagnosed cases has been increasing in Australia, Canada, Europe, Japan and the United States of America, and this increase presents additional risks of transmission through blood transfusion, congenital infection and organ transplantation.
2. Triatomine bugs ("kissing" bugs) live in substandard housing from southern Argentina to southern United States of America; they find a favourable habitat in crevices in the walls and roofs of poorly constructed housing in rural areas and in peripheral urban slums. The bugs become infected after biting an animal or person already infected with the parasite. People can become infected with *T. cruzi* in several ways: they can touch their eyes, mouth or skin breaks after having been into contact with faeces of infected triatomine bugs; they can eat uncooked food contaminated with triatomine bug faeces; mothers can transmit *T. cruzi* to their infants during pregnancy or at birth; and the parasite can be transmitted through contaminated transfused blood or organ transplant.
3. The risk of infection with *T. cruzi* is directly related to poverty. The urban migration from rural areas that occurred in Latin America in the 1970s and 1980s changed the traditional epidemiological pattern of Chagas disease into an urban infection that can be transmitted by blood transfusion. Contamination rates in blood banks in some cities of the American continent vary from 3% to up to as much as 53%, indicating that the prevalence of *T. cruzi*-contaminated blood may exceed the prevalence of HIV and hepatitis B and C viruses in blood stocks.
4. There are two phases of the human disease: the acute phase, in which symptoms appear shortly after the infection; and the chronic phase, in which symptoms appear after a silent period that may last several years. During the chronic

phase lesions affect internal organs of 30% of infected persons, namely the heart, oesophagus and colon and the autonomic nervous system. After several years of asymptomatic infection, 20% to 30% of those infected develop cardiac symptoms (which may lead to sudden death), 5% to 10% develop digestive damage (mainly megaviscera), and immunocompromised patients will present central nervous involvement.

5. The treatment of the disease in the acute phase is based on two drugs: nifurtimox and benznidazole. Treatment could be improved with safer and more efficacious medicines or formulations (e.g. paediatric formulations). Increasing evidence shows that treating patients after the acute phase could avoid morbidity and reduce the severity of symptoms.

## ACHIEVEMENTS

6. Intergovernmental initiatives to improve Chagas disease control in Latin America, based on vector and transfusional control and case management, include: the Southern Cone Initiative, begun in 1991 (Argentina, Bolivia, Brazil, Chile, Paraguay and Uruguay); the Initiative of the Andean Countries, initiated in 1997 (Colombia, Ecuador, Peru and Venezuela, (Bolivarian Republic of)); the Initiative of the Countries of Central America, created in 1997 (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama); the Initiative of the Amazon Countries for Surveillance and Control of Chagas Disease begun in 2004 (Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname, and Venezuela (Bolivarian Republic of)) and Mexico in 2003.
7. Important achievements have been made in recent decades, but the situation differs greatly from one area to another. Significant reductions have been seen in the number of acute cases and the populations of intra-domiciliary triatomines in countries such as Brazil, Chile, Guatemala and Uruguay. Estimated annual deaths globally decreased from 45 000 in 1990 to around 11 000 in 2008. Estimated number of infections decreased from 30 million in 1990 to 8 million in 2006. Annual incidence during this 16-year period fell from 700 000 to 56 000. The burden of Chagas disease has been reduced from 2.8 million disability-adjusted life years to less than 500 000.
8. In 2005, Chagas disease was incorporated into WHO's classification of neglected tropical diseases in order to promote synergistic advocacy and control efforts with other similarly neglected diseases.

9. Faced with the spread and globalization of the disease, WHO established a Global Network for Chagas Disease Elimination in July 2007 in order to expand a mostly Latin American concern into a global perspective. One of the first initiatives to result from this Network was the Non-Endemic Countries Initiative, designed to complement the existing Latin American intergovernmental initiatives. In Europe, Belgium, France, Italy, Spain, Switzerland and the United Kingdom of Great Britain and Northern Ireland are participating in this new initiative, as well as Japan and the United States of America.
10. In 2007, WHO received a donation of 2.5 million tablets of nifurtimox over a five-year period, which will help to alleviate the limited availability and accessibility of this medicine.

## NEW CHALLENGES

11. **Dissemination.** The past decade has seen the expansion of Chagas disease into areas previously considered non-endemic for the disease – such as the United States of America and several European and Western Pacific countries – owing to increasing population mobility between Latin America and the rest of the world. As a result cases of Chagas disease may occur in countries where knowledge or experience of the disease is limited and surveillance and control measures are insufficient, especially in blood banks and obstetric services.
12. **Sustainability.** All concerned parties must strive to avoid complacency and reduction of political interest and resources in order to ensure that the achievements in Chagas disease control are maintained and consolidated, including in areas of low endemicity. Expanded surveillance and control activities are required to face the new epidemiological challenges.
13. **Emergence.** Chagas disease has emerged in regions previously considered to be free of the disease, such as the Amazon basin, where mainly sylvatic rather than domestic vectors transmit the parasite and local micro-epidemics of orally-transmitted disease have been observed.
14. **Re-emergence.** Chagas disease has re-emerged where control had once been successful, in regions such as the Chaco region of Argentina and Bolivia. In addition to a decrease in control activities in these areas, efforts to contain the disease are further complicated by the existence of extensive extradomestic populations of the main vectors and the emergence of some resistance to insecticides.

15. **Diagnosis and treatment.** Even with a substantial reduction in transmission, millions of people remain infected, indicating a need for increased access to adequate diagnosis and treatment. This requirement will continue in disease-endemic and non-endemic areas because of expected future levels of active or accidental transmission, particularly given the high burden of medical complications.

## PROSPECTS FOR ELIMINATION OF CHAGAS DISEASE

16. The commitment to elimination of Chagas disease has to be taken not only by countries where it is endemic but also by those where it is not, always prioritizing the endemic areas. A major challenge is to provide more support and reinforce national and regional capacities to reach the goal of eliminating Chagas disease as a public health problem.
17. The Pan American Sanitary Bureau is in a position to provide coordinated and global support to controlling and eliminating Chagas disease. PAHO is expanding on framework concepts contained in the Millennium Development Goals and other internationally agreed goals for neglected diseases. Additionally, PAHO's programmes for sustainable control of communicable diseases are being expanded.
18. There is a need for a common, harmonized and coordinated surveillance system, in order to monitor the elimination of Chagas disease. In this context, countries in which the disease is endemic urgently need coordinated PAHO support for their subregional initiatives for prevention and control, and non-endemic areas also need support for their national and regional programmes, focusing on:
  - epidemiological surveillance of, and health-information systems that cover, vectors, case numbers, and other factors relevant to transmission, all at community level;  
Strengthening implementation of vector-control activities in order to achieve interruption of transmission and to promote research to improve or develop new prevention strategies;
  - prevention of transmission of *T. cruzi* due to blood transfusion and organ transplantation in endemic and non-endemic areas;
  - promoting the development and use of diagnostic tests for screening and diagnosis of *T. cruzi* infection and new medicines to improve treatment;

- prevention and control of congenital transmission, and case management of congenital and noncongenital infections, including strategies for case-finding, diagnosis and treatment at different health-care levels (for instance, through primary health-care integration, communities and other appropriate mechanisms), that can be applied in endemic and non-endemic countries;
- research on Chagas disease control.

19. An earlier version of this report was considered by the Executive Board at its 124<sup>th</sup> session<sup>70</sup>, and the Board adopted resolution EB124.R7.

### **ACTION BY THE HEALTH ASSEMBLY**

20. The Health Assembly is invited to consider the draft resolution contained in resolution EB124.R7.

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<sup>70</sup> See document EB124/2009/REC/2, summary record of the tenth meeting.

## RESOLUTION 12.12: Chagas disease: control and elimination

### Extract from Executive Board Resolution, EB124.R7:

The Executive Board, having considered the report of the Secretariat on Chagas disease: control and elimination, RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Having considered the report of the Secretariat on Chagas disease: control and elimination,

Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease by 2010, as recommended in resolution WHA51.14 of the Fifty-first World Health Assembly;

Underlining that 2009 will mark the 100th anniversary of the description of this disease by Dr Carlos Chagas;

Acknowledging the progress made with vector-control strategies;

Recognizing the success achieved through the intergovernmental initiatives in Latin America;

Taking into account the need for the harmonization of diagnostic and treatment procedures;

Recognizing the need for the provision of adequate care for late complications of the disease;

Underlining the need for more effective, safe and adequate drugs, including paediatric formulations, and for better coverage and distribution of those currently available;

Recognizing that the risk of transmission through blood transfusion, organ transplantation and congenital transmission is increasing;

Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:

- (1) to reinforce efforts to strengthen and consolidate national control programmes and to establish them where there are none;
- (2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living

- conditions, prevention and the integration of specific actions within health services based on primary care;
- (3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;
  - (4) to promote and encourage operational research on control of Chagas diseases in order to:
    - (a) interrupt transmission by domestic insect vectors;
    - (b) develop more suitable, safer and more affordable drugs;
    - (c) reduce the risk of late complications of the infection;
    - (d) establish systems of early detection, in particular for the detection of new infections, of congenital infections in newborns and the reactivation of the disease in immunocompromised patients;
    - (e) optimizing blood transfusion safety and screening procedures in endemic and non-endemic countries with special focus on endemic areas.
  - (5) to develop public health measures in endemic and non-endemic countries, with special focus on endemic areas, for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases;
2. REQUESTS the Director-General:
- (1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;
  - (2) to strengthen implementation of vector-control activities in order to achieve interruption of transmission and to promote research to improve or develop new prevention strategies;
  - (3) to support the countries of the Americas in order to strengthen intergovernmental initiatives and the technical secretariat of PAHO/WHO as a successful form of technical cooperation among countries;
  - (4) to collaborate in order that countries and intergovernmental initiatives set objectives and new goals for the elimination of the transmission of the disease;
  - (5) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;
  - (6) to promote research on elimination of Chagas disease;

- (7) to support efforts at collaboration among multisectoral actors, networking among organizations and other interested parties to support the development and implementation of Chagas disease control programmes;
- (8) to report on progress in the elimination of Chagas disease to future World Health Assemblies.

## **BMJ Analysis: Eliminating Chagas disease: challenges and a roadmap**

**Richard Reithinger (Doi:10.1136/bmj.b1283.**

**Published 14 April 2009)**

[http://www.bmj.com/cgi/content/full/338/apr14\\_2/b1283?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT](http://www.bmj.com/cgi/content/full/338/apr14_2/b1283?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT)

## For more information:

### WHO websites:

- Neglected Tropical Diseases (NTD): [http://www.who.int/neglected\\_diseases/en/](http://www.who.int/neglected_diseases/en/)
- Chagas Disease: [http://www.who.int/neglected\\_diseases/diseases/chagas/en/index.html](http://www.who.int/neglected_diseases/diseases/chagas/en/index.html)
- Chagas Disease (PAHO): <http://www.paho.org/english/hcp/hct/dch/chagas.htm>
- TDR, Chagas Disease: <http://apps.who.int/tdr/svc/diseases/chagas>

### Non-WHO Websites:

- US CDC Chagas Disease: <http://www.cdc.gov/chagas/index.html>
- Economist article (04/09): [http://www.economist.com/world/americas/displaystory.cfm?STORY\\_ID=13446910](http://www.economist.com/world/americas/displaystory.cfm?STORY_ID=13446910)
- CFSPH Fact Sheet: [http://www.cfsph.iastate.edu/FastFacts/pdfs/chagas\\_F.pdf](http://www.cfsph.iastate.edu/FastFacts/pdfs/chagas_F.pdf)
- Infectious Disease Research Institute: <http://www.idri.org/index.php?name=rd&subName=chagas>

## **\*12.13 Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services**

### **Extract from Document A62/18 (Report by the Secretariat):**

1. In most countries health-care delivery involves both public provision and a range of entrepreneurial initiatives, usually referred to as “private sector” or “private provision”. These terms cover many realities from faith-based and other nongovernmental non-profit organizations to individual health-care entrepreneurs and private-for-profit firms and corporations. Private provision is a substantial and growing sector, and capturing an increasing share of the health market across the world. The changing pattern of health-care provision presents new challenges to governments, but in ways that may differ considerably in each specific context.
2. In low-income countries, private provision dominates outpatient (ambulatory) care, whereas public provision dominates hospital and in-patient services. In most low-income countries in sub-Saharan Africa and Asia, small-scale private-for-profit and private-not-for-profit providers have become or are becoming the main source of ambulatory care. Payments to these providers are largely unregulated and on an out-of-pocket fee-for-service basis.
3. Although individual entrepreneurship is also prevalent in middle-income countries, large private firms, including multinational corporations, are capturing a growing share of the direct-service provision market, particularly the high-income segment, and increasingly are competing for contracts with public and social security systems. In Latin America and middle-income countries elsewhere, that is leading to social segmentation with private insurance-based health care for the affluent; social insurance for those in formal employment; and public direct provision for the poor.
4. Many high-income countries rely on extensive networks of private providers for ambulatory, hospital and in-patient care, but also have a long history of engagement with private providers that has led to a high level of regulation.

### **LESSONS FROM REGULATION IN HIGH-INCOME INDUSTRIALIZED COUNTRIES**

5. Most high-income industrialized countries regulate capacity, prices, quality, levels of service and entitlements. Their regulatory capacity has been built

up over decades along with the accelerated move towards universal coverage through public or social security-based financing. Self-regulation of provider behaviour has been replaced by systems in which the State and leading actors in society increasingly regulate access to care, provider behaviour, and quality and efficiency through a range of regulatory mechanisms.

6. The scale, character and calibre of entrepreneurial initiatives that characterized the health sector of high-income countries in the 1990s led to considerable institutional restructuring and innovation in provision of care. The power and independence of professional and corporate groups are substantial, resulting at times in negative effects on coverage; nevertheless, these groups operate in a more competitive environment than hitherto, making them more amenable to negotiated regulation. On the whole, boosting entrepreneurial innovation has been possible without resort to privatization and to increased interaction of the institutions of the health-care system with the State because negotiations on contractual arrangements and other regulations depend on access to pooled financial resources for their functioning.
7. The choice of optimal regulatory strategies in any national context remains a subject of ongoing debate on the degree of interventionism, the weight of public interest in State regulation, the choice of regulatory mechanisms, the role of various actors and sectors in regulating health-care provision, and the balance between different kinds of regulation. Effective regulation requires rules, adherence and a range of tools and approaches that may include financial incentives and disincentives, accreditation, licensing, contracting, and complaint-handling.
8. There is ample evidence, however, that building trust and consensus about health-system goals is a necessary precondition for an effective system and involves institutional and leadership capacity for policy dialogue, and the bringing together of a range of constituencies such as professional associations, corporate providers, unions, academia, civil society organizations, user representatives, and governmental institutions.
9. Experience with harnessing entrepreneurial provision of care shows that regulatory frameworks and strategies can include entrepreneurial dynamism without surrender of responsibility for public policy aimed at achieving an efficient health-care service. Progress towards better outcomes, more health equity and universal access is not automatic, rather a combination of

commitment to the principles and values of primary health care, inclusive leadership, increased reliance on public financing and consistent long-term efforts to build up institutional capacities for regulation.

## **STEERING AND REGULATING HEALTH-CARE PROVISION IN LOW- AND MIDDLE-INCOME COUNTRIES**

10. Provision of primary care, and to a lesser extent, hospital and in-patient care, in low- and middle-income countries, while dominated or extensively shaped by private provision and finance, is usually poorly regulated.
11. Low- and middle-income countries' health costs are financed through unpooled, private, out-of-pocket expenditure, thereby limiting the ability of health authorities to shape health-systems performance. Those countries tend to have a larger share of the population that is excluded because of inability to pay or that faces crippling individual expenditures. They tend to rely more on unregulated or poorly regulated private providers, while their public providers often adopt behaviour and practices similar to those of unregulated private providers.
12. The resulting commercialization of health-care provision is growing rapidly, and is both demand-driven and supply-driven, with a dynamism that is often in stark contrast with public provision. That commercialization is not only the result of an increased market share for unregulated private-for-profit providers, but also of growing commercialization of health-care provision in public facilities.
13. In low- and middle-income countries financial barriers and lack of social protection exclude large parts of the population from access to care. Users are poorly informed of their needs and unable to judge many aspects of quality and cost, thereby being put at risk of over-charging and/or lowering of quality and thus unsafe care, cost escalation and even exclusion of people able to pay.

## **CHALLENGES TO HARNESSING ENTREPRENEURIAL DYNAMISM IN A CONTEXT OF WEAK REGULATION**

14. Harnessing entrepreneurial dynamism for the renewal of primary health care will require many governments to make significant progress in the three areas of strategic intelligence, financial leverage, and institutional capacity for regulation and policy dialogue.
15. The debate about the purported advantages and drawbacks of the reliance on public, private non-profit and private for-profit providers has suffered from a

distinct lack of factual documentation and evidence. There is a need for better empirical information, over a range of contexts, on the characteristics, extent, growth and consequences of unregulated commercial care provision. Such information should cover short- and long-term impact on access, quality of care, health outcomes, health equity and social outcomes as well as the level of trust in health systems and health authorities. An improved evidence base would also allow for more productive exchange of experience between countries on best practices regarding engagement with and regulation of different types of health-care providers.

16. The capacity of governments to work productively with, regulate and oversee health-care providers is to a large extent constrained by the way health care is financed. Countries that spend more through government or social insurance mechanisms generally achieve better and more equitable health results than those who rely more on out-of-pocket spending at the point of service, and those that combine higher public spending with a universalist commitment to access and to low or zero charges at point of use do particularly well, achieving comparatively high levels of access and limiting excessive expenditures.
17. In many low- and middle-income countries reduced institutional capacity constrains constructive engagement with the wide range of actors involved in health-care provision. The trend towards understaffing and underfunding of regulatory institutions, often a consequence of past disinvestment, needs to be reversed. The contribution of civil society organizations for regulating provider behaviour, such as consumer protection organizations, is often insufficiently recognized, thus opportunities to build the social consensus necessary for effective regulation are often missed. Regulatory institutions often lack the staff with the skills and the self-confidence required to move to a more negotiated type of regulation. Governments need to re-invest in long-term efforts to build up their regulatory capacities; such efforts merit far greater support by the global health community.
18. WHO aims to consolidate experience, document best practice and facilitate exchange and joint learning about ways to strengthen government capacity for constructive engagement and effective oversight of the full range of health-care providers.
19. The Secretariat is collaborating with Member States and various other institutions to determine the relative roles of various types of private-for-profit, private-non-

profit and public institutions and individual professionals and the consequences for equity, effectiveness, safety and efficiency. There is a particular focus on the implications of current trends for the promotion of universal coverage and people-centred primary care, two of the core policy directions for the renewal of primary health care.

20. The Secretariat is also seeking to identify innovative approaches to contracting, franchising, provider payment, performance management and other regulatory mechanisms and techniques; to promote best practice models for building institutional capacity for oversight and regulation of the whole range of health-care providers, and to facilitate exchange of experience and joint learning between countries.
21. The Executive Board discussed an earlier version of this report at its 124th session in January 2009 and requested the Secretariat to prepare a new draft resolution.<sup>71</sup>

#### **ACTION BY THE HEALTH ASSEMBLY**

22. The Health Assembly is invited to consider the following draft resolution:

The Sixty-second World Health Assembly,<sup>72</sup>

Having considered the reports on Strengthening the capacity of governments to constructively engage private sector in providing essential health-care services, and on Primary health care, including health system strengthening;<sup>73</sup>

Recognizing the variety of private providers, from faith-based and other nongovernmental non-profit organizations and individual health-care entrepreneurs, both formal and informal, to private-for-profit firms and corporations, and the evidence that they play a significant and growing role in health-care delivery across the world;

Noting that governments across the world are faced with the challenge of constructive engagement with the complex range of health-care providers, in ways that vary considerably according to context;

Noting that the cost and quality of the care provided and the effect on health and social outcomes may vary considerably and that there are serious reasons for

<sup>71</sup> See document EB124/2009/REC/2, summary record of the tenth meeting.

<sup>72</sup> See document A62/18 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

<sup>73</sup> Documents A62/18 and A62/8, respectively.

concern in environments where regulation is poor or absent, yet as a whole the documentation and evidence base in this regard is weak;

Recognizing that governments that have the institutional capacity to govern the broad range of health-care providers can play a constructive role in providing essential health services;

Concerned about evidence that in many countries effective engagement, oversight and regulation of the various private health-care providers may be constrained by imperfect strategic intelligence, limited financial influence and weak institutional capacity;

Aware that building trust and constructive policy dialogue are vital for successful engagement, oversight and regulation;

Noting that the renewal of primary health care provides a policy framework in which to set benchmarks for strengthened government capacity for constructive engagement with, and oversight of, both public and private health-care providers,

1. URGES Member States:

- (1) to gather, by means that include improved information systems and stronger policy dialogue processes, the strategic intelligence required for: an objective assessment of the positive and negative aspects of health-care delivery by private not-for-profit and private for-profit providers; identifying appropriate strategies for productive engagement; and developing regulatory frameworks that ensure universal access with social protection and the reorientation of service delivery towards people-centred primary care;
- (2) to map and assess the capacity and the performance of the government departments and other bodies concerned with oversight and regulation of both public and private health-care provision, including: professional councils; institutional purchasers of health services, such as public funders and state health insurance agencies, and accreditation bodies;
- (3) to investigate the potential contribution to the regulation of health-care provision of non-health-sector governmental and nongovernmental entities, including health-consumer protection agencies and patient groups, and, as appropriate, set up mechanisms to maximize the value of those contributions;

- (4) to build and strengthen for the long term the institutional capacity of these regulatory bodies, through adequate and sustained funding, staffing, and support;
  - (5) to pursue opportunities for intercountry exchange of experience with different strategies for engagement, oversight and regulation of the full range of health-care providers;
2. REQUESTS the Director-General:
- (1) to provide technical assistance to Member States, upon request, in their efforts to strengthen the capacity of health ministries and other regulatory agencies in order to improve engagement with, and oversight and regulation of, the full range of public and private health-care providers;
  - (2) to convene technical consultations, set the research agenda and facilitate intercountry exchange of experience in order to obtain better shared understanding and documentation of the consequences, positive and negative, of the growing diversity of health-care providers, ensuring that particular attention is given to contexts of poor regulation and to consequences in terms of health, health equity, and health systems development;
  - (3) also to convene technical consultations, set the research agenda and facilitate intercountry exchange of experience in order to obtain a better shared understanding of the potential of various strategies to build up the institutional capacity for regulation, oversight and harnessing entrepreneurial dynamism and trustful cooperation among various types of health-care providers;
  - (4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the progress made with the implementation of this resolution.

**For more information:**

**WHO Websites:**

- Health policy: [http://www.who.int/topics/health\\_policy/en/](http://www.who.int/topics/health_policy/en/)
- Health services: [http://www.who.int/topics/health\\_services/en/](http://www.who.int/topics/health_services/en/)
- Health systems: [http://www.who.int/topics/health\\_systems/en/](http://www.who.int/topics/health_systems/en/)
- Health workforce: [http://www.who.int/topics/health\\_workforce/en/](http://www.who.int/topics/health_workforce/en/)

## 12.14 Strategic Approach to International Chemicals Management

### Extract from Document A62/19 (Report by the Secretariat):

1. At its 124th session, the Executive Board decided to place an item on the agenda of the Sixty-second World Health Assembly entitled Strategic Approach to International Chemicals Management.<sup>74</sup> This report outlines the importance of the sound management of chemicals for the protection of human health and provides an update on implementation of the Strategic Approach from a health-sector perspective, including further opportunities for action.

### IMPORTANCE OF SOUND MANAGEMENT OF CHEMICALS FOR THE PROTECTION OF HUMAN HEALTH

2. More than 25% of the global burden of disease is linked to environmental factors, including chemicals exposures. For example, about 800 000 children each year are affected by lead exposure, leading to lower intelligence quotients. The highest exposure levels occur predominantly in children in developing countries. Worldwide, lead exposure also accounts for 2% of the ischaemic heart disease burden and 3% of the cerebrovascular disease burden. Artisanal gold mining in developing countries remains a significant cause of mercury exposure, while mercury-containing medical instruments such as thermometers and sphygmomanometers are a continuing source of exposure in both developed and developing countries. Some 9% of the global disease burden of lung cancer is attributed to occupation and 5% to outdoor air pollution. Cancer of the lung and mesothelioma are caused by exposure to asbestos, which remains in use in some countries. Unintentional poisonings kill an estimated 355 000 people each year. In developing countries, where two thirds of these deaths occur, such poisonings are associated strongly with excessive exposure to, and inappropriate use of, toxic chemicals, including pesticides.
3. Despite what has been known for many years about the public health risks posed by chemicals such as mercury, lead and asbestos, problems still occur. This is particularly the case in developing countries which typically have fewer resources for chemicals risk management. The projected growth in chemicals production and use in the developing world is likely to result in greater negative effects on health if sound chemicals management is not put in place.

<sup>74</sup> Document EB124/2009/REC/2, summary record of the eleventh meeting, section 3.

4. To counter the negative health impacts arising from exposure to hazardous chemicals, in addition to health-sector action, substantial health gains could be made by working with other sectors such as environment, transport and agriculture. The health impacts of chemicals are dealt with in multilateral environment agreements, including the Stockholm Convention on Persistent Organic Pollutants (2001) and the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (1998). The Conference of the Parties to the Basel Convention, in June 2008, drew up the Bali Declaration on Waste Management for Human Health and Livelihood. The decision of the UNEP Governing Council in February 2009 to develop an international instrument on mercury is intended to assist in resolving the health problems caused by mercury. Authorities in some developing countries use the WHO Classification of Pesticides by Hazard (2004) to regulate severely hazardous pesticides in agriculture.
5. Despite actions taken, chemical emergencies that affect human health and require a health-system response continue to occur, for instance: the dumping of toxic waste in Côte d'Ivoire in 2006 resulted in some 85 000 health-related consultations and eight deaths; mass poisoning with sodium bromide in Angola in 2007 affected 467 individuals; 1000 people in Senegal were affected recently by lead poisoning from recycled batteries, with 18 children dying; and the problem of stockpiles of obsolete pesticides remains unresolved in the developing world. These examples are representative of a largely unknown exposure situation in many developing countries, and occur despite many international instruments on chemicals management intended to protect human health. This "gap" between policy formulation and what happens in practice needs to be resolved at international and national levels.

## **IMPLEMENTATION OF THE STRATEGIC APPROACH BY MEMBER STATES**

6. The Strategic Approach comprises three texts: the Dubai Declaration on International Chemicals Management, the Overarching Policy Strategy, and the Global Plan of Action.<sup>75</sup> The Strategic Approach responds to the need to assess and manage chemicals more effectively in order to achieve the 2020 goal, articulated in paragraph 23 of the Johannesburg Plan of Implementation,<sup>76</sup> that

<sup>75</sup> Document WHA59/2006/REC/1, Annex 1.

<sup>76</sup> Adopted by the World Summit on Sustainable Development (Johannesburg, South Africa, September 2002).

chemicals should be used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment. The Strategic Approach is not a legally-binding instrument.

7. Resolution WHA59.15 urged Member States to take full account of the health aspects of chemical safety in national implementation of the Strategic Approach and to participate in efforts to implement it.
8. Member States and other participants will attend the second International Conference on Chemicals Management, scheduled to be held in Geneva, 11–15 May 2009. The Conference will provide a first opportunity for Member States to review progress in implementation of the Strategic Approach. Topics to be discussed include electronic waste, manufactured nanomaterials, chemicals in articles, and the phasing out of lead in paint. The Conference includes a high-level segment with a public health theme and a round-table discussion on public health, the environment and chemicals management.
9. The health sector has substantive roles and responsibilities in chemicals management, which are reflected in the Strategic Approach health-sector priorities,<sup>77</sup> and include:
  - gathering evidence about chemical risks and informing the public
  - preventing and managing chemical emergencies, including medical treatment of victims
  - working with sectors in advocating actions and safer alternatives, with special emphasis on vulnerable populations
  - assessing impacts of chemicals risk management policies through monitoring and evaluation
  - sharing knowledge and participating in international mechanisms to solve problems.
10. In exercising these responsibilities, countries can improve public health relatively quickly and implement the Strategic Approach through the following actions:
  - Collecting information to identify the hazardous chemicals to which their populations are exposed in order to take action on the most important problems.

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<sup>77</sup> Document A59/41.

- Identifying effective interventions on chemicals of major public health concern such as lead, mercury and asbestos. The health sector can make use of experience gained by countries that have successfully promoted effective action.
- Enhancing local arrangements for the public health management of chemical emergencies, focusing on prevention and preparedness, early detection of events to avoid or minimize the impact on public health, rapid response to save lives and reduce suffering, and recovery. The International Health Regulations (2005) place a legal requirement on countries to develop improved capacities for the surveillance and detection of chemical-related outbreaks that could have international public health impacts.
- Taking advantage of the Strategic Approach institutional arrangements, for example by including health priorities in national Strategic Approach implementation plans, participating in ministerial coordination on problems of a multisectoral nature and using regional and international Strategic Approach forums to engage with other sectors in the sound management of chemicals.
- Accessing the Strategic Approach Quick Start Programme Trust Fund, administered by UNEP, which funds projects aimed at strengthening capabilities and capacities for implementation by developing countries and countries with economies in transition. By March 2009, 74 projects had been approved totalling more than US\$ 14 million for implementation by 60 governments and seven civil-society organizations, involving 73 countries of which 34 are least-developed countries and/or small island developing States.

Eleven health ministries and one health-sector civil-society group have been awarded project funding.<sup>78</sup>

<sup>78</sup> Health Ministry projects: mainstreaming chemicals management into development planning in Belarus; updating a national chemicals management profile in Kazakhstan; management of priority industrial carcinogens in Indonesia, Sri Lanka and Thailand; recycling and disposal of long-lasting insecticidal bednets in Madagascar; management of public health pesticides in Morocco; a national pollutant release and transfer register in Panama; and strengthening chemicals management in Peru, the Philippines and Uruguay. Civil-society project: regional project on minimization of domestic sources of mercury by the Argentine Society of Doctors for the Environment.

## FACILITATION OF STRATEGIC APPROACH IMPLEMENTATION BY THE SECRETARIAT

11. Resolution WHA59.15 requested the Director-General to facilitate implementation of the Strategic Approach by the health sector. WHO has an active programme of work on chemical safety and the Strategic Approach health-sector priorities are reflected in the Organization's workplan. Information about the Strategic Approach is being disseminated to the health sector, including health ministries, poisons centres and other networks, scientific institutions and nongovernmental organizations. The Secretariat has a Strategic Approach Focal Point and provides a professional staff member to the Strategic Approach secretariat, as requested by the International Conference on Chemicals Management.
12. WHO's Secretariat is contributing to Strategic Approach regional and subregional meetings and, with UNEP, convened the first Inter-Ministerial Conference on Health and Environment in Africa (Libreville, 26–29 August 2008). WHO participates in the Quick Start Programme Trust Fund Executive Board and the Committee which considers applications for funding, and is the executing agency for four of the Quick Start Programme projects. WHO is working with partners in the Inter-Organization Programme for the Sound Management of Chemicals<sup>79</sup> to produce capacity-building guidance and resource materials for countries.<sup>80</sup> In addition, WHO is assisting in preparations for the second International Conference on Chemicals Management.
13. The Secretariat will provide further support to Member States by:
  - Consolidating and sharing evidence on the health impacts of chemicals of major public health concern, along with information on actions that have been successful. In addition, WHO could establish key indicators of success, such as the time to phase out mercury use in health care.
  - Providing technical support and guidance, for example in the public health management of chemical emergencies and in assessing the burden of disease attributable to chemicals.
  - Working with the Strategic Approach secretariat to provide a service to facilitate access to the Strategic Approach Trust Fund; to establish an informal network of health-sector focal points for sharing experience; and

<sup>79</sup> ILO, FAO, UNEP, UNIDO, the United Nations Institute for Training and Research, WHO and OECD, plus UNDP and the World Bank as observers.

<sup>80</sup> Details available on [www.who.int/iomc](http://www.who.int/iomc).

to collect and share information on the capacity-building needs of the health sector.

#### **ACTION BY THE HEALTH ASSEMBLY**

14. The Health Assembly is invited to note the report.

## For more information:

### WHO Websites:

- Chemical Safety: [http://www.who.int/topics/chemical\\_safety/en/](http://www.who.int/topics/chemical_safety/en/)
- Inter-Organization Programme for the Sound Management of Chemicals: <http://www.who.int/iomc/en/>
- Intergovernmental Forum on Chemical Safety: <http://www.who.int/ifcs/en/>
- International Programme on Chemical Safety: <http://www.who.int/ipcs/en/>
- Pesticides: <http://www.who.int/topics/pesticides/en/>
- Poisons: <http://www.who.int/topics/poisons/en/>

### Non-WHO Websites:

- European Commission, REACH: [http://ec.europa.eu/environment/chemicals/reach/reach\\_intro.htm](http://ec.europa.eu/environment/chemicals/reach/reach_intro.htm)
- UK Government, Chemical Safety in the Home: [http://www.direct.gov.uk/en/HomeAndCommunity/InYourHome/KeepingSafeAtHome/DG\\_10030574](http://www.direct.gov.uk/en/HomeAndCommunity/InYourHome/KeepingSafeAtHome/DG_10030574)
- CDC NIOSH: <http://www.cdc.gov/NIOSH/topics/chemical-safety/>
- Health & Environment Alliance, Chemicals: <http://www.env-health.org/r/69>
- Chemicals Health Monitor: <http://www.chemicalshealthmonitor.org/>
- CEHAPE: [http://cehape.env-health.org/article.php3?id\\_article=7](http://cehape.env-health.org/article.php3?id_article=7)

## 12.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis

### Extract from Document A62/20 (Report by the Secretariat):

1. In 2007, the Health Assembly in resolution WHA60.19 noted considerable progress made in tuberculosis control globally since 1991 and acknowledged the WHO Stop TB strategy, which incorporates the internationally recommended DOTS strategy, as a comprehensive approach to global control. Recognizing the alarming emergence and transmission of drug-resistant tuberculosis,<sup>81</sup> Member States were urged to develop and implement plans for prevention and control in line with the Stop TB Partnership's Global Plan to Stop TB 2006–2015 as part of their national health development plans. However, data suggest the problem of multidrug resistance is worsening: in 2008, WHO's fourth global report on anti-tuberculosis drug resistance<sup>82</sup> noted the highest levels of multidrug resistance ever recorded in a general population, with an estimated half a million cases occurring globally, including 50 000 cases of extensively drug-resistant tuberculosis. Recognizing its relevance for global security, the Executive Board agreed that an item on the prevention and control of multidrug and extensively drug-resistant tuberculosis should be added to the provisional agenda of the World Health Assembly.<sup>83</sup> Notwithstanding the achievements over the past decade, prevention and management of drug-resistant tuberculosis require much stronger control which, in turn, requires resolving of weaknesses of health systems. The challenges posed by drug-resistant tuberculosis offer important opportunities to strengthen health systems with the goal of achieving universal coverage for health care.
2. The care and control of tuberculosis have progressed significantly during the past decade and the incidence of new cases is estimated to have fallen slightly each year since 2003. In 2007, 9.3 million new cases are estimated to have occurred and 63% were treated under programmes using the Stop TB strategy, with over 85% treatment success. An estimated 37% of cases worldwide, however, remain

<sup>81</sup> Multidrug-resistant tuberculosis is defined as resistance to at least rifampicin and isoniazid, the two most powerful anti-tuberculosis medicines. Extensively drug resistant-tuberculosis is defined as multidrug-resistant tuberculosis that is also resistant to any one of the fluoroquinolones and to at least one of three injectable second-line antibiotics (amikacin, capreomycin or kanamycin).

<sup>82</sup> Document WHO/HTM/TB/2008.394.

<sup>83</sup> Document EB124/2009/REC/2, summary record of the eleventh meeting, section 3, and the twelfth meeting, section 1.

un-notified, with patients receiving either no treatment or treatment that is unlikely to reach internationally recommended standards.

3. Emergence and spread of multidrug- and extensively drug-resistant tuberculosis are facilitated by inadequate case detection and inappropriate treatment. While country-level data collection and reporting need further improvements, several countries have reported increasing levels of anti-tuberculosis drug resistance. Twenty-seven countries,<sup>84</sup> 15 of which are in eastern Europe and central Asia, account for 85% of the total burden of multidrug-resistant tuberculosis. China, India and the Russian Federation together constitute over half the burden but the problem of multidrug- and extensively drug-resistant tuberculosis is global and present in almost all countries surveyed. Fifty-five countries have, at the time of writing, reported at least one case of extensively drug-resistant tuberculosis, but in most low-income countries the magnitude of the problem is unknown.
4. Altogether countries, in their planning for 2008, expected a total of about only 25 000 patients with multidrug-resistant tuberculosis to be detected and treated, of which about half would have been treated according to internationally recommended standards, representing only about 3% of the 500 000 estimated new cases of multidrug-resistant tuberculosis. Yet treatment is feasible and cost-effective if WHO guidelines are followed, with cure rates of up to 80% among multidrug-resistant cases and up to 60% among extensively drug-resistant cases in low-resource settings. Inappropriate treatment that is not in line with the recommended guidelines runs the risk of raising mortality, increasing resistance and spreading resistance even further.
5. Well-functioning national control programmes with high cure and detection rates are detecting only low levels of multidrug-resistant tuberculosis. Conversely, multidrug-resistant tuberculosis emerges as a result of underinvestment in the Stop TB strategy.<sup>85</sup> The emphasis for action therefore needs to be both on strengthening basic control to prevent the emergence of drug resistance and on diagnosing and treating the cases of multidrug- and extensively drug-resistant tuberculosis effectively in order to prevent transmission. The frameworks for controlling both drug-susceptible and drug-resistant disease exist in the Stop

<sup>84</sup> These are the countries with 4000 or more cases of multidrug-resistant tuberculosis estimated to occur annually: Armenia, Azerbaijan, Bangladesh, Belarus, Bulgaria, China, Democratic Republic of the Congo, Estonia, Ethiopia, Georgia, India, Indonesia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Myanmar, Nigeria, Pakistan, Philippines, Republic of Moldova, Russian Federation, South Africa, Tajikistan, Ukraine, Uzbekistan, and Viet Nam.

<sup>85</sup> Document WHO/HTM/TB/2006.368.

TB strategy and in the WHO guidelines for the programmatic management of drug-resistant tuberculosis. Nevertheless, major obstacles persist, which include: weak general health systems, with consequent gaps in basic tuberculosis control; health workforce crisis; inadequate laboratory capacity; insufficient expansion of programmes to treat drug-resistant tuberculosis; non-engagement of private-care providers; inadequate collaboration between HIV and tuberculosis programmes; problems with production, supply and rational use of anti-tuberculosis medicines; inattention to infection control; insufficient funding for research and development; and inadequate financial resources.

6. Weak national health systems impede basic control and facilitate re-appearance and spread of drug-resistant tuberculosis. Effective control requires appropriate national policies, trained and motivated staff, and quality-assured laboratory- and medicine-supply systems supported by an adequately funded tuberculosis programme. All health-care facilities used by patients with symptoms of tuberculosis must be engaged with general and specialized hospitals, academic institutions and the array of diverse private-care providers need to be involved as a priority. A network of patient-friendly health clinics and staff is essential to ensure that treatment is supervised in a supportive manner and is quality-assured, free of cost, and easy to access. If patients discontinue their treatment, there must be mechanisms to trace them and re-establish treatment. Moreover, informed, motivated and resourced communities can contribute to case finding and adherence support especially in resource-poor settings.
7. WHO estimates that 57 countries, including 36 in sub-Saharan Africa, 15 of them with a high tuberculosis-burden, are facing a serious shortage of health-service providers.<sup>86</sup> Cases of detection and treatment success rates in these countries are generally low. Insufficient workforce, uneven distribution, weak capacity, high workload, frequent transfers, low motivation, and weak supervision are among the important deficiencies. There is no standard solution to resolve these problems, but effective strategies should focus on improving recruitment, helping the existing workforce to perform better, and slowing the rate at which health workers leave the workforce, all in line with a comprehensive strategic plan for human resources for health.
8. Presently, less than 5% of the estimated cases of multidrug-resistant tuberculosis are being diagnosed. Many countries, especially in Africa, lack laboratory

<sup>86</sup> *The world health report 2006: working together for health*. Geneva, World Health Organization, 2006.

capacity to culture *Mycobacterium tuberculosis* and do drug-susceptibility tests. Laboratory capacity, neglected for a long time, needs rapid expansion under international norms and standards, as part of the strengthening of a broader national public health laboratory system; the Global Laboratory Initiative of WHO and partners is helping to enhance coordination of the response. New technologies that can accelerate the diagnosis of drug-resistant tuberculosis are available, but not yet widely implemented, the main obstacle being lack of an adequate, safe laboratory infrastructure and appropriately trained staff.

9. National programmes need policies on where and how to treat drug-resistant tuberculosis cases. In some countries, patients are admitted to hospital for long periods of time, which is labour-intensive and costly, raises important ethical and social issues, and increases the risk of nosocomial transmission if infection control is weak. New models of care enabling safe and effective treatment supplemented by community-based support have proven to be feasible and effective in low-resource settings. To expand treatment services effectively and rapidly, countries will need centres of excellence to ensure adequate capacity building of health-care providers for tuberculosis management.
10. A large proportion of tuberculosis patients are diagnosed and treated in the private sector in many countries and the quality of management is uneven: the patients detected are not notified and their treatment outcomes are unknown. Models of collaboration with the private sector for care and control including management of multidrug-resistant tuberculosis, in which patients do not have to pay for costs of care, have proved effective in resource-poor settings and are necessary for rapid expansion of multidrug-resistant tuberculosis management. Health ministries should involve the private-care sector in ensuring provision of quality treatment through public–private mix approaches linked with the national tuberculosis programme.
11. People living with HIV are more susceptible to developing tuberculosis, including drug-resistant tuberculosis. Also, HIV infection greatly increases the fatality rate among multidrug- and extensively drug-resistant tuberculosis. Improved and strengthened collaboration between tuberculosis and HIV programmes is required to prevent rapid transmission of drug-resistant tuberculosis and resulting high mortality among communities heavily affected by HIV. To this

end, WHO recommended that collaborative tuberculosis/HIV activities should be expanded.<sup>87</sup>

12. Quality-assured medicines are essential for successful treatment of tuberculosis. Manufacturing processes must meet international standards and the quality of the finished product must be assured. WHO standards for quality medicines are not always observed. Quality-assured fixed-dose combinations, developed as a tool to prevent the emergence of resistance, are not widely used. Inadequate supply of quality-assured second-line medicines has been a major issue. Since 2000, the Green Light Committee, established by WHO and partners, has provided access to medicines that are quality assured to WHO standards, and concessionally priced, for projects worldwide that apply WHO guidelines.<sup>88</sup> Concerted action on the part of governments, drug-regulatory authorities, the pharmaceutical industry, and WHO is required to ensure that adequate and uninterrupted supply of quality-assured anti-tuberculosis medicines are available and accessible to all those in need.
13. Availability of over-the-counter anti-tuberculosis medicines in retail pharmacies and irrational prescriptions by care providers in many countries have facilitated emergence of drug resistance. Some countries have successfully restricted prescribing and dispensing of anti-tuberculosis medicines to accredited facilities where full adherence to internationally recommended standards of treatment can be ensured. Such practices should be encouraged and supported. Countries should also undertake active promotion of rational use of medicines through comprehensive approaches involving drug regulatory authorities, national tuberculosis programmes, health-care providers, the pharmaceutical industry, pharmacists and consumers.
14. Infection control in health-care and institutional settings, essential to prevent disease transmission, has yet to receive adequate attention in the policy and practice of control of communicable diseases such as tuberculosis in resource-poor countries. Recent outbreaks of extensively drug-resistant tuberculosis with high mortality have stimulated activities to institute infection control in some settings. To better protect health-care workers and decrease the risk of tuberculosis transmission in institutional settings, such as correctional facilities

<sup>87</sup> Documents WHO/HTM/TB/2004.330 and WHO/HTM/HIV/2004.1.

<sup>88</sup> By end 2008, the Green Light Committee had approved 60 countries for multidrug-resistant tuberculosis management and treatment for a total of 49 858 multidrug-resistant tuberculosis patients since 2000. Of the 27 priority multidrug-resistant tuberculosis countries, all have Green Light Committee approval, except Nigeria and South Africa.

and within households, infection control requires engagement with a wide range of stakeholders across the health system including hospital administrators, architects, engineers, as well as doctors, nurses and laboratory staff.

15. Research in tuberculosis has only recently been established on a reasonable scale, although research funding in 2007 showed little increase over 2006. Global control of multidrug-resistant tuberculosis will depend, ultimately, on wide availability of new, rapid diagnostic tests capable of providing results within hours without complex equipment or laboratory biosafety requirements; new medicines to shorten treatment and treat multidrug- and extensively drug-resistant tuberculosis within months rather than years; and a vaccine to prevent tuberculosis, be it drug-susceptible or resistant. Greater attention to and resources for, tuberculosis research are essential.
16. To achieve the target set out in the Global Plan to Stop TB 2006–2015, 1.5 million cases of multidrug- and extensively drug-resistant tuberculosis will need to be treated in the 27 countries with the highest burden in the seven years from 2009 to 2015. The projected number of treated cases increases from 70 000 in 2009 to 382 000 cases in 2015. Combined with a cost per patient treated that is usually in the range US\$ 3000–10 000,<sup>89</sup> the total cost of treating 1.5 million cases amounts to US\$ 11 500 million over seven years, rising from US\$ 500 million in 2009 to US\$ 3100 million in 2015; the latter figure is 43 times the funding available in 2009 and 53% of the total funding required for tuberculosis control. Most funding is required in the European Region (US\$ 7800 million), followed by Asia (US\$ 2800 million). In order to mobilize the required funding for improved management of multidrug- and extensively drug-resistant tuberculosis, preparation of country-specific budgets as part of national strategic plans is the first step that needs to be taken. WHO has prepared a planning and budgeting tool for this purpose. Domestic resources need to be accessed especially in middle-income countries. If sufficient domestic funding cannot be mobilized, countries should make full use of resources available from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility (UNITAID), and other donor agencies and funding mechanisms.

## **ACTION BY THE HEALTH ASSEMBLY**

17. The Health Assembly is invited to note the report and provide guidance.

<sup>89</sup> Costs vary according to the drug regimen, the model of care that is used, and prices of inputs (for example, higher costs for staff are expected in countries with higher incomes).

## For more information:

### WHO Websites:

- Tuberculosis: <http://www.who.int/topics/tuberculosis/en/>
- A World Free of TB: <http://www.who.int/tb/en/>
- Stop TB Partnership: <http://www.stoptb.org/>
- Beijing Meeting: [http://www.who.int/tb\\_beijingmeeting/en/](http://www.who.int/tb_beijingmeeting/en/)

### Non-WHO Websites:

- Global Fund: <http://www.theglobalfund.org/en/>
- TB Alert, MDR TB: <http://www.tbalert.org/worldwide/MDR.php>
- CDC Division of TB Elimination: <http://www.cdc.gov/tb/default.htm>
- Médecins Sans Frontières: [http://www.msf.org/msfinternational/invoke.cfm?objectid=7EB75D5F-15C5-F00A-25379B7AD832DCF0&component=toolkit.article&method=full\\_html](http://www.msf.org/msfinternational/invoke.cfm?objectid=7EB75D5F-15C5-F00A-25379B7AD832DCF0&component=toolkit.article&method=full_html)
- AIDSmap: <http://www.aidsmap.com/en/news/618C4802-2F77-4BEF-982D-A9A53B032298.asp>
- TB Survival Project: <http://www.tbsurvivalproject.org/FAQ/faq.html>
- EuroTB: <http://www.eurotb.org/>

## 12.16 Food safety

### Extract from Document A62/21 (Report by the Secretariat):

1. The Fifty-third World Health Assembly in resolution WHA53.15, *inter alia*, requested the Director-General to give greater emphasis to food safety and collaborate with FAO and other international organizations. The Director-General was also urged to put in place a global strategy for the surveillance of foodborne diseases and for the efficient gathering and exchange of information in and between countries. As a result WHO organized a meeting on the strategic planning of food safety (Geneva, February 2001), and, following further consultation with Member States, published the Global strategy for food safety in 2002.<sup>90</sup> As a result of the Global strategy, WHO and FAO set up the International Food Safety Authority Network in 2005. The Executive Board at its 124th session proposed food safety as a separate item on the provisional agenda of the Health Assembly.<sup>91</sup> The present report provides an overview of global food safety as well as the opportunities for action and the tools and methods for achieving solutions. It does not deal with food security.

### SITUATION OVERVIEW

2. Food safety and foodborne diseases are a growing public health problem. WHO estimates that foodborne and waterborne diarrhoeal diseases taken together kill about 2.2 million people annually, 1.9 million of them children. A large number of communicable diseases, including emerging zoonotic diseases, are transmitted through food, and many other diseases, including cancers, are also associated with chemicals and pathogens in the food supply. But the full extent of the associated burden of disease and the related cost of unsafe food is not known. Reliable estimates are needed in order to guide food safety management at national and international levels. WHO's Initiative to estimate the Global Burden of Foodborne Diseases from all major causes (microbiological, parasitic and chemical) is designed to provide those estimates.
3. Foodborne disease outbreaks have had devastating health and economic consequences in both developed and developing countries and could hamper achievement of Millennium Development Goal 1 (Eradicate extreme poverty and

<sup>90</sup> For full details of the Global strategy please visit [www.who.int](http://www.who.int) and click on Health Topics to reach the Food Safety page.

<sup>91</sup> EB124/2009/REC/2, summary record of the eleventh meeting, section 3.

hunger) and Goal 4 (Reduce child mortality). In addition, economic development in countries that rely on food export as a major economic driver could be seriously affected if the safety of those exports is in question.

4. The spread of pathogens and contaminants across national borders means that foodborne diseases now threaten global public health security. Recent events related to both chemical contamination (e.g. melamine and dioxin) and microbiological contamination of food products with traditional (e.g. *Salmonella* spp.) or new (Ebola Reston virus) pathogens highlight the global aspect of the problem. However, the application of new methods, such as genetic characterization of pathogens and of bio-marker technology (used to understand the molecular mechanism of action of new medicines in humans) for chemicals in food, opens the way to linking related cases and identifying the specific causes of disease. At the same time, more national and international food standards are being based on a systematic and increasingly statistical approach to microbiological and chemical risk assessment that uses new methods developed by WHO/FAO Expert Groups and the FAO/WHO Codex Alimentarius Commission.
5. It is now clear that many or most new human infectious diseases over recent decades have originated from animals and that transmission has often also been through food. Examples include severe acute respiratory syndrome, bovine spongiform encephalopathy and variant Creutzfeldt–Jakob disease, highly pathogenic avian influenza, and haemorrhagic fevers such as Rift Valley fever.

## OPPORTUNITIES FOR ACTION

6. There is now both a need and an opportunity for Member States and the Secretariat to take food safety action to a new level. As food safety issues are international, the solutions must also be international, and all sectors must be involved given that food safety problems may originate in any sector of the food production chain, including in the environment, animal feed, on the farm, production and retail, preparation practices, and even the consumer's kitchen. Efficient multisectoral collaboration will be a prerequisite for food safety, involving all relevant partners at the international and national levels.
7. International agreement on global management of food safety, based on general scientific principles, cross-sectoral collaboration and action at international and national levels, offers many new solutions that rely on efficient exchange of data, good science and practical experience. New integrated approaches as well

as linkages between monitoring and surveillance data for animals, food and patients offer the opportunity for scientifically-based action and assessment of the effect of management action. The application of new frameworks and management options to mitigate existing food-related risks could significantly reduce the incidence of foodborne disease over the medium- to long-term.

## TOOLS AND METHODS

8. The International Food Safety Authorities Network provides a new vehicle to link and support national authorities in order to enable the sharing of data, knowledge, competence and experience as well as emergency information. It is managed in collaboration with FAO, and presently consists of 176 Member States. Its importance is recognized in the Beijing Declaration on Food Safety of November 2007. The FAO-OIE-WHO Global Early Warning System for Major Animal Diseases, including zoonoses, launched in 2006, shares emergency information between the animal and human health sectors at the international level.
9. The WHO Foodborne Disease Burden Epidemiology Reference Group, established in 2006, is working to assemble burden of disease estimates using summary measures of population health and will provide a global report by 2012, based on representative country studies performed using new protocols developed by the group.
10. WHO's new strategic directions in human health aspects of zoonoses focus on strengthening zoonosis surveillance; forecasting and alert and response mechanisms; providing tools for the assessment, management and communication of zoonotic risks; strengthening capacity building; and improving national and international networking and cross-sectoral cooperation. Surveillance requirements for systems to manage antimicrobial resistance in animal, food and human reservoirs are currently being defined. Those requirements reflect WHO's revised list of critically important antimicrobials for human health (developed in collaboration with FAO and OIE).<sup>92</sup> New methods offer the promise of integrated, laboratory-based surveillance and action focused on areas with the highest risk. This can only be achieved through intersectoral collaboration and communication between human health, veterinary and

<sup>92</sup> Critically important antimicrobials for human medicine: categorization for the development of risk management strategies to contain antimicrobial resistance due to non-human antimicrobial use. Report of the second WHO Expert Meeting, Copenhagen, 29–31 May 2007. Geneva, World Health Organization, 2007.

food-related disciplines. The WHO Global Salm-Surv network, set up in 2000 for detecting, controlling and preventing foodborne and other enteric infections, operates to enable such collaboration and communication in 156 Member States.

11. The Secretariat is devising new initiatives to provide scientific advice on both risks and benefits of food, in collaboration with FAO, featuring clear and simple messages for consumers on safety, nutrition and life-style advice, and will be presented to Member States. The WHO training programme on Five Keys to Safer Food<sup>93</sup> is being applied to different target groups in most regions.
12. In the future, data characterizing chemical contamination in food can be combined with national data on food consumption, thus enabling a clear mapping of the exposure of populations to chemical contaminants and chemicals in food. The Global Environment Monitoring System-Food Contamination Monitoring and Assessment Programme<sup>94</sup> provides information on levels, trends and significance of chemical contaminants in food, based on data from all regions of the world. It could be used to present similar data on foodborne pathogens.
13. Sound scientific food safety risk assessment is the basis for policy development and for managing food safety. The need for and complexity of such scientific advice have grown dramatically in recent years. WHO is investigating new ways of ensuring international provision of scientific advice, avoiding the waste of resources caused by repetitive assessments in countries or regions.

#### **ACTION BY THE HEALTH ASSEMBLY**

14. The Health Assembly is invited to note the report.

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<sup>93</sup> See [www.who.int/foodsafety/consumer/](http://www.who.int/foodsafety/consumer/).

<sup>94</sup> See [www.who.int/foodsafety/chem./gems/](http://www.who.int/foodsafety/chem./gems/).

## For more information:

### WHO Websites:

- Food Safety: [http://www.who.int/topics/food\\_safety/en/](http://www.who.int/topics/food_safety/en/)
- Campylobacter: <http://www.who.int/topics/campylobacter/en/>
- E Coli infections: [http://www.who.int/topics/escherichia\\_coli\\_infections/en/](http://www.who.int/topics/escherichia_coli_infections/en/)
- Foodborne diseases: [http://www.who.int/topics/foodborne\\_diseases/en/](http://www.who.int/topics/foodborne_diseases/en/)
- Listeria Infections: [http://www.who.int/topics/listeria\\_infections/en/](http://www.who.int/topics/listeria_infections/en/)
- Salmonella: <http://www.who.int/topics/salmonella/en/>
- Codex Alimentarius: [http://www.codexalimentarius.net/web/index\\_en.jsp](http://www.codexalimentarius.net/web/index_en.jsp)
- Food Safety: <http://www.who.int/foodsafety/en/>
- Foodborne Disease Surveillance: [http://www.who.int/foodborne\\_disease/en/](http://www.who.int/foodborne_disease/en/)
- WHO Global Salm-Surv: <http://www.who.int/salmsurv/en/>

### Non-WHO Websites:

- UK Food Standards Agency: <http://www.food.gov.uk/>
- US Medline Plus, Food Safety: <http://www.nlm.nih.gov/medlineplus/foodsafety.html>
- European Food Safety Authority (EFSA): [http://www.efsa.europa.eu/EFSA/efsa\\_locale-1178620753812\\_home.htm](http://www.efsa.europa.eu/EFSA/efsa_locale-1178620753812_home.htm)
- US Food & Drug Administration (FDA): <http://www.fda.gov/>

## 12.17 Viral hepatitis

### Extract from Document A62/22 (Report by the Secretariat):

#### THE DISEASES AND BURDEN

1. The group of viruses that cause acute and/or chronic liver infection and inflammation (hepatitis) is responsible for major public health problems globally. Infection with hepatitis A, B, C, D and E viruses can cause acute liver disease. Hepatitis B and C viruses can also cause chronic infections that remain silent for decades, placing infected persons at risk for premature death from liver cirrhosis (scarring) or primary liver cancer in later life. As all five viruses differ in their global distribution and routes of transmission, tailored prevention strategies will be required. Two forms of viral hepatitis, hepatitis A and hepatitis B, are preventable by vaccines.
2. Hepatitis B and C viruses are the major causes of severe illness and death related to viral hepatitis. About 2000 million people have been infected with hepatitis B virus worldwide, of whom more than 350 million are chronically infected, and between 500 000 and 700 000 people die annually from hepatitis B virus infection. Some 130–170 million people are chronically infected with hepatitis C virus. An estimated 57% of cases of liver cirrhosis and 78% of primary liver cancer result from hepatitis B or C virus infection.
3. Hepatitis B virus infection early in life is associated with the highest risk of chronic infection. People with chronic infection risk progression to cirrhosis and primary liver cancer. About 90% of infants infected around the time of birth, 30% of children infected in early childhood and 6% of those infected after five years of age will develop chronic hepatitis B virus infection. The likelihood of progression to chronic infection is the same whether infection is symptomatic or asymptomatic. People with chronic hepatitis B virus infection have a 15% to 25% risk of dying prematurely from hepatitis B virus-related cirrhosis and liver cancer. People with chronic hepatitis C virus infection are also at high risk for developing cirrhosis and liver cancer. Both superinfection by, and coinfection with, hepatitis D virus in hepatitis B virus-infected patients result in worse outcomes than infection with hepatitis B virus alone; this includes a higher rate of liver failure in acute infections and a greater likelihood of developing liver cancer in chronic infections.

4. Exposure to blood through injections with nonsterile equipment or transfusion of infected blood products is a common and preventable cause of hepatitis B and C virus infections. Unsafe injection practices are estimated to be responsible for 21 million new hepatitis B virus infections and two million new hepatitis C virus infections a year. A significant proportion of the blood supply is either not screened at all for hepatitis B or C virus or not screened properly. The probability of transmission of hepatitis B and C viruses through transfusion of unsafe blood can be as high as about 70% and 92%, respectively, depending on the volume transfused and viral load. Injecting drug use represents the highest risk for hepatitis C virus infection, with prevalence rates in people reporting this behaviour ranging between 30% and 60%.
5. It is estimated that about 1.4 million new hepatitis A virus infections occur globally each year. Infection is usually by the fecal–oral route either through person-to-person contact or ingestion of contaminated food or water. Paradoxically, as water and sanitation systems improve in developing countries, infections occur later in life, when the risk for severe disease from hepatitis A is greatest. This shifting epidemiology is responsible for increased numbers of cases in some countries and the emergence of community-wide outbreaks of hepatitis A.
6. Hepatitis E virus infection occurs sporadically and in epidemics, causing significant morbidity and death, especially in pregnant women. It is estimated that one third of the world's population has been infected with hepatitis E virus. However, the true burden of hepatitis E is unknown.
7. Foodborne transmission of both hepatitis A and E viruses is common; indeed, hepatitis A virus is among the viruses most frequently involved in foodborne infections. Foodborne contamination may be the result of infected food handlers unknowingly contaminating food. Hepatitis A and E viruses persist in the environment and are able to resist food-production processes routinely used to inactivate and/or control bacterial pathogens.
8. Hepatitis B virus/HIV and hepatitis C virus/HIV coinfections are an increasing problem in countries with concentrated HIV epidemics and among injecting drug users. For those coinfecting persons who are being treated with antiviral medicines, underlying viral hepatitis is becoming a major cause of death.

## PREVIOUS HEALTH ASSEMBLY ACTION AND SECRETARIAT ACTIVITIES

9. The Health Assembly has considered specific aspects of hepatitis prevention in past resolutions. First, in 1992, in resolution WHA45.17 on Immunization and vaccine quality it urged Member States to integrate hepatitis B vaccine into national immunization programmes in countries where it is feasible. The Secretariat acted on this resolution by recommending that all countries integrate hepatitis B vaccine into national immunization programmes by 1997. Support from the GAVI Alliance for the introduction of hepatitis B vaccine has resulted in great increases in vaccination coverage in the past decade. As of 2007, more than 88% of Member States have introduced hepatitis B vaccine, overall coverage with three doses of vaccine was 65%, and globally 27% of newborn infants received the birth dose of hepatitis B vaccine. Secondly, in 2005, in resolution WHA58.22 on Cancer prevention and control the Health Assembly called for including reduction in hepatitis B virus infection among the outcome objectives of national cancer control programmes. At the time of writing, implementation of this resolution and its monitoring are still in progress. Thirdly, as part of the Global plan of action on workers' health 2008–2017, endorsed by the Health Assembly in 2007,<sup>95</sup> the Secretariat's activities would include working with Member States for immunization of health-care workers against hepatitis B. Little progress has been made in the short time since the resolution endorsing the plan was adopted. In addition, the Health Assembly has considered a number of hepatitis prevention issues relating to immunization,<sup>96</sup> safe blood supply,<sup>97</sup> food safety<sup>98</sup> and safe injections.<sup>99</sup>
10. In 1998 the WHO-cosponsored Conference Regarding Disease Elimination and Eradication as Public Health Strategies (Atlanta, Georgia, United States of America, 23–25 February 1998) concluded that hepatitis B is “a primary candidate for elimination or eradication”. In 1999, WHO joined UNICEF and UNFPA to recommend the exclusive use of auto-disable syringes for all immunization injections by the year 2003.<sup>100</sup> Much progress has been made with

<sup>95</sup> Resolution WHA60.26.

<sup>96</sup> Resolutions WHA44.33 on World Summit on Children: follow-up action, WHA53.12 on Global Alliance for Vaccines and Immunization, and WHA61.15 on Global immunization strategy.

<sup>97</sup> Resolutions WHA28.72 on Utilization and supply of human blood and blood products and WHA58.13 on Blood safety: proposal to establish World Blood Donor Day.

<sup>98</sup> Resolutions WHA53.15 on Food safety, WHA56.23 on Joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission, and WHA58.32 on Infant and young child nutrition.

<sup>99</sup> Resolution WHA55.18 on Quality of care: patient safety.

<sup>100</sup> Document WHO/V&B/99.25.

the support of the GAVI Alliance for the procurement of non-reusable syringes for immunization. WHO has issued position papers for hepatitis B vaccine (2004)<sup>101</sup> and hepatitis A vaccine (2000).<sup>102</sup> In 2005, the Western Pacific Region set a goal of reducing chronic hepatitis B virus infection rates to less than 2% among five-year-old children by 2012. In 2008, WHO together with FAO, convened an expert meeting on viruses in foods to provide scientific advice in support of risk-management activities. Recently, the European Region has developed clinical protocols for the management of hepatitis B virus/HIV coinfection, hepatitis C virus/HIV coinfection, and prevention of hepatitis A, B and C virus infection in people living with HIV. In November 2008, WHO's Strategic Advisory Group of Experts on immunization recommended that "all regions and associated countries develop goals for hepatitis B control appropriate to their epidemiologic situations" The Regional Committee for the Eastern Mediterranean will consider the issue of hepatitis prevention and control broadly at its fifty-sixth session later in 2009. Several countries have established national goals for the elimination of transmission of hepatitis B virus.

## OPPORTUNITIES FOR PREVENTION AND CONTROL

11. Coordinating programmes for the prevention and control of hepatitis with other related programmes will contribute to the strengthening of health systems in all countries. To date, prevention and control efforts have been successful but fragmented. WHO does not have a comprehensive strategy for viral hepatitis. Thus, the time is right to create new opportunities for prevention, including establishing goals and strategies for disease control, increasing education and promoting screening and treatment of the 500 million people or so already infected with hepatitis B and C viruses. The impact of these efforts on mortality and morbidity will be significant because of the tremendous burden of disease. WHO is in a position to provide coordinated, global leadership and support to preventing and controlling viral hepatitis.
12. Progress has been made in preventing hepatitis B virus infection through immunization of infants. Despite this, coverage with hepatitis B vaccine has not yet reached the goal set by the Global Immunization Vision and Strategy 2006–2015 of 90% national vaccination coverage by 2010 and lags behind global coverage levels for vaccination against diphtheria, tetanus and pertussis.

<sup>101</sup> Weekly Epidemiological Record, 2004; 79:255–263.

<sup>102</sup> Weekly Epidemiological Record, 2000; 75:38–44.

Vaccination of infants at birth, a safe and effective means of preventing perinatal infections that are associated with the worst health outcomes, remains low and is an important element in strengthening health systems as part of efforts to provide services to mother and child around the time of pregnancy. Health-care workers are still not being vaccinated against hepatitis B in most developing countries and vaccination coverage levels are not monitored. Elimination of hepatitis B virus transmission is feasible for future generations, however, vaccines are too late to protect those 350 million who already have chronic hepatitis B virus infections.

13. Many new and effective treatments that can significantly delay progression of liver disease, prevent the onset of liver cancer, and reduce deaths are available for the more than 500 million people living with hepatitis B and C virus infection. The challenge remains to ensure that these people have timely access to testing, care and effective treatments, especially in resource-limited settings.
14. Demand for hepatitis A vaccine is increasing in large parts of the world that are experiencing an increase in symptomatic cases and more frequent epidemics because of changing epidemiology. Candidate vaccines against hepatitis C and E virus infections should be further developed.
15. Because unsafe health-care practices remain common in many parts of the world, all countries need to make concerted efforts to implement strategies to prevent hepatitis in health-care settings based on safe blood supply and safe injections. Safe injections cause no harm to the recipient, do not expose the provider to any avoidable risk and do not result in any dangerous waste. The primary means of preventing transmission of hepatitis viruses in blood donations is the collection of blood from voluntary, unpaid blood donors who are at low risk of infection. In 2006, only 54 countries reported that they had achieved 100% voluntary blood donation. The second means of prevention in blood product transmission is quality-assured screening of all donated blood for hepatitis B and C virus markers. As of 2006, 55 countries reported not screening all donated blood for hepatitis B virus and 85 countries reported not screening all donated blood for hepatitis C virus. The third strategy is the rational use of blood in order to minimize unnecessary transfusions. Limited data are available on blood utilization, but studies suggest that blood transfusion is widely over-used in both developed and developing countries. Safe injection devices that are not reusable and have features to prevent needlestick injuries need to be

used universally, and the training of all health-care providers on best injection practices, including proper sharps waste management, should be strengthened.

16. WHO is in a position to provide coordinated global support and leadership in the development of a comprehensive approach to prevention and control of viral hepatitis with priorities that apply across the health system and include the following.
  - Protect all infants from infection with hepatitis B virus through full immunization, beginning as early in life as possible and linked with maternal and child health services.
  - Increase coverage of hepatitis B vaccination among health-care workers in order to prevent transmission of hepatitis B virus in the workplace and ensure access to post-exposure prophylaxis for blood-borne pathogens.
  - Ensure safe blood supplies by: recruiting only voluntary, unpaid blood donors; introducing effective blood donor selection and screening of all donated blood for markers of hepatitis B and C virus infection with highly sensitive and specific assays and following basic standardized procedures; and training clinicians and nurses in safe clinical transfusion practices.
  - Ensure that all injections are safe through sustainable procurement of sufficient quantities of appropriate syringes, training on safe injection practices and ensuring that sharps waste is properly managed.
  - Improve food safety by preparing and introducing international guidelines for the management of viruses and toxins in foods.
  - Integrate interventions for the prevention, treatment and care of hepatitis B and C virus infections into services for injecting drug users, including access to sterile needles and syringes, hepatitis B vaccination and antiviral treatment.
  - Guide implementation of hepatitis A vaccination to prevent the emergence of hepatitis A in developing countries.
  - Support the new preventive strategies including development of vaccines for other causes of viral hepatitis (especially hepatitis C and E).
  - Expand care and treatment services for people chronically infected with hepatitis viruses.
  - Increase awareness among communities and health-care workers of the opportunities to prevent viral hepatitis.

- Improve technologies for vaccination, screening and health care in order to prevent chronic liver disease and liver cancer.
- Ensure that priority is given to prevention and care of viral hepatitis in moves towards achieving health equity and that the necessary resources are identified.
- Engage multiple programmes in comprehensive approaches to prevent infection and manage disease, and in particular create links with HIV diagnostic and treatment services and with national cancer control programmes. These services and programmes can provide good entry points for both infected and most-at-risk people, and coordination can promote synergies for prevention, therapy and laboratory work.

#### **ACTION BY THE HEALTH ASSEMBLY**

17. The Health Assembly is invited to take note of the report and provide further strategic guidance.

## For more information:

### WHO Websites:

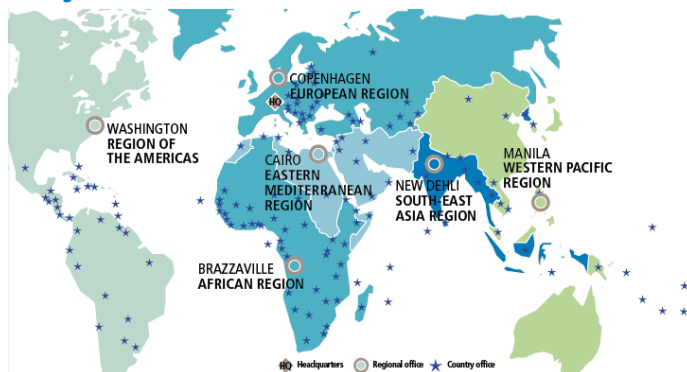
- Hepatitis: <http://www.who.int/topics/hepatitis/en/>
- NUVI Hepatitis B: <http://www.who.int/nuvi/hepb/en/>

### Non-WHO Websites:

- US CDC Hepatitis: <http://www.cdc.gov/hepatitis/>
- US Women's Health, Viral Hepatitis FAQs: <http://www.womenshealth.gov/FAQ/viral-hepatitis.cfm>
- European Viral Hepatitis Educational Initiative: <http://www.evhei.com/home/home.cfm>
- Association of Medical Microbiologists, Facts about Viral Hepatitis: [http://www.amm.co.uk/files/factsabout/fa\\_virhep.htm](http://www.amm.co.uk/files/factsabout/fa_virhep.htm)

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- Iraq
- Kuwait
- Lebanon
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- Oman
- Pakistan
- Qatar
- Saudi Arabia
- Somalia
- Sudan
- Syrian Arab Republic
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- Yemen

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- Cook Islands
- Fiji
- Japan
- Kiribati
- Lao People's Democratic Republic
- Malaysia
- Marshall Islands
- Micronesia (Federated States of)
- Mongolia
- Nauru
- New Zealand
- Niue
- Palau
- Papua New Guinea
- Philippines
- Republic of Korea
- Samoa
- Singapore
- Solomon Islands
- Tonga
- Tuvalu
- Vanuatu
- Viet Nam

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- Azerbaijan
- Belarus
- Belgium
- Bosnia and Herzegovina
- Bulgaria
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- Cyprus
- Czech Republic
- Denmark
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- Kyrgyzstan
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- Republic of Moldova
- Romania
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- Serbia
- Slovakia
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- United Kingdom
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- Saint Lucia
- Saint Vincent and the Grenadines
- Suriname
- Trinidad and Tobago
- United States of America
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- Maldives
- Myanmar

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- Sri Lanka
- Thailand
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- Liberia
- Madagascar
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- Mozambique
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- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
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- Swaziland
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