WHCA ACTION GUIDE
World Health Communication Associates

The "Unofficial" WHCA Action Guide to the:

WHO - 61st World Health Assembly

MAY 2008, GENEVA

PLEASE USE THIS SPACE FOR MAKING NOTES

DRAFT

WHCA ACTION GUIDE

World Health Communication Associates

The "Unofficial" WHCA Action Guide to the:

WHO - 61st World Health Assembly

MAY 2008, GENEVA

DRAFT

INTRODUCTION

This "unofficial" WHCA Action Guide is a compilation of information from the WHO website regarding the 61st World Health Assembly. It is presented for use by the 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" being held in Geneva 18-19 May 2008. The proceedings of this workshop will be published on the WHCA/WHEN website at www.whcaonline.org.

A big thank you to WHCA Associates *Carinne Allinson* and *Tuuli Sauren* for the compilation, editing and design of this document.

Franklin Apfel
Managing Director

World Health Communication Associates
Little Harborne, Church Lane, Compton Bishop,
Somerset BS26 2HD
United Kingdom
whca@onetel.net

DRAFT

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 serves as secretariat to WHEN.

DRAFT

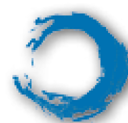


TABLE OF CONTENTS

INTRODUCTION

SECTION I : Introduction to the WHO World Health Assembly 5

SECTION II : Practical information : 61st World Health Assembly 7

SECTION III: Overview of the 61st World Health Assembly agenda and resolutions 10

SECTION IV: Agenda discussion topics and resolutions 13

11.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits 13

11.2 Poliomyelitis: mechanism for management of potential risks to eradication 14

Resolution 18

11.4 Implementation of the International Health Regulations (2005) 21

Resolution 28

11.5 Prevention and control of non-communicable diseases: implementation of the global strategy 31

11.7 Global immunization strategy 56

Resolution 63

11.8 Female genital mutilation 66

Resolution 70

11.9 Health of migrants 74

Resolution 81

11.10 Strategies to reduce the harmful use of alcohol 85

Resolution 93

11.11 Climate change and health 96

Resolution 102

11.12 Monitoring achievement of the health-related Millennium Development Goals 106

11.13 Counterfeit medical products 113

20 Outcome of the second session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control 125

ANNEX 1. Structure of WHO 128

ANNEX 2. WHO Budget 135

DRAFT

SECTION I: INTRODUCTION TO THE WHO WORLD HEALTH ASSEMBLY

(Adapted from WHO website, 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 (see Annex 1) 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 2) and at the headquarters in Geneva, Switzerland.

DRAFT

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.

DRAFT

SECTION II : PRACTICAL INFORMATION: 61ST WORLD HEALTH ASSEMBLY

(adapted from A61/DIV/2)

DATE AND PLACE OF THE HEALTH ASSEMBLY

The Sixty-first World Health Assembly will open in Geneva on Monday, 19 May 2008, at 10:00; it will close on Saturday, 24 May 2008. 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

The Health Assembly will meet in the Assembly block of the Palais des Nations. The Assembly block is conveniently reached by Doors 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.

REGISTRATION

Delegates and other participants will be able to register and receive their badges before the opening of the Health Assembly. The Registration Desk will be open:

At the main entrance of WHO headquarters

- On Friday, 16 May, from 14:00 until 17:00; Saturday, 17 May, from 09:00 until 12:00, and Sunday, 18 May, from 10:00 until 16:00
- On Monday, 19 May, from 07:30 until 17:00
- From Tuesday, 20 May, to Friday, 23 May, from 08:00 until 17:00
- On Saturday, 24 May, from 09:00 until end of session.

After registration, a shuttle service will be available to take delegates from WHO (door 253) to the Palais.

DRAFT

INQUIRY OFFICE

The Inquiry Office is located in the hall between Doors 13 and 15 (ext. 76556). It provides guidance on a range of matters of interest to participants, and will direct them to other services such as travel, mail, finance and communications. Personal mail can also be collected there. Lost property may be handed in or claimed at this office.

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 Place Neuve 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.

A tram service, tram "13", is also available. It runs 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).

DRAFT

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.

DELEGATES' LOUNGE

Hall 14 near the Assembly Hall is available for the convenience of delegates.

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, hot meals being served from 11:30 to 14:00.

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.

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.

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.

DRAFT

SECTION III: OVERVIEW OF THE 61ST 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 Committee on Nominations
   - 1.3 Reports of the Committee on Nominations
     - Election of the President
     - 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. Report of the Executive Board on its 121st and 122nd sessions
3. Address by Dr Margaret Chan, Director-General (14.30 19th May)
4. Invited speaker (to follow 3)
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: Technical Meeting Room

10. Opening of the Committee
11. Technical and health matters
    - 11.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
    - 11.2 Poliomyelitis: mechanism for management of potential risks to eradication
    - 11.3 Smallpox eradication: destruction of variola virus stocks

DRAFT

11.4 Implementation of the International Health Regulations (2005)

11.5 Prevention and control of non-communicable diseases: implementation of the global strategy

11.6 Public health, innovation and intellectual property: draft global strategy and plan of action

11.7 Global immunization strategy

11.8 Female genital mutilation

11.9 Health of migrants

11.10 Strategies to reduce the harmful use of alcohol

11.11 Climate change and health

11.12 Monitoring achievement of the health-related Millennium Development Goals

11.13 Counterfeit medical products

11.14 Progress reports on technical and health matters

A. Control of human African trypanosomiasis (resolution WHA57.2)

B. Strengthening nursing and midwifery (resolution WHA59.27)

C. International trade and health (resolution WHA59.26)

D. Health promotion in a globalized world (resolution WHA60.24)

E. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

F. Infant and young child nutrition: biennial progress report (resolution WHA58.32)

COMMITTEE B: Administrative and Managerial issues

12. Opening of the Committee

13. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

14. Programme budget and financial matters

14.1 Programme budget 2006–2007: performance assessment

14.2 Financial report and audited financial statements for the period 1 January 2006–31 December 2007

DRAFT

14.3 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

14.4 Special arrangements for settlement of arrears [if any]

14.5 Assessment of new Members and Associate Members [if any]

14.6 Amendments to the Financial Regulations and Financial Rules [if any]

15. Audit and oversight matters

15.1 Report of the External Auditor to the Health Assembly

15.2 Report of the Internal Auditor

16. Staffing matters

16.1 Human resources: annual report

16.2 Amendments to the Staff Regulations and Staff Rules

16.3 Appointment of representatives to the WHO Staff Pension Committee

17. Management matters

17.1 Method of work of the Health Assembly

17.2 Multilingualism: implementation of action plan

18. Collaboration within the United Nations system and with other intergovernmental organizations

- United Nations reform process and WHO's role in harmonization of operational development activities at country level

19. International Agency for Research on Cancer: amendments to Statute

20. Outcome of the second session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control

DRAFT

SECTION IV: AGENDA DISCUSSION TOPICS AND RESOLUTIONS (*)

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

Extract from Document A61/4 (Report by the Secretariat):

The Secretariat announced the launching of an interim traceability mechanism for all influenza A (H5N1) viruses submitted to the Global Influenza Surveillance Network. Through this mechanism, each A (H5N1) virus so submitted is assigned a unique identifier and data on it are stored in an electronic database. Data include the location of each virus, information on analyses that have been done on the virus, further use of the virus in the development of H5N1 vaccine viruses, and recipients of the vaccine viruses and other viruses. This Influenza Virus Tracking System is accessible on http://www.who.int/fluvirus_tracker.

For more information:

WHO Websites:

- Avian 'Flu: 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
- WHO EURO, Influenza (generally): http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=influenza

Non-WHO Websites:

- ECDC, Avian Influenza: http://ecdc.europa.eu/Health_topics/Avian_Influenza/Avian_Influenza.html
- ECDC, Influenza (generally): http://ecdc.europa.eu/Health_topics/influenza/Index.html
- ECDC, Pandemic Influenza: http://ecdc.europa.eu/Health_topics/Pandemic_Influenza/Pandemic_Influenza.html

DRAFT

*11.2 Poliomyelitis: mechanism for management of potential risks to eradication

Extract from Document A61/5 (Report by the Secretariat):

In May 2007, the Health Assembly in resolution WHA60.14, on the mechanism for management of potential risks to poliomyelitis eradication, urged Member States to strengthen active surveillance of acute flaccid paralysis and to prepare for the long-term biocontainment of polioviruses. It also requested the Director-General to submit proposals to the Sixty-first World Health Assembly for minimizing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis (i.e. after interruption of wild poliovirus globally).

Mechanisms identified:

1. Interruption of transmission of all wild polioviruses globally
2. Protection of areas free of wild poliovirus
3. Characterization of long-term risks associated with polioviruses
4. Coordination of long-term poliovirus risk management strategies
5. Development of safer processes for production of inactivated poliovirus vaccines and affordable strategies for their use
6. Concurrence on a mechanism for coordinating long-term polio risk management
7. Establishment of a timeline for initiating mechanisms to minimize the long-term risks of polioviruses

Interruption of transmission of all wild polioviruses globally. Full implementation of intensified eradication activities[1] will be essential in order to vaccinate every child with multiple doses of the appropriate oral poliovirus vaccine, in particular in those areas where not all the end-2007 milestones were reached. Further efforts are being focused on: the Southern Region of Afghanistan; the 72 highest-risk blocks (out of a total of 433 blocks) of Bihar State, India; the high-risk local government areas that have been identified in the northern states of Nigeria where transmission of wild poliovirus has never been interrupted (especially those local government areas in Borno, Jigawa, Kano, Katsina, Kebbi and Sokoto states); and the

[1] Conclusions and recommendations of the Advisory Committee on Poliomyelitis Eradication, Geneva, 27–28 November 2007. Weekly epidemiological record, 2008, 83(3):25-36.

DRAFT

North-West Frontier Province and large areas of Sindh and Balochistan in Pakistan. Outbreak response activities must be fully implemented in Angola and Chad, where transmission of imported viruses has continued since 2005 and 2003, respectively. To implement the intensified eradication plan for 2008–2009, the budget of US$ 1306 million must be fully financed.

Protection of areas free of wild poliovirus. Maintaining certification-standard surveillance of acute flaccid paralysis in all Member States, including the 56 that did not attain this level of performance in 2007, is essential to ensuring effective outbreak response to any wild poliovirus importation into a poliomyelitis-free area. Minimizing the consequences of an importation of poliovirus requires maintaining routine immunization coverage against poliomyelitis at greater than 80% in all Member States. The risk of inadvertent reintroduction of wild poliovirus can be further reduced by completing the measures set out under phase I (Laboratory survey and inventory) of the WHO global action plan for laboratory containment of wild polioviruses[2] in the 39 poliomyelitis-free Member States that have yet to do so.

Characterization of long-term risks associated with polioviruses. The primary risks associated with polioviruses after interruption of transmission of wild poliovirus are:

- outbreaks due to circulating vaccine-derived polioviruses as a result of the continued use of oral poliovirus vaccine; the annual risk of one such outbreak globally is currently estimated at 60% to 95%, dropping to between 1% and 3% by the third year following synchronized cessation of a vaccination with oral poliovirus vaccine
- vaccine-associated paralytic poliomyelitis resulting from continued administration of oral poliovirus vaccine to non-immune individuals: an estimated 250–500 cases currently occur each year globally
- immunodeficiency-associated excretion of vaccine-derived polioviruses: currently, at most three persons are known to be chronically excreting such a virus,[3] but in no instance has this been associated with any secondary cases
- reintroduction of a wild or Sabin-strain poliovirus from a poliovirus-retaining site (e.g. a diagnostic, research and quality-control laboratory, and poliovirus vaccine manufacturer); currently, more than 600 sites are known to contain wild poliovirus stocks, as reported by Member States that have completed activities

[2] Second edition, document WHO/V&B/03.11.

[3] The working definition of chronic excretion of such virus is for more than five years.

DRAFT

outlined in phase I of the WHO global action plan for laboratory containment of wild polioviruses.[4]

Further study is required to characterize better the risks of circulating vaccine-derived polioviruses, those viruses whose excretion is associated with immunodeficiency and poliovirus stocks, as well as to formulate the strategies for mitigating each.

Coordination of long-term poliovirus risk management strategies. Minimizing the risk of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission requires Member States:

(a) to coordinate the application of appropriate safeguards and biocontainment conditions for the handling and storage of residual polioviruses (wild, Sabin-strain and vaccine-derived) and potentially poliovirus-infected materials;

(b) to synchronize the cessation of routine immunization with oral poliovirus vaccine;

(c) to adhere to internationally-agreed processes for the use of oral poliovirus vaccine (i.e. live polioviruses) in response to new outbreaks of poliomyelitis.

Development of safer processes for production of inactivated poliovirus vaccines and affordable strategies for their use. Affordable options for the use of inactivated poliovirus vaccines should be available to any country that perceives that the medium-term or long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis warrants continued routine immunization against poliomyelitis after the eventual synchronized cessation of the use of oral poliovirus vaccine. Ideally, once vaccination with all oral poliovirus vaccine has ceased, low-income countries that wanted to maintain immunization with inactivated poliovirus vaccines would be in a position to do so at a cost similar to that with oral poliovirus vaccine. Research continues on fractional dosing and schedules with fewer doses of inactivated poliovirus vaccine, the use of adjuvants and alternative seed strains for production of inactivated poliovirus vaccine, and further process optimization for manufacturing inactivated poliovirus vaccine. The results so far indicate that new "cost-neutral" options for use of inactivated poliovirus vaccine and its safe domestic production in low-income countries may soon be feasible.

Concurrence on a mechanism for coordinating long-term polio risk management. WHO's Constitution provides the Health Assembly with three

[4] Second edition, document WHO/V&B/03.11.

DRAFT

categories of normative instruments with which international consensus could be negotiated on the above-mentioned elements of the overall strategy for minimizing the long-term risks of reintroduction of poliovirus or re-emergence of poliomyelitis after interruption of wild poliovirus transmission. This includes conventions and agreements, regulations and recommendations. Recognizing that the International Health Regulations (2005) are a regulation under Article 21 of the Constitution and that the Regulations require States Parties to notify any case of "poliomyelitis due to wild-type poliovirus", the drafting and negotiation of an annex to the Regulations was proposed to the Executive Board at its 122nd session in January 2008 as a potential mechanism to establish international consensus on long-term strategies for managing the risk of reintroduction of poliovirus or re-emergence of poliomyelitis. After considerable discussion, the Board adopted resolution EB122.R1 on "poliomyelitis: mechanism for management of potential risks to eradication", which recommends a draft resolution to the Health Assembly that requests the Director-General to submit "a proposal or proposals for review by the Executive Board for a mechanism to mitigate the risk of the reintroduction of poliovirus ..."

Establishment of a timeline for initiating mechanisms to minimize the long-term risks of polioviruses. Minimizing the long-term risks of polioviruses requires stopping the use of oral poliovirus vaccine in routine immunization as soon as possible after interruption of wild poliovirus transmission globally, when the levels of population immunity and surveillance sensitivity are high. Coordinated activities to minimize the long-term risks of polioviruses should begin as soon as there is a high probability that all wild poliovirus transmission will be interrupted globally. As wild poliovirus type 1 has proven the most difficult of the serotypes to interrupt transmission and as it is unlikely to circulate undetected for more than six months in the presence of good surveillance, mechanisms for coordinating international risk-management strategies could be initiated as early as six months after detection of the last case of paralytic poliomyelitis caused by a circulating wild poliovirus type 1 globally.

DRAFT

RESOLUTION 11.2: Poliomyelitis

The Health Assembly is invited to consider the draft resolution contained in resolution EB122.R1:

The Executive Board, having considered the report on poliomyelitis: a mechanism for the management of potential risks to eradication, RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on poliomyelitis: a mechanism for the management of potential risks to eradication;

Recalling resolution WHA60.14, which urged Member States in which wild poliovirus is still present, especially the four countries in which poliomyelitis is endemic, to intensify poliomyelitis eradication activities in order rapidly to interrupt all remaining transmission of wild poliovirus;

Recognizing the need to make rapidly available the necessary financial resources to eradicate poliomyelitis and minimize the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission;

Recognizing the need for international coordination of the strategies to minimize and manage the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission globally;

Noting that planning for such international consensus must begin as soon as possible after transmission of wild poliovirus is interrupted globally,

1. URGES all remaining poliomyelitis-affected Member States to engage all levels of political and civil society in order to ensure that every child is consistently reached and vaccinated during every supplementary immunization activity against poliomyelitis, so that all remaining transmission of wild poliovirus is interrupted rapidly;
2. URGES all Member States:
   (1) to strengthen active surveillance of acute flaccid paralysis in order to detect rapidly any circulating poliovirus and prepare for certification of poliomyelitis eradication;
   (2) to complete the activities outlined in phase I of the WHO global action plan for laboratory containment of wild polioviruses and prepare to

DRAFT

implement appropriate long-term safeguards and biocontainment conditions for remaining wild polioviruses within at most 12 months after detection of the last case of poliomyelitis caused by a circulating wild virus;

(3) to achieve rapidly and to maintain routine immunization coverage against poliomyelitis at a level greater than 80% of the childhood population;

(4) to make available rapidly the necessary financial resources to eradicate poliomyelitis, and to minimize the risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission;

3. REQUESTS the Director-General:

(1) to continue to provide technical support to the remaining countries affected by poliomyelitis in their efforts to interrupt the final chains of transmission of wild poliovirus;

(2) to assist in mobilizing the financial resources necessary for full implementation of the intensified eradication effort and for ensuring that the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis are minimized;

(3) to undertake the necessary research to characterize fully the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis and to develop appropriate strategies and products for managing these risks, including safer processes for production of inactivated poliovirus vaccine and affordable strategies for its use;

(4) to develop a new strategy for renewed fight to eradicate poliomyelitis from the remaining countries drawing on experience from regions where poliomyelitis is eradicated and on operations research in order to determine the most efficient and cost-effective interventions;

(5) to report to the Health Assembly when she determines that transmission of wild poliovirus type 1 is likely to have been interrupted globally, and to submit with that report a proposal or proposals for review by the Executive Board for a mechanism to mitigate the risk of the reintroduction of poliovirus that does not involve amending the International Health Regulations (2005) or developing another binding instrument.

DRAFT

For more information:

WHO Communication Officers: Polio

Sona Bari
Telephone: +41 22 791 1476
Mobile: +41 79 475 5511
baris@who.int

Oliver Rosenbauer
Telephone: +41 22 791 3832
Mobile: +41 79 500 6536
rosenbauero@who.int

WHO Websites:

- Poliomyelitis: http://www.who.int/topics/poliomyelitis/en/
- WHO EURO, Poliomyelitis: http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=poliomyelitis
- Global Polio Eradication Initiative: http://www.polioeradication.org/

Non-WHO Websites:

- ECDC, Polio: http://ecdc.europa.eu/Health_topics/Polio/Index.html
- UNICEF, eradicating polio: http://www.unicef.org/immunization/index_polio.html

DRAFT

*11.4 Implementation of the International Health Regulations (2005)

Extract from Document A61/7 (Report by the Secretariat):

1. In resolution WHA58.3, the Fifty-eighth World Health Assembly decided that States Parties to the International Health Regulations (2005) and the Director-General would submit their first report on the implementation of the International Health Regulations (2005) to the Sixty-first World Health Assembly, and that the Health Assembly would on that occasion consider the schedule for the submission of further such reports and the first review on the functioning of the Regulations.
2. Resolution WHA59.2, on application of the International Health Regulations (2005), requested the Director-General to report annually on progress achieved in providing support to Member States on compliance with, and implementation of, the Regulations. The present report updates the first such report, which was submitted to the Sixtieth World Health Assembly,[5] with a summary of implementation activities and compliance issues worldwide. Its structure follows that of the Secretariat's report on areas of work for implementation, issued in June 2007.[6]
3. In order to help to compile State Party reports to the Health Assembly, the Secretariat is sending a questionnaire to States Parties requesting a summary of progress in implementation of the Regulations since May 2005, and, in particular, from the date of their entry into force (15 June 2007). The results will be submitted to the Health Assembly in due course.
4. Resolution WHA58.3 also requested the Director-General to replace Annex 9 of the International Health Regulations (2005) with the Health Part of the Aircraft General Declaration as revised by ICAO, and to inform the Health Assembly. The revised Health Part of the Aircraft General Declaration (see Annex) entered into force on 15 July 2007.

GLOBAL PARTNERSHIP

5. Both World Health Day 2007 and *The world health report 2007*[7] focused on how collective international public health action can build a safer future for humanity

---

[5] Document A60/8.

[6] Document WHO/CDS/EPR/IHR/2007.1.

[7] *The world health report 2007. A safer future: global public health security in the 21st century.* Geneva, World Health Organization, 2007.

DRAFT

and explored the links between health and public safety in a changing world. The report has contributed significantly to raising awareness of the Regulations as an important instrument, providing the global framework for preventing, detecting, assessing and, when necessary, supporting a coordinated response to events that may constitute a public health emergency of international concern.

6. Further, the Secretariat has designed several multilingual packages for online training of staff members at all levels of the Organization and of the staff of national health authorities in order to ensure that they fully understand their new roles and responsibilities under the Regulations. As of 1 February 2008, this training had been completed by 94 country offices in the six WHO regions.

7. In fostering partnerships for implementation of the Regulations, WHO has maintained close ties with other organizations of the United Nations system and international agencies, including FAO, IAEA, ICAO, IMO, OIE and the United Nations World Tourism Organization. It relies heavily on its technical partners in WHO collaborating centres (over 300 centres in more than 60 countries), the Global Outbreak Alert and Response Network, the Radiation Emergency Medical Preparedness and Assistance Network, the Network on Environmental Health in Emergencies (e.g. for chemical incidents), the International Association of National Public Health Institutes, and other international, national and regional centres of excellence. The Secretariat and Member States are continuing their efforts to engage the support of the donor community and development agencies as well as other stakeholders, such as Airports Council International, the International Air Transport Association, the International Shipping Federation and the International Organization for Standardization. WHO is also continuing its work with regional and subregional organizations such as ASEAN, the European Community and MERCOSUR.

8. In June 2007, the Secretariat launched a new, dedicated public web site that contains useful information for States Parties to the International Health Regulations (2005), other stakeholders in the fields of public health surveillance, detection, reporting and response, and the international travel and transport community.[8] Core documents and other materials on the web site are issued in all six official languages.

[8] See www.who.int/ihr.

DRAFT

STRENGTHENING NATIONAL CAPACITY

9. WHO continues to adapt its regional strategies for national disease surveillance and response systems in order to meet the core requirements for surveillance and response (as specified in Annex 1A of the Regulations). In support of capacity-building activities, the WHO Lyon Office for National Epidemic Preparedness and Response is working closely with regional and country offices on strengthening national surveillance and response systems in order better to detect, assess, notify and report events and to respond to public health risks and emergencies of international concern, in accordance with the Regulations.

10. Under the Regulations, each State Party shall assess, within two years following the entry into force of these Regulations for that State Party, the ability of existing national structures and resources to meet the minimum requirements described in Annex 1A. As of February 2008, assessments of their national capacities had been carried out by 76 States Parties which are in the process of developing and implementing plans of action to ensure that the core capacities specified in Annex 1A of the Regulations are present and functioning no later than five years from the entry into force of these Regulations for a particular State Party (the deadline set in Article 5.1). These assessments were either made in the context of pre-existing WHO regional strategies for disease surveillance and response or especially tailored to the requirements of the Regulations. Plans are being made to involve the poliomyelitis eradication surveillance infrastructure in these assessments, where appropriate.

11. With regard to issues of international travel and transport, the Secretariat has prepared for States Parties several documents and other materials, including guidance on the use of the new model international certificate of vaccination or prophylaxis, contained in Annex 6 of the Regulations, and on the implementation and issuance of the new ship sanitation certificates, contained in Annex 3. In this connection, the Secretariat is posting on its web site an updated list of ports that are authorized by States Parties to issue these certificates. It is also preparing third editions of the *Guide to hygiene and sanitation in aviation* and the *Guide to ship sanitation*, which will provide supplementary guidance to States Parties in assessing public health risks associated with international travel and transport.

DRAFT

PREVENTION OF AND RESPONSE TO INTERNATIONAL PUBLIC HEALTH EMERGENCIES

12. In the area of global alert and response to acute public health events, the establishment of National IHR Focal Points in each State Party and the designation of WHO IHR Contact Points in all six WHO regions remain crucial to implementation of the Regulations. As of February 2008, National IHR Focal Points had been designated by 188 States Parties to the Regulations. For its part, the Secretariat is ensuring the accessibility and effectiveness of WHO IHR Contact Points in all regional offices. In order to facilitate the sharing of information with States Parties through their National IHR Focal Points, the Secretariat has launched a restricted-access Event Information Site. As of February 2008, 499 accounts for the site have been created. Since 15 June 2007, 231 public health events have been entered into the event management system, about 10% of which were communicated to WHO through National IHR Focal Points. As it is expected that the number of communications received from these Focal Points will increase, guidance on the use of the decision instrument in Annex 2 of the Regulations is being tested. WHO's procedures relating to detection, verification, risk assessment and response have been adjusted to ensure conformity with the Organization's functions under the Regulations. On 15 June 2007, the date of entry into force of the Regulations for most States Parties, the Secretariat tested communications protocols within the Organization, involving all six regional offices, the Director-General and all Regional Directors.
13. The application of the Regulations to the management of specific health risks has been analysed, most notably in relation to the current outbreaks of avian influenza, human infections with avian influenza viruses and preparations for a possible influenza pandemic. This analysis continues, and has underscored the need to strengthen further the capacity of countries to implement their draft national pandemic plans, with the Regulations as an essential tool to assist them in this task. Further support provided to countries for national pandemic preparedness plans has included the integration and review of the relevant provisions and procedures established by the Regulations. The Regulations have also been applied to other significant health events, including the international travel of patients with extensively drug-resistant tuberculosis in 2007 and the epidemics of Marburg and Ebola haemorrhagic fevers in 2006 and 2007. In the areas of food safety and chemical and radiological public health risks, given the Regulations' broad scope, a consistent Organization-wide approach is being

DRAFT

taken to actions that may fall under the Regulations; the Secretariat is also strengthening its response capacity. Examples include providing information to the International Food Safety Authorities Network Emergency Contact Points regarding procedures of the Regulations relevant to their operations and the need to ensure effective links with their corresponding National IHR Focal Points at the country level, and establishing national stockpiles of materials for use in response to radionuclear and chemical emergencies. Furthermore, the Director-General has established a new Health Security and Environment cluster, effective as of 1 November 2007, in order to bring together the work of technical programmes with major responsibilities under the Regulations.

LEGAL ISSUES AND MONITORING

14. The Regulations entered into force on 15 June 2007 and bind 194 States.[9] Reservations and other communications from States Parties about implementation of the Regulations may be consulted on the new public web site referred to in paragraph 8 above, and in the International Health Regulations (2005) themselves.[10]

15. Pursuant to resolution WHA58.3, an IHR Roster of Experts has been established, and currently more than 50 States Parties have nominated an expert. In accordance with the requirements of the Regulations, an additional 134 experts have been nominated by the Director-General to serve on the roster, 65 of whom have been confirmed as members. Rules of Procedure for the Emergency Committee have been prepared. Extensive advice on legal and other implementation issues is being provided within the Secretariat and to States Parties, including in the area of adjustments to national legislation.

16. The Secretariat monitors progress in establishing National IHR Focal Points, their communications and their access to the Event Information Site. It is further planned to monitor national progress in establishing the core capacity requirements specified in Annex 1 through the development of specific indicators.

---

[9] In accordance with Article 60 of the International Health Regulations (2005), the Director-General sent, on 5 February 2007, a notification to Montenegro, which became a Member State of WHO after the adoption of the International Health Regulations (2005). The Regulations entered into force for Montenegro on 5 February 2008.

[10] *International Health Regulations (2005)*, Geneva, World Health Organization, 2nd edition, 2008.

DRAFT

REGIONAL ACTIVITIES

17. The primary responsibility for the implementation of the Regulations lies with States Parties, with strong support from WHO's regional and country offices. The Regulations were brought to the attention of several WHO regional committees last year. At the technical level, regional strategies have been developed or adjusted to integrate activities and time frames relating to the Regulations, including strengthening disease surveillance and response capacities and reaching to public health issues at points of entry. In some regions, assessment tools and general guidance on implementation has been introduced for this purpose. Interregional cooperation has increased as a result and is an effective way of pooling resources and sharing experiences on implementation.
18. Intense activity in the area of preparedness and response for avian and human pandemic influenza has been used by WHO regional offices as an entry point to bolster implementation of the Regulations and to raise awareness further of the synergies between these activities and implementation of the Regulations. Briefings and workshops have been held for National IHR Focal Points, WHO country office staff and national stakeholders in all six regions. In most regions, a subregional approach has been preferred in order to allow for more detailed discussions on the long-term and short-term challenges faced in, and opportunities offered by, implementation of the Regulations.
19. In terms of coordinated public health risk assessment and management, WHO IHR Contact Points at the regional level, and other specific programme contacts such as International Food Safety Authorities Network Emergency Contact Points for food-safety-related events, continue to be available on a 24-hour, seven-days-a-week basis, for urgent communications with National IHR Focal Points. These communication channels are regularly tested to ensure their effectiveness and contact details are kept up to date. To this end, both regional offices and many States Parties are in the process of establishing or further strengthening emergency operation centres, or their equivalent, in order to provide those working on alert and response operations with a single platform for the detection of, and response to, public health events and emergencies.
20. An earlier version of this report was considered by the Executive Board at its 122nd session.[11] The Board also adopted, after a roll-call vote, resolution EB122.R3, which contained bracketed text.

[11] See document EB122/2008/REC/2, summary record of the second meeting (section 2), third meeting and fifth meeting.

DRAFT

ANNEX 9 OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

THIS DOCUMENT IS PART OF THE AIRCRAFT GENERAL DECLARATION,

PROMULGATED BY THE INTERNATIONAL CIVIL AVIATION ORGANIZATION

HEALTH PART OF THE AIRCRAFT GENERAL DECLARATION[12]

Declaration of Health

Name and seat number or function of persons on board with illnesses other than airsickness or the effects of accidents, who may be suffering from a communicable disease (a fever—temperature 38°C/100°F or greater—associated with one or more of the following signs or symptoms, e.g. appearing obviously unwell; persistent coughing; impaired breathing; persistent diarrhoea; persistent vomiting; skin rash; bruising or bleeding without previous injury; or confusion of recent onset, increases the likelihood that the person is suffering a communicable disease) as well as such cases of illness disembarked during a previous stop..

....

....

....

Details of each disinfecting or sanitary treatment (place, date, time, method) during the flight. If no disinfecting has been carried out during the flight, give details of most recent disinfecting ....

Signature, if required, with time and date

....

Crew member concerned

[12] This version of the Aircraft General Declaration entered into force on 15 July 2007. The full document may be obtained from the web site of the International Civil Aviation Organization at http://www.icao.int.

DRAFT

RESOLUTION 11.4: International Health Regulations (2005)

Extract from Executive Board resolution EB122.R3

The Executive Board, having considered the report on the implementation of the International Health Regulations (2005), RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on the implementation of the International Health Regulations (2005);

Recalling resolution WHA58.3 on revision of the International Health Regulations, which decided that the Sixty-first World Health Assembly would consider the schedule for the submission of further reports by States Parties and the Director-General on the implementation of the International Health Regulations (2005) and the first review of their functioning, pursuant to paragraphs 1 and 2 of Article 54 of the Regulations;

Underscoring the importance of establishing a schedule to review and evaluate the functioning of Annex 2, pursuant to paragraph 3 of Article 54 of the International Health Regulations (2005);

Mindful of the request to the Director-General in resolution WHA59.2 on application of the International Health Regulations (2005) to report to the Sixtieth World Health Assembly and annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of, the International Health Regulations (2005);

Recognizing the need to rationalize reporting on all aspects of implementation of the International Health Regulations (2005) in order to facilitate the work of the Health Assembly,

1. REAFFIRMS its commitment to implement fully the International Health Regulations (2005) in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3 of the Regulations;
2. DECIDES:
   (1) in accordance with paragraph 1 of Article 54 of the International Health Regulations (2005), that States Parties and the Director-General shall report to the Health Assembly on the implementation of the

DRAFT

Regulations biennially, with the next report to be submitted to the Sixty-third World Health Assembly;

(2) in accordance with paragraph 2 of Article 54 of the International Health Regulations (2005), that the first review of the functioning of the Regulations shall be made by the Sixty-third World Health Assembly;

(3) in accordance with paragraph 3 of Article 54 of the International Health Regulations (2005), that the first review and evaluation of the functioning of Annex 2 shall be submitted to the Sixty-third World Health Assembly for its consideration;

3. URGES Member States:

(1) to ensure that the contact details of the centre that has been designated as the National IHR Focal Point are complete and up to date and to encourage relevant staff within the centre to access and use the Event Information Site on the WHO web site;

(2) to take steps to ensure that the national core capacity requirements specified in Annex 1 to the Regulations are put in place, strengthened and maintained, in accordance with Articles 5 and 13 of the International Health Regulations (2005);

(3) to designate an expert, if they have not already done so, for the IHR Roster of Experts, in accordance with Article 47 of the International Health Regulations (2005);

(4) to continue to support each other and collaborate with WHO in the implementation of the International Health Regulations (2005), in accordance with resolution WHA58.3 and relevant provisions of those Regulations;

4. REQUESTS the Director-General:

(1) to submit every two years a single report, including information provided by States Parties and about the Secretariat's activities, to the Health Assembly for its consideration, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);

(2) to provide support to Member States with most vulnerable health systems in strengthening core capacity requirements for surveillance and response at airports, ports and ground crossings, paying special attention to the sub-Saharan Africa laboratory network.

DRAFT

For more information:

WHO Communication Officers:

Gregory Hartl
Telephone: +41 22 791 4458
Mobile: +41 79 203 6715
hartlg@who.int

Sari Setiogi
Telephone: +41 22 791 3576
Mobile: +41 79 701 9467
setiogis@who.int

WHO Websites:

- IHR (2005): 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/

Non-WHO Websites:

- UK Health Protection Agency: http://www.hpa.org.uk/hpa/international/IHR.htm

DRAFT

11.5 Prevention and control of non-communicable diseases: implementation of the global strategy

Extract from Document A61/8 (Report by Secretariat):

1. The global burden of non-communicable diseases continues to grow; tackling it constitutes one of the major challenges for development in the twenty-first century. In resolution WHA53.17, the Health Assembly reaffirmed that the global strategy for the prevention and control of non-communicable diseases[13] is directed at reducing premature mortality and improving quality of life, and requested the Director-General, inter alia, to continue giving priority to the prevention and control of such diseases. The global strategy sets out the roles of the main players in the struggle against non-communicable diseases, namely: Member States, the Secretariat and international partners.
2. In 2007, the Health Assembly adopted resolution WHA60.23, entitled "Prevention and control of non-communicable diseases: implementation of the global strategy", which requested the Director-General, inter alia, to prepare an action plan for the prevention and control of non-communicable diseases, to be submitted to the Sixty-first World Health Assembly through the Executive Board; and to provide support where needed for elaboration, intensified implementation and monitoring of national plans for prevention and control of non-communicable diseases.
3. Accordingly, a draft action plan was drawn up and discussed by the Executive Board at its 122nd session in January 2008. The Board decided in decision EB122(11) to organize an informal consultation for Member States, which was held in Geneva on 29 February 2008. In light of the comments made the draft action plan has been duly amended.
4. The draft plan, which is attached at Annex, sets out objectives, actions to be implemented over the six-year period of the Medium-term strategic plan 2008–2013, and performance indicators for Member States, the Secretariat and international partners in order to guide their work on the prevention and control of non-communicable diseases at national, regional and global levels.

ACTION BY THE HEALTH ASSEMBLY

5. The Health Assembly is invited to note the report and to endorse the draft action plan.

---

[13] Document A53/14.

DRAFT

DRAFT ACTION PLAN FOR THE GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

INTRODUCTION

1. The global burden of non-communicable diseases continues to grow; tackling it constitutes one of the major challenges for development in the twenty-first century. Non-communicable diseases, principally cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases, caused an estimated 35 million deaths in 2005. This figure represents 60% of all deaths globally, with 80% of deaths due to non-communicable diseases occurring in low- and middle-income countries, and approximately 16 million deaths involving people under 70 years of age. Total deaths from non-communicable diseases are projected to increase by a further 17% over the next 10 years. The rapidly increasing burden of these diseases is affecting poor and disadvantaged populations disproportionately, contributing to widening health gaps between and within countries. As non-communicable diseases are largely preventable, the number of premature deaths can be greatly reduced. As requested by the Health Assembly in resolution WHA60.23, the Secretariat has drawn up a draft action plan in order to guide Member States, the Secretariat and international partners in working towards the prevention and control of non-communicable diseases. The draft plan was discussed by the Executive Board at its 122nd session in January 2008, and during an informal consultation with Member States, held in Geneva on 29 February 2008. In addition, the views of non-governmental organizations and representatives of the food and non-alcoholic beverages industry were gathered at two other meetings organized for that purpose. The following plan incorporates the contributions provided by Member States and other stakeholders and will support achievement of the goals of the global strategy for the prevention and control of non-communicable diseases.

PURPOSE

2. In leading and catalysing an intersectoral, multilevel response, with a particular focus on low- and middle-income countries and vulnerable populations, the plan has the overall purpose of:

DRAFT

- mapping the emerging epidemics of non-communicable diseases and analysing their social, economic, behavioural and political determinants as the basis for providing guidance on the policy, programmatic, legislative and financial measures that are needed to support and monitor the prevention and control of non-communicable diseases;
- reducing the level of exposure of individuals and populations to the common modifiable risk factors for non-communicable diseases – namely, tobacco use, unhealthy diet and physical inactivity, and the harmful use of alcohol – and their determinants, while at the same time follow lifestyle patterns that foster good health; and
- strengthening health care for people with non-communicable diseases by developing evidence-based norms, standards and guidelines for cost-effective interventions and by reorienting health systems to respond to the need for effective management of diseases of a chronic nature.

3. The plan is based on current scientific knowledge, available evidence and a review of international experience. It comprises a set of actions which, when performed collectively by Member States and other stakeholders, will tackle the growing public-health burden imposed by non-communicable diseases. In order for the plan to be implemented successfully, high-level political commitment and the concerted involvement of governments, communities and health-care providers are required; in addition, public-health policies will need to be reoriented and allocation of resources improved.

SCOPE

4. Current evidence indicates that four types of non-communicable diseases – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – make the largest contribution to mortality in the majority of low- and middle-income countries and require concerted, coordinated action. These diseases are largely preventable by means of effective interventions that tackle shared risk factors, namely: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. In addition, improved disease management can reduce morbidity, disability, and death and contribute to better health outcomes.
5. The four types of diseases and their risk factors are considered together in this action plan in order to emphasize common causes and highlight potential synergies in prevention and control. This is not to imply, however, that all the

DRAFT

risk factors are associated in equal measure with each of the diseases. Details of disease-related causal links and interventions are provided in the relevant strategies and instruments, namely: the WHO Framework Convention on Tobacco Control, and the WHO Global Strategy on Diet, Physical Activity and Health. A similar approach to diseases and health conditions is being followed as part of WHO's work to reduce the harmful use of alcohol.[14]

6. Within any country, there will be a range of diseases, disabilities and conditions for which the risk factors and the needs for screening, treatment and care overlap with those for non-communicable diseases considered in this action plan. Among these are blindness, deafness, oral diseases, certain genetic diseases, and other diseases of a chronic nature, including some communicable diseases like HIV/AIDS and tuberculosis. The demands that non-communicable diseases place on patients, and comparable strategies are effective for their management.[15]

7. The priorities for action cut across all WHO regions, reflecting similar challenges in many areas: intersectoral collaboration, partnerships and networking, capacity strengthening in countries and in WHO country offices, resource mobilization, and strategic support for collaborative research.

RELATIONSHIP TO EXISTING STRATEGIES AND PLANS

8. The foundation for this draft action plan is the global strategy for the prevention and control of non-communicable diseases, whose aim to reduce premature mortality and improve quality of life was reaffirmed by the Health Assembly in 2000 (resolution WHA53.17). The plan also builds on the implementation of the WHO Framework Convention on Tobacco Control, adopted by the Health Assembly in 2003 (resolution WHA56.1), and the Global Strategy on Diet, Physical Activity and Health, endorsed by the Health Assembly in 2004 (resolution WHA57.17). The plan also focuses on the harmful use of alcohol as a risk factor

[14] Actions proposed in this plan are in accordance with existing WHO resolutions and strategies to reduce alcohol-related harm including, at regional level, resolution SEA/RC59/R8, resolution EUR/RC55/R1, resolution EM/RC53/R5, resolution WPR/RC57.R5. Further work will be guided by the outcome of current global processes for tackling harmful use of alcohol.

[15] There are many other non-communicable conditions of public-health importance. They include osteoporosis, renal diseases, oral diseases, genetic diseases, neurological diseases, and diseases causing blindness and deafness. Many of these conditions are the subjects of other WHO strategies, action plans and technical guidance and are therefore not considered directly by this plan. Similarly, mental health disorders are not included here despite the heavy burden of disease that they impose, as they do not share the same risk factors (other than the harmful use of alcohol), and because they require different intervention strategies. Public-health considerations in the area of mental health are covered in the WHO mental health gap action programme, the implementation of whose strategies, programmes and policies was recognized as a need in resolution WHA55.10.

DRAFT

for non-communicable diseases on the basis of continuing work in WHO and the resolutions of its governing bodies, including the regional committees. The plan is also guided by the Medium-term strategic plan 2008–2013 and the Eleventh General Programme of Work. The actions for the Secretariat set out in the plan are aligned with strategic objective 3 and strategic objective 6 in the Medium-term strategic plan 2008–2013, which provide details of expected results, targets and indicators for the Organization's work on prevention and control of non-communicable diseases.

9. This plan is intended to support coordinated, comprehensive and integrated implementation of strategies and evidence-based interventions across individual diseases and risk factors, especially at the national level. The aim is to provide an overall direction to support the implementation of national and regional strategies and action plans, where these have been elaborated, and the development of sound and feasible action plans where none exist. The action plan will, therefore, support the continued and strengthened implementation of regional resolutions and plans.[16]

RESOURCES

10. The Programme budget 2008–2009 describes the financial resources required by the Secretariat for the current biennium in respect of work undertaken to meet strategic objective 3 and strategic objective 6. For the next bienniums, additional resources will be required and allocation and mobilization of resources will be re-examined. In order for the plan to be implemented effectively at the national and global levels, considerable efforts will be required to mobilize resources, and strong, highly coordinated regional and global partnerships will be vital. One aim of the plan is to ensure that concerted action can be conducted on a global scale. This will require all partners – including intergovernmental and nongovernmental organizations, academic and research institutions, and the private sector – to play a stronger role in a global network for non-communicable disease prevention and control.

[16] The following are included: resolution AFR/RC50/R4, "Non-communicable diseases: strategy for the African Region"; resolution CD47.R9, "Regional strategy and plan of action on an integrated approach to the prevention and control of chronic diseases, including diet, physical activity"; resolution SEA/RC60/R4, "Scaling up prevention and control of chronic non-communicable diseases in the South-East Asia Region"; resolution EUR/RC56/R2, "Prevention and Control of Non-communicable Diseases in the WHO European Region"; resolution EM/RC52/R7, "Non-communicable diseases: challenges and strategic directions"; and resolution WPR/RC57/R4, "Non-communicable disease prevention and control".

DRAFT

TIME FRAME

11. This action plan will be implemented over the same period as the Medium-term strategic plan 2008–2013. Actions to be completed or initiated during the first two years are specifically identified in the following pages. The implementation of the plan will be reviewed towards the end of the first biennium, in 2009, and reprogrammed with a detailed time frame for the second and third bienniums.

OBJECTIVES AND ACTIONS

12. This section sets out the **six objectives** of the plan and gives details of the respective actions and performance indicators for the stakeholders at all levels, namely, domestic, national and international.

OBJECTIVE 1: To raise the priority accorded to non-communicable disease in development work at global and national levels, and to integrate prevention and control of such diseases into policies across all government departments.

13. The international public health advocacy in this area must be driven by one key idea: **non-communicable diseases are closely linked to global social and economic development.** These diseases and their risk factors are closely related to poverty and contribute to poverty; they should, therefore, no longer be excluded from global discussions on development. If the high mortality and heavy burden of disease experienced by low- and middle-income countries are to be tackled comprehensively, global development initiatives must take into account the prevention and control of non-communicable diseases. Instruments such as the Millennium Development Goals provide opportunities for synergy, as do mechanisms that harmonize development aid and strategies for poverty alleviation.

14. At the national level, key messages should explain that:
    - **National policies in sectors other than health have a major bearing on the risk factors for non-communicable diseases**, and that health gains can be achieved much more readily by influencing public policies in sectors like trade, taxation, education, agriculture, urban development, food and pharmaceutical production than by making changes in health policy alone. National authorities may wish, therefore, to adopt an approach to the prevention and control of these diseases that involves all government departments.

DRAFT

- **Throughout the life course, inequities in access to protection, exposure to risk, and access to care are the cause of major inequalities in the occurrence and outcome of non-communicable diseases.** Global and national action must be taken to respond to the social and environmental determinants of non-communicable diseases, promoting health and equity and building on the findings of the Commission on Social Determinants of Health.

15. **Proposed action for Member States**

It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States should undertake the actions set out below.

(a) Assess and monitor the public-health burden imposed by non-communicable diseases and their determinants, with special reference to poor and marginalized populations.

(b) Incorporate the prevention and control of non-communicable diseases explicitly in poverty-reduction strategies and in relevant social and economic policies.

(c) Adopt approaches to policy development that involve all government departments, ensuring that public-health issues receive an appropriate cross-sectoral response.

(d) Implement programmes that tackle the social determinants of non-communicable diseases with particular reference to the following: health in early childhood, the health of the urban poor, fair financing and equitable access to primary health care services.

16. **Action for the Secretariat**

(a) Raise the priority given to the prevention and control of non-communicable diseases on the agendas of relevant high-level forums and meetings of national and international leaders [2008–2009].[17]

(b) Work with countries in building and disseminating information about the necessary evidence base and surveillance data in order to inform policy-makers, with special emphasis on the relationship between non-communicable diseases, poverty and development [2008–2009].[17]

(c) Develop and disseminate tools that enable decision-makers to assess the impact of policies on the determinants of, risk factors for, and consequences

[17] See paragraph 11 above.

DRAFT

of non-communicable diseases; and provide models of effective, evidence-based policy-making [2008–2009].[17]

(d) Draw up a document in support of policy coherence, pointing out connections between the findings of the Commission on Social Determinants of Health and the prevention and control of non-communicable diseases; and take forward the work on social determinants of health as it relates to non-communicable diseases.

17. **Proposed action for International Partners**

(a) Include the prevention and control of non-communicable diseases as an integral part of work on global development and in related investment decisions.[18]

(b) As appropriate, work with WHO to involve all stakeholders in advocacy in order to raise awareness of the increasing magnitude of the public-health problems posed by non-communicable diseases, and of the fact that tackling the determinants of and risk factors for such diseases has the potential to be a significant method of prevention.

(c) Support WHO in creating forums where key stakeholders—including nongovernmental organizations, professional associations, academia, research institutions and the private sector—can contribute and take concerted action against non-communicable diseases.

OBJECTIVE 2: To establish and strengthen national policies and plans for the prevention and control of non-communicable diseases

18. Countries need to establish new, or strengthen existing, policies and plans for the prevention and control of non-communicable diseases as an integral part of their national health policy and broader development frameworks. Such policies should encompass the following three components, with special attention given to dealing with gender, ethnic, and socioeconomic inequalities together with the needs of persons with disabilities:

- the development of a national multi-sectoral framework for the prevention and control of non-communicable diseases;

[18] Specific examples of this action include the first CARICOM Regional Summit on Chronic, Non-Communicable Diseases (Port-of-Spain, 15 September 2007), following which the heads of government of the Caribbean Community released a joint declaration; and the work of the WHO European Region, which has helped the World Bank and other international agencies to accord greater priority to non-communicable diseases, and which signed a joint declaration to support countries of the Commonwealth of Independent States.

DRAFT

- the integration of the prevention and control of non-communicable diseases into the national health development plan;
- the reorientation and strengthening of health systems, enabling them to respond more effectively and equitably to the health-care needs of people with chronic diseases, in line with the WHO-developed strategy for strengthening health systems.

19. **Proposed action for Member States**

National multi-sectoral framework for the prevention and control of non-communicable diseases

(a) Develop and implement a comprehensive policy and plan for the prevention and control of major non-communicable diseases, and for the reduction of modifiable risk factors.

(b) Establish a high-level national multi-sectoral mechanism for planning, guiding, monitoring and evaluating enactment of the national policy with the effective involvement of sectors outside health.

(c) Conduct a comprehensive assessment of the characteristics of non-communicable diseases and the scale of the problems they pose, including an analysis of the impact on such diseases of the policies of the different government sectors.

(d) Review and strengthen, when necessary, evidence-based legislation, together with fiscal and other relevant policies that are effective in reducing modifiable risk factors and their determinants.

Integration of the prevention and control of non-communicable diseases into the national health development plan

(a) Establish an adequately staffed and funded non-communicable disease and health promotion unit within the Ministry of Health or other comparable government health authority.

(b) Establish a high-quality surveillance and monitoring system that should provide, as minimum standards, reliable population-based mortality statistics and standardized data on non-communicable diseases, key risk factors and behavioural patterns, based on the WHO STEPwise approach to risk factor surveillance.

(c) Incorporate evidence-based, cost-effective primary and secondary prevention interventions into the health system with emphasis on primary health care.

DRAFT

Reorientation and strengthening of health systems[19]

(a) Ensure that provision of health care for chronic diseases is dealt with in the context of overall health system strengthening and that the infrastructure of the system, in both the public and private sectors, has the elements necessary for the effective management of and care for chronic conditions. Such elements include appropriate policies, trained human resources, adequate access to essential medicines and basic technologies, standards for primary health care, and well-functioning referral mechanisms.

(b) Adopt, implement and monitor the use of evidence-based guidelines and establish standards of health care for common conditions like cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, integrating whenever feasible, their management into primary health care.

(c) Implement and monitor cost-effective approaches for the early detection of breast and cervical cancers, diabetes, hypertension and other cardiovascular risk factors.

(d) Strengthen human resources capacity, improve training of physicians, nurses and other health personnel and establish a continuing education programme at all levels of the health-care system, with a special focus on primary health care.

(e) Take action to help people with non-communicable diseases to manage their own conditions better, and provide education, incentives and tools for self-management and care.

(f) Develop mechanisms for sustainable health financing in order to reduce inequities in accessing health care.

20. **Action for the Secretariat**

National multi-sectoral framework for the prevention and control of non-communicable diseases

(a) Conduct a review of international experience in the prevention and control of non-communicable diseases, including community-based programmes, and identify and disseminate lessons learnt [2008–2009].[20]

(b) Recommend, based on a review of international experience, successful approaches for inter-sectoral action against non-communicable diseases.

---

[19] These actions are proposed in view of the fact that in many Member States the organizational and financial arrangements with respect to health care are such that the long-term needs of people with non-communicable diseases are rarely dealt with successfully.

[20] See paragraph 11 above.

DRAFT

(c) Provide guidance for the development of national policy frameworks, including evidence-based public health policies for the reduction of risk factors, and provide technical support to countries in adapting these policies to their national context [2008–2009].[21]

Integration of the prevention and control of non-communicable diseases into the national health development plan

(a) Expand, over the time frame of this plan, the technical capacity of WHO's regional and country offices and develop networks of experts and collaborating or reference centres for the prevention and control of non-communicable diseases in support of national programmes.

(b) Develop norms for surveillance and guidelines for primary and secondary prevention, based on the best available scientific knowledge, public-health principles and existing WHO tools [2008–2009].[21]

(c) Review and update diagnostic criteria, classifications and, where needed, management guidelines for common non-communicable diseases [2008–2009].[21]

(d) Provide support to countries, in collaboration with international partners, in strengthening opportunities for training and capacity-building with regard to the public-health aspects of the major non-communicable diseases [2008–2009].[21]

Reorientation and strengthening of health systems

(a) Ensure that the response to non-communicable diseases is placed at the forefront of efforts to strengthen health systems.

(b) Provide technical guidance to countries in integrating cost-effective interventions against major non-communicable diseases into their health systems [2008–2009].[21]

(c) Provide support to countries in enhancing access to essential medicines and affordable medical technology, building on the continuing WHO programmes promoting both good-quality generic products, and the improvement of procurement, efficiency and management of medicine supplies [2008–2009].[21]

(d) Assess existing models for self-examination and self-care, and design improved affordable versions where necessary, with a special focus on populations with low health awareness and/or literacy.

[21] See paragraph 11 above.

DRAFT

21. **Proposed action for international partners**

    (a) Support the development and strengthening of international, regional, and national alliances, networks and partnerships in order to support countries in mobilizing resources, building effective national programmes and strengthening health systems so that they can meet the growing challenges posed by non-communicable diseases [2008–2009].[21]

    (b) Support implementation of intervention projects, exchange of experience among stakeholders, and regional and international capacity-building programmes.

OBJECTIVE 3: To promote interventions to reduce the main shared modifiable risk factors for non-communicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol

22. Strategies for reducing risk factors for non-communicable diseases aim at providing and encouraging healthy choices for all. They include multi-sectoral actions involving the elaboration of high-level policies and plans as well as programmes related to advocacy, community mobilization, environmental interventions, health system organization and delivery, legislation and regulation. As the underlying determinants of non-communicable diseases often lie outside the health sector, strategies need the involvement of both public and private actors in multiple sectors such as agriculture, finance, trade, transport, urban planning, education, and sport. Different settings may be considered for action, for example, schools, workplaces, households and local communities. Surveillance of the four major behavioural risk factors and associated biological risk factors (including raised blood pressure, raised cholesterol, raised blood glucose, and overweight/obesity) is an important component of action to assess prevalence and is considered in detail under objective 2 and objective 6.

23. Member States may wish to enact or strengthen, as appropriate according to national contexts, interventions to reduce risk factors for non-communicable diseases, including ratifying and implementing the WHO Framework Convention on Tobacco Control, implementing the recommendations of the Global Strategy on Diet, Physical Activity and Health, the Global Strategy for Infant and Young Child Feeding, and other relevant strategies through national strategies, policies and action plans.

DRAFT

24. **Proposed action for Member States**

Tobacco control

Consider implementing the following package of six cost-effective policy interventions (the MPOWER package), which builds on the measures for reducing demand contained in the WHO Framework Convention for Tobacco Control:[22]

(a) monitor tobacco use and tobacco-prevention policies
(b) protect people from tobacco smoke in public places and workplaces
(c) offer help to people who want to stop using tobacco
(d) warn people about the dangers of tobacco
(e) enforce bans on tobacco advertising, promotion and sponsorship[23]
(f) raise tobacco taxes and prices.

Promoting healthy diet

Implement the actions recommended in, but not limited to, the Global Strategy on Diet, Physical Activity and Health in order to:

(a) promote and support exclusive breastfeeding for the first six months of life and promote programmes to ensure optimal feeding for all infants and young children;
(b) develop a national policy and action plan on food and nutrition, with an emphasis on national nutrition priorities including the control of diet-related non-communicable diseases;
(c) establish and implement food-based dietary guidelines and support the healthier composition of food by:
- reducing salt levels
- eliminating industrially produced *trans*-fatty acids
- decreasing saturated fats
- limiting free sugars

(d) provide accurate and balanced information for consumers in order to enable them to make well-informed, healthy choices;
(e) prepare and put in place, as appropriate, and with all relevant stakeholders, a framework and/or mechanisms for promoting the responsible marketing

[22] Implementation of other measures contained in the WHO Framework Convention on Tobacco Control may be considered as part of national comprehensive tobacco-control programmes.

[23] In Article 13 of the WHO Framework Convention on Tobacco Control, paragraph 1 states that: "Parties recognize that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products." At the same time, Article 13 recognizes that the ability of some countries to undertake comprehensive bans may be limited by their constitution or constitutional principles.

DRAFT

of foods and non-alcoholic beverages to children, in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

Promoting physical activity

Implement the actions recommended in, but not limited to, the Global Strategy on Diet, Physical Activity and Health in order to:

(a) develop and implement national guidelines on physical activity for health;

(b) implement school-based programmes in line with WHO's health-promoting schools initiative;

(c) ensure that physical environments support safe active commuting, and create space for recreational activity, by the following:

- ensuring that walking, cycling and other forms of physical activity are accessible to and safe for all;
- introducing transport policies that promote active and safe methods of travelling to and from schools and workplaces, such as walking or cycling;
- improving sports, recreation and leisure facilities;
- increasing the number of safe spaces available for active play.

Reducing the harmful use of alcohol[24]

In order to respond effectively to the public-health challenges posed by harmful use of alcohol—in accordance with existing regional strategies and guided by the outcome of current and future WHO global activities to reduce harmful use of alcohol—Member States may wish to:

(a) consider the following areas:

- under-age drinking (as defined in the country);
- the harmful use of alcohol by women of reproductive age;
- driving or operating machinery while under the influence of alcohol (including all traffic-related injuries involving alcohol);
- drinking to intoxication;
- alcohol-use disorders;
- the consumption of alcoholic beverages that have been illegally produced and distributed;

[24] Under item 11.10 of the provisional agenda, the Health Assembly is considering preparation of a draft global strategy.

DRAFT

- the impact of harmful use of alcohol on other health conditions, in particular on cancers, liver and cardiovascular diseases, and injuries.

(b) adopt measures in support of an appropriate monitoring system for the harmful use of alcohol.

25. **Action for the Secretariat**

(a) Use existing strategies such as the WHO Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health, the Global Strategy for Infant and Young Child Feeding, and other relevant strategies that have been the subject of resolutions adopted by the Health Assembly, in order to provide technical support to countries in implementing or strengthening nationwide action to reduce risk factors for non-communicable diseases and their determinants [2008–2009].[25]

(b) Guide the development of pilot or demonstration community-based programmes of intervention.

(c) Support the development of networks of community-based programmes at the regional and global levels [2008–2009].[25]

(d) Provide support to countries in implementing the MPOWER package and provide technical support to implement other measures contained in the WHO Framework Convention on Tobacco Control in response to specific national needs [2008–2009].[25]

(e) Ensure synergy with the work of the Convention Secretariat and the implementation of the WHO Framework Convention on Tobacco Control in applying the tobacco-control component of this plan [2008–2009].[25]

26. **Proposed action for international partners**

Provide support for and participate in the development and implementation of technical guidance and tools in order to reduce the main shared modifiable risk factors for non-communicable diseases.

OBJECTIVE 4: To promote research for the prevention and control of non-communicable diseases

27. A coordinated agenda for non-communicable disease research is an essential element in the effective prevention and control of non-communicable diseases. In establishing such an agenda, the aim is to enhance international collaboration to promote and support the multidimensional and multi-sectoral research that

[25] See paragraph 11 above.

DRAFT

is needed in order to generate or strengthen the evidence base for cost-effective prevention and control strategies. Priority areas include the analytical, health system, operational, economic and behavioural research that are required for programme implementation and evaluation.

28. **Proposed action for Member States**

   (a) Invest in epidemiological, behavioural, and health-system research as part of national programmes for the prevention of non-communicable diseases and develop—jointly with academic and research institutions—a shared agenda for research, based on national priorities.

   (b) Encourage the establishment of national reference centres and networks to conduct research on socioeconomic determinants, gender, the cost-effectiveness of interventions, affordable technology, health system reorientation and workforce development.

29. **Action for the Secretariat**

   (a) Develop a research agenda for non-communicable diseases in line with WHO's global research strategy,[26] collaborate with partners and the research community and involve major relevant constituencies in prioritizing, implementing, and funding research projects. A prioritized research agenda for non-communicable diseases should generate knowledge and help to translate knowledge into action through innovative approaches in the context of low- and middle-income countries. Such an agenda could include:

   - the assessment and monitoring of the burden of non-communicable diseases and its impact on socioeconomic development;
   - the monitoring of the impact of poverty and other indicators of socioeconomic disparity on the distribution of risk factors;
   - the assessment of national capacity for the prevention and control of non-communicable diseases and the evaluation of approaches to fill existing gaps in capacity;
   - the evaluation of impact of community-based interventions on risk factor levels, and on morbidity and mortality associated with non-communicable diseases in different populations;
   - the assessment of the cost-effectiveness of clinical and public-health

[26] Action to elaborate the research agenda for non-communicable diseases will be initiated in 2008, in close coordination with ACHR and other partners.

DRAFT

interventions for improving health behaviours and health outcomes;

- the evaluation of different strategies for early detection and screening of non-communicable diseases in different populations, with an emphasis on cancers, diabetes and hypertension;
- the evaluation of interventions for secondary prevention on cardiovascular disease outcomes in different settings;
- the study of the effectiveness of different organizational patterns in health-care institutions in improving health care for chronic conditions, with a special focus on primary health care;
- the analysis of research on factors affecting consumer behaviour and dietary choices, including marketing;
- the study of approaches for improving access to, and availability of, essential medicines, essential medical technologies and other central elements of health care; and of approaches for improving the development of affordable new drugs for neglected diseases like Chagas disease, and for rheumatic fever, together with vaccines like that against human papillomavirus;
- the assessments of the role, efficacy, and safety of traditional medicines in the management of non-communicable diseases [2008–2009].[27]

(b) Encourage WHO collaborating centres to incorporate the research agenda into their plans and facilitate collaborative research through bilateral and multilateral collaboration and multi-centre projects.

30. **Proposed action for international partners**

(a) Support low- and middle-income countries in building capacity for epidemiological and health-systems research, including the analytical and operational research required for programme implementation and evaluation in the area of non-communicable diseases.

(b) Support, and work jointly on, priority research on non-communicable diseases at the global, regional and subregional levels, particularly research on socioeconomic determinants, lifestyle and behaviour modification, community-based interventions, equity, reorientation of health systems and primary health care, together with research that explores models of care that are applicable to resource-poor settings.

[27] See paragraph 11 above.

DRAFT

(c) Strengthen and support WHO collaborating centres and national reference centres and monitor initiatives and partnerships involved in research related to the prevention and control of non-communicable diseases.

OBJECTIVE 5: To promote partnerships for the prevention and control of non-communicable diseases

31. Providing effective public health responses to the global threat posed by non-communicable diseases requires strong international partnerships. The building and coordinating of results-oriented collaborative efforts and alliances are essential components of the global strategy. Partnerships are also vital because resources for the prevention and control of non-communicable diseases are limited in most national and institutional budgets. Collaborative work should be fostered among United Nations agencies, other international institutions, academia, research centres, nongovernmental organizations, consumer groups, and the business community.
32. Since the major determinants of non-communicable diseases lie outside the health sector, collaborative efforts and partnerships must be intersectoral and must operate “upstream” in order to ensure that a positive impact is made on health outcomes in respect of non-communicable diseases.
33. **Proposed action for Member States**
    (a) Participate actively in regional and subregional networks for the prevention and control of non-communicable diseases.
    (b) Establish effective partnerships for the prevention and control of non-communicable diseases, and develop collaborative networks, involving key stakeholders, as appropriate.
34. **Action for the Secretariat**
    (a) Establish an advisory group in 2008 in order to provide strategic and technical input and conduct external reviews of the progress made by WHO and its partners in the prevention and control of non-communicable diseases [2008–2009].[27]
    (b) Encourage the active involvement of existing regional and global initiatives in the implementation and monitoring of the global strategy for the prevention and control of non-communicable diseases, and of related strategies.

DRAFT

(c) Support and strengthen the role of WHO collaborating centres by linking their plans to the implementation of specific interventions in the global strategy [2008–2009].[28]

(d) Facilitate and support, in collaboration with international partners, a global network of national, regional, and international networks and programmes such as the WHO regional networks for non-communicable disease prevention and control.[29]

35. **Proposed action for international partners**

(a) Collaborate closely with and provide support to Member States and the Secretariat in implementing the various components of the global strategy for the prevention and control of non-communicable diseases.

(b) Give priority to non-communicable diseases in international and regional initiatives to strengthen health systems based on primary health care.

(c) Support the establishment and strengthening of coordinated global, regional and subregional networks for the prevention and control of non-communicable diseases.

OBJECTIVE 6: To monitor non-communicable diseases and their determinants and evaluate progress at the national, regional and global levels

36. Monitoring non-communicable diseases and their determinants provides the foundation for advocacy, policy development and global action. Monitoring is not limited to tracking data on the magnitude of and trends in non-communicable diseases, it also includes evaluating the effectiveness and impact of interventions and assessing progress made.

37. An evaluation of the implementation of the plan and of progress made will be carried out at the mid-point of the plan's six-year time frame and at the end of the period. The mid-term assessment will offer an opportunity to learn from the experience of the first three years of the plan, taking corrective measures where actions have not been effective and reorienting parts of the plan in response to unforeseen challenges and issues.

[28] See paragraph 11 above.

[29] The network of African non-communicable disease interventions (NANDI) in the African Region; *Conjunto de acciones para la reducción multifactorial de enfermedades no transmisibles* (the CARMEN network) in the Region of the Americas; the South-East Asia network for NCD prevention and control (SEANET–NCD) in the South-East Asian Region; the countrywide integrated non-communicable diseases intervention (the CINDI programme) in the European Region; the eastern Mediterranean approach to non-communicable disease (EMAN) in the Eastern Mediterranean Region; and the Western Pacific non-communicable disease network (MOANA) in the Western Pacific Region.

DRAFT

38. **Proposed action for Member States**

(a) Strengthen surveillance systems and standardized data collection on risk factors, disease incidence and mortality by cause, using existing WHO tools.

(b) Contribute, on a routine basis, data and information on trends in respect of non-communicable diseases and their risk factors disaggregated by age, gender, and socioeconomic groups; and provide information on progress made in implementation of national strategies and plans.

39. **Action for the Secretariat**

(a) Develop and maintain an information system to collect, analyse and disseminate data and information on trends in respect of mortality, disease burden, risk factors, policies, plans and programmes using currently available data sources like the WHO Global InfoBase and other existing global information systems.[30] This database will be expanded to handle new information on subjects such as health services coverage, related costs, and quality of care [2008–2009].[31]

(b) Establish a reference group for non-communicable diseases and risk factors, made up of experts in epidemiology, in order to support the work of the Secretariat and advise countries on data collection and analysis [2008–2009].[31]

(c) Strengthen technical support to Member States in improving their collection of data and statistics on risk factors, determinants and mortality.

(d) Convene a representative group of stakeholders, including Member States and international partners, in order to evaluate progress on implementation of this action plan. The group will set realistic and evidence-based targets and indicators for use in both the mid-term and final evaluations [2008–2009].[31]

(e) Prepare progress reports in 2010 and 2013 on the global status of prevention and control of non-communicable diseases.

[30] Data sources and global information systems include the WHO's statistical information system (for age standardized mortality data), the Global Burden of Disease Project, the Health Metrics Network, the Global Tobacco Surveillance System surveys, data on diet and physical activity from national and subnational surveys, the Global Information System on Alcohol and Health, the WHO STEPwise approach to risk factor surveillance and the WHO surveys on national capacity for the prevention and control of non-communicable diseases.

[31] See paragraph 11 above.

DRAFT

40. **Proposed action for international partners**

(a) Work collaboratively and provide support for the actions set out for Member States and the Secretariat in monitoring and evaluating, at the regional and global levels, progress in prevention and control of non-communicable diseases.

(b) Mobilize resources to support the system for regional and global monitoring and evaluation of progress in the prevention and control of non-communicable diseases.

INDICATORS

41. There is a need for measurable process and output indicators to permit accurate monitoring and evaluation of actions taken and their impact. Indicators are essential in order to measure progress in implementing the plan and will focus on actions taken by the Secretariat and on the actions of Member States, including in resource-poor settings.

42. Each country may develop its own set of indicators, based on priorities, and resources; however, in order to track prevention and control of non-communicable diseases at global and regional levels, there is a need to collect data and information in a standardized manner.

43. The indicators mentioned below are examples of measurements that WHO will use in monitoring and reporting on the global status of the prevention and control of non-communicable diseases. Baseline values are available in WHO for many of the indicators; however, where baselines are not currently available, mechanisms will be established in 2008 and 2009 to collect relevant data.

- Number of countries that have an established unit for the prevention and control of non-communicable diseases (with dedicated staffing and budget) in the Ministry of Health or equivalent national health authority.
- Number of countries that have adopted a multi-sectoral national policy for non-communicable diseases in conformity with the global strategy for the prevention and control of non-communicable diseases.
- Number of countries with reliable, nationally representative mortality statistics by cause.
- Number of countries with reliable standardized data on the major non-communicable disease risk factors (based on WHO tools).
- Number of countries with reliable population-based cancer registries.

DRAFT

- Number of countries that have excise tax rates of at least 50% of the retail price of a pack of the most commonly-used cigarettes.
- Number of countries with complete smoke-free legislation covering all types of places and institutions, as defined in the WHO Report on the Global Tobacco Epidemic, 2008.[32]
- Number of countries with bans on tobacco advertising, promotion and sponsorship, as defined in the WHO Report on the Global Tobacco Epidemic, 2008.[32]
- Number of countries that have incorporated smoking cessation support (including counselling and/or behavioural therapies) into primary health care, as defined in the WHO Report on the Global Tobacco Epidemic, 2008.[32]
- Number of countries that have adopted multi-sectoral strategies and plans on healthy diet, based on the WHO Global Strategy on Diet, Physical Activity and Health.
- Number of countries that have adopted multi-sectoral strategies and plans on physical activity based on the WHO Global Strategy on Diet, Physical Activity and Health.
- Number of countries that have developed national food-based dietary guidelines.
- Number of countries that have developed national recommendations on physical activity for health.
- Number of countries that have developed policies, plans and programmes for preventing public-health problems caused by harmful use of alcohol.
- Number of countries with a national research agenda and a prioritized research plan for non-communicable diseases and their risk factors in line with WHO's global research strategy.
- Number of countries that provide early detection and screening programmes for cardiovascular risk.
- Number of countries with comprehensive national cancer-control programmes, covering priorities in prevention, early detection, treatment and palliative care.
- Number of countries providing early detection and screening programmes for cervical cancer and/or breast cancer.
- Number of countries in which patients have access to affordable essential medicines for pain relief and palliative care, including oral morphine.

[32] *WHO Report on the Global Tobacco Epidemic, 2008: the MPOWER package*. Geneva, World Health Organization, 2008.

DRAFT

- Number of radiotherapy devices per 100 000 population.
- Number of countries in which essential medicines for management of chronic respiratory diseases, hypertension, and diabetes are affordable and accessible in primary health care.
- Prevalence of tobacco use among adults aged 25–64 years.[33]
- Prevalence of low consumption of fruit and vegetables among adults aged 25–64 years.[33]
- Prevalence of low levels of physical activity among adults aged 25–64 years.[33]
- Prevalence of overweight/obesity among adults aged 25–64 years.[33]
- Prevalence of raised blood pressure among adults aged 25–64 years.[33]
- Prevalence of raised fasting blood glucose concentration among adults aged 25–64 years.[33]

[33] As defined in the WHO STEPwise approach to risk factor surveillance.

DRAFT

For more information:

WHO Communication Officers:

Chronic diseases/Health promotion

Iqbal Nandra
Telephone: +41 22 791 5589
Mobile: +41 79 509 0622
nandrai@who.int

Mental health

Menno Van Hilten
Telephone: +41 22 791 2675
Mobile: +41 79 457 0929
vanhiltenm@who.int

Tobacco

Alison Clements-Hunt
Telephone: +41 22 791 5539
Mobile: +41 79 477 2633
clementshunta@who.int

Nutrition and development

Sharad Agarwal
Telephone: +41 22 791 1905
Mobile: +41 79 509 0686
agarwals@who.int

Stéfanie Laniel
Telephone: +41 22 791 1018
Mobile: +41 79 475 5524
laniels@who.int

Injuries and violence prevention

Laura Sminkey
Telephone: +41 22 791 4547
Mobile: +41 79 249 3520
sminkeyl@who.int

DRAFT

WHO Websites:

- Chronic (non-communicable) diseases: http://www.who.int/topics/chronic_diseases/en/
- Chronic diseases and health promotion: http://www.who.int/chp/en/
- Chronic respiratory diseases: http://www.who.int/respiratory/en/
- Global Alliance against Chronic Respiratory Diseases: http://www.who.int/gard/en/
- Global school health initiative: http://www.who.int/school_youth_health/gshi/en/
- Global strategy on diet and physical activity: http://www.who.int/dietphysicalactivity/en/
- "Move for Health": http://www.who.int/moveforhealth/en/
- Non-communicable diseases and mental health: http://www.who.int/nmh/en/
- WHO EURO, Chronic disease: http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=chronic_disease
- WHO, SEARO: http://www.searo.who.int/en/Section1174/Section1459.htm
- WHO, PAHO: http://www.paho.org/english/DD/PUB/topicHome.asp?KW=reviewedPublications&Lang=E&ID='499'&Title=Non-communicable+Diseases
- WHO, AFRO: http://www.afro.who.int/dnc/index.html

Non-WHO Websites:

- Health EU: http://ec.europa.eu/health-eu/health_problems/other_non-communicable_diseases/index_en.htm
- Indian Non-communicable diseases Network (INN): http://www.ncd.in/
- World Bank: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/EXTECAREGTOPHEANUT/EXTECAREGTOPHIVAIDS/0,,contentMDK:21389597~menuPK:571178~pagePK:2865114~piPK:2865167~theSitePK:571172,00.html

DRAFT

*11.7 Global immunization strategy

Extract from Document A61/10 (Report by Secretariat):

1. Vaccine-preventable diseases are responsible for about 25% of the 10 million deaths occurring annually among children under five years of age. With the availability of new vaccines, such as those against rotavirus and pneumococcal diseases, a much larger proportion of children can now be protected against a broader range of infectious diseases. Further improvements in coverage with vaccines currently used by most national immunization programmes, including measles, tetanus, pertussis and *Haemophilus influenzae* type b vaccines, are also averting deaths. Thus, vaccines help to reduce infant mortality significantly and are contributing to the achievement of the target in United Nations Millennium Development Goal 4 for reducing the under-five mortality rate.
2. In resolution WHA58.15, the Fifty-eighth World Health Assembly, recognizing the role that vaccines and immunization can play in reducing under-five mortality, welcomed the Global Immunization Vision and Strategy 2006–2015 developed by WHO and UNICEF as a framework for strengthening national immunization programmes. This report summarizes efforts by Member States to increase immunization coverage and to extend the benefits of immunization with new vaccines to an increasing number of children.

SUCCESS OF MEASLES MORTALITY REDUCTION EFFORTS

3. In resolution WHA56.20, the Health Assembly urged full implementation of the WHO–UNICEF strategic plan for measles mortality reduction 2001–2005, and, at the end of 2005, the major public health goal of reducing global measles mortality by 50% compared with the 1999 level had been surpassed, with a reduction of 60%. In resolution WHA58.15, the Health Assembly welcomed the Global Immunization Vision and Strategy, one of whose goals is to reduce global measles deaths by 90% by 2010 (or earlier) compared with 2000.[34] Between 2000 and 2006, global mortality due to measles was reduced by 68% from an estimated 757 000 deaths in 2000 to 242 000 in 2006. The largest percentage reduction in estimated measles mortality during this period occurred in the African Region (91%), accounting for 70% of the global reduction in measles

[34] Document WHA58/2005/REC/1, Annex.

DRAFT

mortality. In 2006, global routine coverage with measles vaccine reached 80% for the first time, increasing from 72% in 2000.

4. These public health accomplishments helped to prevent nearly 9.2 million measles deaths between 2000 and 2006, with accelerated immunization activities accounting for 2.8 million of the deaths averted. They were made possible by the concentrated focus of immunization partners on the most effective strategies to control measles rapidly and on regions with the highest numbers of measles deaths. The sharp decline in measles deaths is the direct result of (a) the commitment and dedication of Member States severely affected by measles to provide better access to routine childhood immunization; (b) Member States' measles vaccination activities in which more than 478 million children aged nine months to 15 years were vaccinated against measles between 2000 and 2006 in 47 high-priority countries; (c) technical and financial support provided through the Measles Initiative, a partnership formed in 2001 and spearheaded by WHO, UNICEF, the American Red Cross, the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America), and the United Nations Foundation; and (d) intensified surveillance of suspected measles cases with laboratory confirmation.

IMPORTANT PROGRESS WITH ROUTINE IMMUNIZATION

5. Less striking than the measles success, but equally important, have been improvements in routine immunization coverage since 1999. These have been most marked in lowest-income countries, and particularly in sub-Saharan Africa; other regions, apart from South-East Asia, have continued to sustain high levels of immunization coverage. In 2006, a record 102 million children under one year of age were vaccinated worldwide with three doses of diphtheria, tetanus and pertussis vaccine, and the number of unvaccinated children decreased to 26.3 million compared with 28.1 million in 2005. Elements that have contributed to this achievement include national multi-year planning, district-level planning and monitoring, and the establishment of national budget lines, funded with domestic and external resources, including those provided by the GAVI Alliance for immunization services strengthening. As a result, routine immunization coverage, seemingly in stagnation since the early 1990s, now shows an encouraging rising trend, particularly in sub-Saharan Africa.

DRAFT

6. The district planning and monitoring approach promoted by WHO is based on five key strategies that were initially repackaged in western Africa into a single strategy, which has since rapidly gained acceptance globally as the "reaching every district" strategy. As an example, with this strategy, vaccination coverage of children in Ethiopia with a third dose of diphtheria, tetanus and pertussis vaccine improved in 14 of the worst-performing districts, from an average of 35% in 2002 to 71% in 2005.
7. The strategy of child health days, led by UNICEF, has also helped to promote routine immunization. Consistent with the emphasis of the Global Immunization Vision and Strategy on linking immunization with other health interventions, child health days are regular events designed to deliver an integrated package of preventive services such as immunization, vitamin A supplementation, de-worming, growth monitoring and distribution of insecticide-treated bed-nets. They have become routine in many African countries, have achieved high coverage and have been shown to reduce inequalities in access to basic health services. Child health days are usually conducted twice a year and the integrated package that they offer is defined according to epidemiological needs and local circumstances. Preliminary analysis of experience so far in Ethiopia, Uganda and the United Republic of Tanzania shows that child health days have helped to deliver multiple interventions effectively (including immunization), to improve routine immunization coverage, and to reduce operational costs per child reached.
8. Vaccination weeks to promote immunization coverage using new and existing vaccines are regularly organized in the Region of the Americas and the European Region. Endorsed by all Member States in the Region of the Americas in 2003, vaccination weeks have already reached more than 147 million children and adults in that Region, especially in difficult-to-reach populations, isolated communities and towns with low immunization coverage. During the second European Immunization Week in April 2007, 25 Member States in the European Region were involved, underlining the importance of immunization through workshops, debates, training courses, exhibitions and media events. In northern India, vaccination weeks are held regularly for raising immunization coverage levels.

DRAFT

NEW AND UNDERUSED VACCINES

9. The introduction of new and underused vaccines continued to make progress. By the end of 2006, 164 Member States had introduced hepatitis B vaccine into their routine infant immunization programme, and global coverage with three doses of hepatitis B vaccine had reached 60%. Similarly, the *Haemophilus influenzae* type b vaccine is now in routine use in 108 Member States, and global immunization coverage is increasing. These developments are accompanied by Member States' increasing uptake of newly licensed vaccines against rotavirus diarrhoea and human papillomavirus infection and of the pneumococcal conjugate vaccine. The fast progress in introducing new vaccines has been facilitated by Member States' growing recognition of the value of the protection conferred by vaccines and immunization. Such progress has also been made possible by the establishment of global financing mechanisms, including the GAVI Alliance, and the important role played by regional procurement mechanisms, for example the Revolving Fund for Vaccine Procurement in the Region of the Americas.
10. More vaccines will soon become available on a large scale for use, among others, against meningococcal diseases, Japanese encephalitis and typhoid. In addition, governments, multilateral agencies, foundations, and research institutions, among others, have substantially increased their investment in the development of new vaccines. As a result, various new vaccines are likely to be available for introduction in the next 10 years. These include, in particular, vaccines against dengue, tuberculosis and malaria. However, countries increasingly have to decide which of these life-saving tools they should finance and use on a routine basis.

FURTHER EFFORTS REQUIRED

11. In spite of progress, much remains to be done if the full potential of immunization is to be exploited in achieving Millennium Development Goal 4.
12. Measles remains a leading cause of death among young children. In 2006, there were an estimated 242 000 measles deaths globally. This figure can be reduced if the strong political commitment seen since the beginning of the decade is sustained. In addition, diseases for which vaccines have recently become available represent a high burden. About 1.1 million deaths of children under the age of five could be prevented through immunization with new vaccines against pneumococcal disease and rotavirus diarrhoea. Vaccines against human

DRAFT

papillomavirus infection could prevent nearly 250 000 annual deaths of women from cervical cancer.

13. According to WHO/UNICEF estimates, more than 26.1 million young children did not receive the first scheduled dose of measles vaccine through routine immunization services in 2006. Intensified efforts to ensure that at least 90% of infants receive this dose before their first birthday would save many additional lives. In addition, countries such as India and Pakistan, with large populations and high measles mortality, should be supported in their efforts to reduce measles mortality. Indeed, some financial resources have already been pledged towards these two countries' efforts: in addition to increased resource allocation for immunization by Member States, US$ 147 million has been raised through the International Finance Facility for Immunisation and an additional US$ 100 million has been pledged by Measles Initiative partners.
14. With regard to routine immunization, large variations in coverage among regions and countries are still seen, and many children are yet to benefit from potentially life-saving vaccines, particularly in South Asia and sub-Saharan Africa. Globally, some 26.3 million infants did not receive three doses of diphtheria, tetanus and pertussis vaccine in 2006.
15. Efforts must focus on further increasing routine access to immunization services through the broad array of strategies that have proved themselves successful, such as the reaching every district strategy, child health days and immunization weeks.
16. As for the introduction of new or underused vaccines, whereas much progress has been made with the routine use of hepatitis B vaccine, this has taken 15 years since the Forty-fifth World Health Assembly recommended its universal use in 1992 (resolution WHA45.17). A similar time lag is unfortunately now being experienced with *Haemophilus influenzae* type b vaccine, for which global coverage remains low at 22%.
17. The need for accelerated introduction of new vaccines in all high-burden countries must be matched by adequate financial support, including support for countries with low-middle and middle incomes. Such countries are not eligible for funding from the GAVI Alliance and support for them has heretofore been insufficient or lacking.
18. More tools and research are therefore required to support Member States in their decision-making processes, especially the generation of an evidence base

DRAFT

through detailed analysis of the impact, in terms of cost benefits and public health, of these new vaccines.

19. It is also crucial that the growing demand for new vaccines should be matched with a greater number of manufacturers (including those in developing countries) of products that have been prequalified by WHO, thus laying the foundation for a healthy market and a reliable supply of affordable products of assured quality.

20. Safe vaccines are essential, if public trust in immunization is to be maintained. The Secretariat works with Member States to strengthen the capacity of national regulatory authorities to perform routine post-marketing surveillance for vaccine safety. Continuous efforts are required to strengthen this capacity further in all Member States and to ensure prompt exchange of information about, investigation of and rapid response to adverse events following vaccination.

21. To meet the above challenges and reach the immunization objectives already expressed in the United Nations General Assembly special session on children (2002) and further enunciated in the Global Immunization Vision and Strategy, strong disease surveillance and programme monitoring systems are required. WHO and its partners have developed a global framework for vaccine-preventable disease surveillance and immunization programme monitoring. This framework combines the use of countrywide active surveillance, passive aggregate disease reporting, sentinel site surveillance, and prospective, time-limited projects to generate the comprehensive epidemiological data required to guide immunization programmes. It also outlines strategies such as ongoing monitoring of vaccine management and vaccine safety, as well as cross-sectional programme reviews to assess the state of programmes at the district and health facility levels.

22. As has been demonstrated by the global poliomyelitis eradication initiative, efficient surveillance systems can be established, even in resource-poor settings, at quite low cost relative to the cost of the intervention itself. The poliomyelitis surveillance network provides a structure for rapidly detecting and responding to diseases of national and international importance. Where appropriate, this network should serve as the platform both for an integrated disease surveillance system that provides epidemiological data on other communicable diseases, and for detection and response to emerging infectious disease threats. Funding for disease surveillance is usually disease specific and time limited. In the presence of weak national systems, parallel systems tend to be established in order to

DRAFT

generate data suited to the needs of specific programmes. These uncoordinated efforts may address short-term needs, but are unsustainable in the long term. The global framework provides an opportunity for immunization partners to coordinate their efforts to secure sustainable funding for surveillance and programme monitoring.

REAPING THE FULL BENEFITS OF VACCINES AND IMMUNIZATION

23. The basis of the remarkable progress of the past few years, as described above, includes research and development efforts for new vaccines, a reliable supply of more affordable vaccines of assured quality, and the mobilization of substantial new resources through partnerships and innovative mechanisms such as the International Finance Facility for Immunisation and the advance market commitment established through the GAVI Alliance for a pneumococcal conjugate vaccine.
24. The achievements outlined in this report demonstrate that safe and effective health technologies exist, efficient strategies are well known, and resources can be mobilized to support the vision that vaccines and immunization should be allowed to contribute their full potential to the reduction of under-five mortality.
25. Members of the Executive Board, at its 122nd session in January 2008, noted successes achieved through immunization, areas requiring further progress, and challenges,[35] and adopted resolution EB122.R7.

[35] See document EB122/2008/REC/2, summary records of the sixth and seventh meetings.

DRAFT

RESOLUTION 11.7: Global Immunization Strategy

Extract from Executive Board Resolution, EB122.R7:

The Executive Board, having considered the report on the global immunization strategy, RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on the global immunization strategy;

Applauding the remarkable investments in human and financial resources made by Member States and partner agencies in support of vaccines and immunization as well as the launch of innovative financing mechanisms such as the International Finance Facility for Immunisation, and the advance market commitment for a pneumococcal conjugate vaccine through the GAVI Alliance;

Recalling resolution WHA56.20 on reducing global measles mortality, and commending Member States' and their partners' success in exceeding the goal of reducing deaths worldwide due to measles by 50% by the end of 2005 compared with the 1999 level;

Commending also Member States' and their partners' progress in increasing the availability, affordability and uptake of hepatitis B vaccine worldwide;

Encouraged by the progress in molecular biology and genetics that is accelerating the discovery and development of new vaccines and by the increasing number of developing country manufacturers producing vaccines that meet WHO requirements for vaccines of assured quality;

Alarmed that many developing countries are not on track to meet the internationally agreed target in Millennium Development Goal 4 for reducing the under-five mortality rate;

Concerned that there are insufficient resources available for introduction of new vaccines, especially in low- and middle-income countries;

Stressing the vital role that vaccine and immunization programmes can play in reducing infant mortality and in facilitating the delivery of a package of life-saving interventions,

1. URGES Member States:

   (1) to implement fully the strategy for reducing measles mortality in order to achieve the goal set in the Global Immunization Vision and Strategy

DRAFT

2006–2015 of a 90% reduction in the global measles mortality rate between 2000 and 2010;

(2) to enhance efforts to improve delivery of high-quality immunization services in order to achieve the target of equitable coverage of at least 80% in all districts by 2010 set in the Global Immunization Vision and Strategy 2006–2015;

(3) to further expand access to, and coverage of, available and cost-effective new lifesaving vaccines of assured quality, in accordance with national priorities, for all target populations in order to accelerate the achievement of Millennium Development Goal 4;

(4) to develop, strengthen and/or maintain surveillance systems for vaccine-related adverse events;

2. REQUESTS the Director-General:

(1) to work with Member States to sustain political commitment at all levels for achieving high immunization coverage rates with all available cost-effective vaccines;

(2) to collaborate with international partners, including UNICEF and the GAVI Alliance, in order to continue to mobilize the financial resources required to achieve this objective;

(3) to collaborate with international partners and donors as well as vaccine producers to mobilize necessary resources to support low- and middle-income countries with the aim of increasing the supply of affordable vaccines of assured quality;

(4) to take measures, as appropriate, to assist developing countries to establish and strengthen their capacity for vaccine research, development and regulation, for the purpose of improving the output of vaccine production with the aim of increasing the supply of affordable vaccines of assured quality;

(5) to provide guidelines and technical support to Member States in order to minimize vaccine-related adverse events;

(6) to facilitate scientific, technical and financial investments into the research and development of safe and effective vaccines against poverty-related and neglected diseases;

(7) to monitor progress towards achievement of global immunization goals and report on such progress to the Sixty-fourth World Health Assembly.

DRAFT

For more information:

WHO Communication Officers: Immunization and vaccines

Alison Brunier
Telephone: +41 22 791 4468
bruniera@who.int

Hayatee Hasan
Telephone: +41 22 791 2103
hasanh@who.int

Melinda Henry
Telephone: +41 22 791 2535
Mobile: +41 79 477 1738
henrym@who.int

WHO Websites:

- Immunization: http://www.who.int/topics/immunization/en/
- Vaccines: http://www.who.int/topics/vaccines/en/
- Immunizations, Vaccines and Biologicals: http://www.who.int/immunization/en/

Non-WHO Websites:

- UNICEF: http://www.unicef.org/immunization/index.html
- ECDC, Vaccines & Immunisation: http://ecdc.europa.eu/Health_topics/VI/VI.html
- GAVI (formerly Global Alliance on Vaccines & Immunization): http://www.gavialliance.org/

DRAFT

*11.8 Female genital mutilation

Extract from Document A61/11 (Report by the Secretariat):

1. Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural functioning of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including an increased risk of maternal morbidity and an increased perinatal mortality rate among babies born to women who have undergone the practice.
2. It is estimated that between 100 million and 140 million girls and women worldwide[36] have been subjected to type I, II or III procedures,[37] and that about three million girls and women are at risk of undergoing one of these types every year in Africa. Female genital mutilation has been documented in 28 countries in Africa and in several countries in Asia and the Middle East. Some forms of the practice have also been reported from other countries, including among certain ethnic groups in Central and South America. Although no prevalence data are available, there is evidence of increasing numbers of girls and women living outside their place of origin, including in North America and Western Europe, who have undergone or may undergo female genital mutilation in their host country.
3. Over the past two or three decades, local, national and international actors have significantly increased their efforts to eliminate female genital mutilation, and have made progress on several fronts. The practice is internationally recognized as a violation of human rights, and many countries have put in place policies and legislation to ban it. Many communities are, it seems, showing less support for the practice. Research findings have increased knowledge about the practice itself and the reasons for its continuation, as well as experience with interventions that can contribute to its abandonment. Advocacy at the international level has

[36] Extrapolated from estimates that 92 million girls and women currently aged 10 and over have undergone the practice in Africa.

[37] Type I – excision of the prepuce, with or without excision of part or all of the clitoris; Type II – excision of the clitoris with partial or total excision of the labia minora; Type III – excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

DRAFT

created a momentum suggesting that it is possible to significantly reduce the prevalence of female genital mutilation within one generation.

4. Following the adoption of resolution WHA47.10 by the Health Assembly in 1994, on traditional practices (including female genital mutilation) harmful to the health of women and children, the Secretariat has provided increased technical support to Member States for preventing the practice and managing its consequences. Such support has included the elaboration and dissemination of a series of guidance documents on the prevention and management of the practice's health complications for use at policy, programmatic and pre-service training levels.
5. The results of a WHO study in six African countries on the obstetric sequelae of female genital mutilation[38] showed that deliveries among women who had undergone the practice (compared with deliveries among women who had not) were significantly more likely to be complicated by caesarean section, post-partum haemorrhage, episiotomies and prolonged stay in hospital. In addition, babies born to mothers who had undergone the practice (compared with babies born to mothers who had not) had a greater risk of dying during birth or of needing resuscitation immediately after birth.
6. WHO's ongoing support for research on female genital mutilation includes assessments of how community-based interventions that are successful can be replicated elsewhere, of the elements in decision-making that contribute to continuation or abandonment of the practice, and of the role played by perceptions of women's sexuality in the continuation of the practice. The Secretariat intends, over the next few years, to evaluate the economic costs of female genital mutilation, both immediate medical costs and long-term costs of morbidities and psychological consequences. It will also appraise the effects of legal measures. It plans to develop web-based and other audiovisual media for the training of health professionals to prevent female genital mutilation where possible, and to successfully manage its health consequences in women, girls and newborn babies.
7. All the WHO regional offices in regions where the practice is prevalent are engaged in activities aimed at eliminating it. Since 1989, when the Regional Committee for Africa in resolution AFR/RC39/R9 called on Member States to adopt appropriate policies and strategies to eliminate female circumcision, that Regional Office has

[38] *Lancet*, 2006; 367:1835–1841.

DRAFT

supported its Member States in programmes for the elimination of the practice, in line with its 20-year Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa. In South-East Asia, the Regional Office works with the Ministry of Health in Indonesia, which is concerned about the increasing tendency for female genital mutilation to be practiced by health professionals. In Europe, there are concerns about female genital mutilation among immigrant populations, and the Regional Office is providing guidance to Member States with regard to health care and the law governing female genital mutilation. The Regional Office for the Eastern Mediterranean has produced guidelines on the elimination of female genital mutilation.

8. Nonetheless, the rate of progress towards a significant decline in the practice is slow. In some countries there appears to be an increasing tendency for female genital mutilation to be carried out by health professionals, a development that is of particular concern. Thus, there is an urgent need to reinforce actions, commitment and resources to achieve the goal of eliminating the practice within one generation.

9. WHO is therefore coordinating the revision of the 1997 WHO/UNFPA/UNICEF joint statement on female genital mutilation to reinforce international commitment in the fight to eliminate the practice. Officially launched in February 2008 during the Fifty-second session of the United Nations Economic and Social Council's Commission on the Status of Women, the revised interagency statement reflects new evidence and incorporates lessons learnt over the past decade. It highlights the now-extensive recognition of the human rights and legal dimensions of the problem. It also summarizes findings from recent research on the prevalence of female genital mutilation, the reasons why the practice continues, and its damaging effects on the health of women, girls and newborn babies. It points to a series of actions that need to be undertaken by a variety of different actors. The joint statement is the result of extensive consultation with different international, regional and national partners, and 10 other United Nations bodies have signed the statement (UNESCO, WHO, UNICEF, United Nations Economic Commission for Africa, UNDP, UNHCR, UNFPA, Office of the High Commissioner on Human Rights, United Nations Development Fund for Women, and UNAIDS).

10. At its 122nd session,[39] the Executive Board strongly supported strengthening efforts at national, regional and international levels to eliminate female genital

[39] See document EB122/2008/REC/2, summary record of the sixth, ninth and tenth meetings.

DRAFT

mutilation, a practice that violates women's and girls' human rights. Several members expressed particular concern about the increasing tendency for female genital mutilation to be done by health professionals and underlined WHO's role in working to reverse and halt this medicalization of the practice. Although the Board was unanimous in its support of the draft resolution, members could not agree on the final wording of some of the proposed amendments. Therefore two paragraphs in the draft resolution submitted to the Health Assembly for its consideration contain bracketed text.

DRAFT

RESOLUTION 11.8: Female Genital Mutilation

Extract from Executive Board Resolution EB122.R13:

The Executive Board, having considered the report on female genital mutilation, SUBMITS to the Sixty-first World Health Assembly for its consideration the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on female genital mutilation;

Recalling resolution WHA47.10 on Maternal and child health and family planning: traditional practices harmful to the health of women and children;

[Reaffirming OR Reaffirming the goals and commitments contained in OR Recalling] the Beijing Declaration and Platform for Action of the Fourth World Conference on Women (Beijing, 1995), the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and their five- and ten-year reviews [and related reports], as well as the United Nations Millennium Declaration 2000 and the commitments relevant to the girl child made at the United Nations General Assembly special session on children (2002), and in United Nations General Assembly resolution 60/1 on the 2005 World Summit Outcome;

Affirming that the International Covenant on Civil and Political Rights (1976), the Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Convention on the Rights of the Child (1989), constitute an important contribution to the legal framework for the protection and promotion of the human rights of girls and women, and recognizing the importance African States attach to the African Charter on the Rights and Welfare of the Child (1990) and the Solemn Declaration on Gender Equality in Africa (2004) in this regard;

Recognizing the entry into force of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in Maputo on 11 July 2003, whose provisions on female genital mutilation mark a significant milestone towards the abandonment of this practice;

Recalling also resolution 51/2 of the United Nations Commission on the Status of Women on ending female genital mutilation (March 2007);

DRAFT

Recognizing that female genital mutilation violates the human rights of girls and women including their right to the enjoyment of the highest attainable standard of physical and mental health;

Noting that, whereas there is evidence of decline in the practice, it is still widespread in some parts of the world, with an estimated 100 million to 140 million girls and women having undergone the practice and at least another three million being at risk of undergoing the practice every year;

Deeply concerned about the serious health consequences of female genital mutilation; the risk of immediate complications, which include severe pain, shock, haemorrhage, tetanus, sepsis, urine retention, ulceration of the genital region and injury to adjacent genital tissue; the long-term consequences, which include increased risk of maternal morbidity, recurrent bladder and urinary tract infection, cysts, infertility and adverse psychological and sexual consequences; and increased risk of neonatal death for babies born to mothers having undergone female genital mutilation;

Also concerned about emerging evidence of an increase in carrying out female genital mutilation by medical personnel in all regions where it is practised;

Emphasizing that concerted action is needed in sectors such as education, finance, justice and women's affairs as well as in the health sector, and that many different kinds of actor must be engaged, from governments and international agencies to nongovernmental organizations,

1. URGES all Member States:
   (1) to accelerate actions towards the elimination of female genital mutilation, including education and information necessary for full understanding of the gender, health and human rights dimensions of female genital mutilation;
   (2) to enact and enforce legislation to protect girls and women from all forms of violence, particularly female genital mutilation, and ensure implementation of laws prohibiting female genital mutilation by any person, including medical professionals;
   (3) to support and enhance community-based efforts to eliminate the practice of female genital mutilation, particularly ensuring men's and local leaders' participation in the process to eliminate the practice;
   (4) to work with all sectors of government, international agencies and nongovernmental organizations in support of the abandonment of

DRAFT

the practice as a major contribution to attainment of the Millennium Development Goals on promoting gender equality and empowerment of women, reducing child mortality, and improving maternal health;

(5) to formulate and promote guidelines for the care, particularly during childbirth, of girls and women who have undergone female genital mutilation;

[(6) to develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health care, OR care and services including those for sexual and reproductive health, in order to assist women and girls who are subjected to this violence;]

2. REQUESTS the Director-General:

(1) to increase support to Member States for implementing actions to advocate for the elimination of female genital mutilation and other forms of violence against girls and women;

(2) to work with partners both within and outside the United Nations system to promote actions to protect the human rights of girls and women;

(3) to increase support for research on different aspects of female genital mutilation in order, inter alia, to achieve its elimination;

(4) to assist Member States with strengthening their health information systems for monitoring progress made towards elimination of female genital mutilation;

(5) to report every three years, to the Health Assembly, through the Executive Board, on actions taken by the WHO Secretariat, Member States and other partners.

DRAFT

For more information:

WHO Communication Officers:

Gender and women's health

Sophie Berlamont
Telephone: +41 22 791 5543
berlamonts@who.int

Safe pregnancy

Marie Agnes Heine
Telephone: +41 22 791 2710
Mobile: +41 79 449 5784
heinem@who.int

WHO Websites:

- Female genital mutilation: http://www.who.int/topics/female_genital_mutilation/en/

Non-WHO Websites:

- UNICEF: http://www.unicef.org/protection/index_genitalmutilation.html
- Circumcision Information Resources (CIRP) (links to various scholarly and religious webpages): http://www.cirp.org/pages/female/
- FORWARD (Foundation for Women's Health, Research and Development, UK): http://www.forwarduk.org.uk/key-issues/fgm

DRAFT

*11.9 Health of migrants

Extract from Document A61/12 (Report by the Secretariat):

MIGRATION FLOWS AND THE GLOBALIZED WORLD

1. The volume of population movements, whether voluntary or forced, is increasing. Their impact—either as outpourings or influxes—is attracting considerable interest at regional, national and subnational levels, and from governments, civil society and the media.
2. Migration can be defined as "a process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes".[40] Migrants themselves encompass the overlapping categories of migrant workers and their families, long-term and short-term immigrants, internal migrants, international students, internally displaced people, asylum seekers, refugees, returnees, irregular migrants and victims of human trafficking.
3. According to United Nations estimates, 120 million of the approximately 175 million migrants worldwide are migrant workers and their families. Documented and undocumented workers have a different status and, therefore, varying levels of access to basic social services. Though the majority of migrant workers are men, more women and children are becoming international labour migrants, thus rendering them more vulnerable to human trafficking.
4. A large proportion of migrants globally move through legal channels, and their migration does not necessarily have negative health impacts. Some of them, however, will have difficulty in accessing health care. The migration process itself may have negative health implications for migrants, in particular among subgroups such as vulnerable migrants, trafficked persons, refugees and smuggled migrants, involving demonstrated health risks. Improved definition of the populations under consideration is necessary to allow the health status and access to health care of the various subgroups of migrants to be analysed in greater depth.
5. Migration may require humanitarian responses, especially to substantial displacements resulting from natural disasters or conflicts within or between countries. It also poses challenges to the organization and delivery of effective

[40] *Glossary on Migration, International Migration Law Series*, International Organization for Migration, 2004.

DRAFT

and culturally sensitive social services. Migrants' fundamental health needs are not always adequately met, thus raising concerns with regard to equity, social cohesion and inclusiveness. There is also a strong association between population movements and the spread of disease. For all the above reasons, migrants' health is becoming an increasingly important public health matter, for Member States and for the work of the Secretariat. Consequently this report addresses two distinct but related issues: the health needs of vulnerable migrants and the public health implications of migration.

Basic principles of a public health approach to the health of migrants

6. A population health approach is necessary in order to align strategies, policy options and interventions for improving health outcomes among particular subgroups of migrants. Several basic principles influence the development of a public health approach for migrants. The main public health goal is to avoid disparities in health status and access to health services between migrants and the host population. The second, closely associated, principle is to ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population. The third principle, associated with migrations resulting from disaster or conflict, is to put in place lifesaving interventions so as to reduce excess mortality and morbidity. The fourth principle is to minimize the negative impact of the migration process on migrants' health outcomes. Together, these four principles may be taken as the basis for a policy framework for defining public health strategies for migrants.

Determinants associated with the health of migrants

7. Population movements generally render migrants more vulnerable to health risks and expose them to potential hazards and greater stress arising from displacement, insertion into new environments and reinsertion into former environments.
8. Recent migrants often have to deal with poverty, marginality and limited access to social benefits and health services, especially during the early stages of insertion into a new environment (either inside or outside their country of origin or return). For their part, low-skilled and seasonal migrant workers are often

DRAFT

concentrated in sectors and occupations with high levels of occupational health risks. Family members, including children, may also be involved in this work and thus exposed to these risks.

9. Victims of human trafficking, especially women and children, are particularly vulnerable to health problems and are more likely than other groups to suffer from communicable and non-communicable diseases, as well as from mental health problems.

10. Migration, when triggered by disaster or conflict, food insecurity, disease, or climate change and other environmental hazards, is closely linked both to the destruction of livelihoods and, often, to disruptions to the health system.

11. Health inequities arise largely as a result of discrimination, inequalities in income, and unequal access to education, employment and social support networks, to all of which disadvantages vulnerable immigrant or refugee populations and trafficked persons are disproportionately prone. While equal access to health care is important, so too are health promotion and disease prevention measures, which are often overlooked when discussing the health of migrants.

12. Interventions that address the social determinants of health are possible through intersectoral actions that target the causes at societal level. Hence these economic, political, social and environmental determinants of migrants' health underline the importance of developing intersectoral policies, including those aimed at reducing the risk of disasters that can influence both the migration process and its most serious health consequences.

Health issues stemming from migration

13. Health information on migrants' health and on their access to health services is scarce. Few country health information systems disaggregate data in a way that permits analysis of the main health issues either found among migrants or resulting directly from migration. Qualitative studies call attention to migrants' different perceptions of health and of approaches to health-seeking behaviour, which indicate that quantitative studies should be complemented with qualitative studies—though again, the relevant data are limited.

14. An important health dimension is the health risks that migrants carry with them and the public health implications. Migrants travel with their epidemiological profiles, their level of exposure to infectious agents, their genetic and lifestyle-related risk factors, their culture-based health beliefs, and their susceptibility

DRAFT

to certain conditions. Also, they carry the vulnerability present in their original communities. If, for instance, immunization coverage is low in the country of origin or return, the original population risk will be carried to the destination country until coverage of migrants reaches the same level as that for the host population. Similarly, if the prevalence of a given communicable disease or any neglected disease is higher in the country of origin or return, there is an increased likelihood among migrants of being affected by the condition and/or transporting it across borders. Conversely, when diseases have a high prevalence in destination countries, migrants may become affected and take them back to their country of origin or return. There is also evidence that certain non-communicable diseases, such as hypertension, cardiovascular diseases, diabetes and cancer, are an increasing burden on migrant populations and impose considerable demands on health systems of destination countries.

15. Some destination countries perform health assessments for prospective documented migrants, or have provisions imposing certain health conditions that may prevent documented migrants from entering the country. This issue poses a challenge in defining public health preventive and treatment measures that adhere to basic human rights. The challenge is even more complicated in dealing with undocumented migrants and forced internal or international migration, since there are no mechanisms to detect health conditions prior to migration.

16. Communicable diseases and sexually transmitted infections are often viewed from a single perspective: the risk migrants bring when entering (or transiting) a country. However, vulnerability must be addressed at all stages of the migration process. Moreover, the differences among migrants—in their patterns of movement, and in their socioeconomic and migratory status—must also be considered.

17. Exposure to risks associated with population movement raises migrants' vulnerability to psychosocial disorders, drug abuse, alcoholism and violence. In addition, limited access to health care during the transit and early insertion phases of migration increases the resultant burden of untreated non-communicable conditions.

DRAFT

Migrants and health systems

18. The foregoing health issues highlight the challenges faced by national health systems. There is a need to reach out to migrants and address their special vulnerabilities and health-care needs. The response entails targeting interventions to reduce migrants' health risks and launching or strengthening programmes and services that are "migrant sensitive", that is, which include care that takes cultural, religious, linguistic and gender needs into consideration, and which offer guidance to migrants on how to deal with their new national health system.
19. In addition, there is the challenge of securing equitable access to health services for migrants. Ensuring such access may take many different approaches depending on the organization and financing of each health system. The aim is to promote financial protection mechanisms to prevent excessive expenditures among already economically vulnerable groups. Consideration should be given to providing sustained health insurance between countries of origin or return, transit and destination, especially for temporary migrants and irregular migrants whose legal status prevents their accessing health services. In certain countries, the rapid influx of migrants over short periods of time constitutes a particular challenge for national health systems.
20. Few workplaces employing migrants provide basic occupational health services, and few migrants benefit from national social security compensation or rehabilitation schemes for occupational disease or injury. Preventing such disease or injury requires the overhauling of working conditions in high-risk sectors as well as the introduction of culturally sensitive approaches to the provision of health and safety training and information in multicultural work settings. Furthermore, the workplace could be used as an entry point for health services delivery and to convey public health messages to migrant workers and their families.

Strategies for improving the health of migrants

21. Member States facing migration challenges have an increasing need to formulate and implement strategies to improve migrants' health. Regional and global strategies can also supplement country-specific activities. Governments must ensure coherence between national policies for health, employment and migration. Further, intercountry collaboration is required to assess and

DRAFT

subsequently tackle occupational risks and their health consequences before, during and after migrants' period of work, both in their country of origin or return and destination.

22. Among the possible strategies for improving the health of migrants are the following:
    - **advocacy and policy development**: promoting migrant-sensitive health policies that adhere to the principles of a public health approach aimed at improving the health of migrants; advocating migrants' health rights; promoting equitable access to health protection and care for migrants; developing mechanisms to enhance social protection in health and safety for migrants; raising awareness of, and promoting international cooperation on, migrants' health in countries of origin or return, transit and destination; encouraging collaboration among health, foreign affairs and other concerned ministries in all countries involved; strengthening interagency, interregional and international cooperation on migrants' health with emphasis on developing partnerships with other organizations such as UNHCR and the International Organization for Migration; and promoting cooperation for health policies among central and local governments as well as among representatives of civil society
    - **assessment, research and information dissemination**: assessing the health of migrants and trends in migrants' health; identifying and filling gaps in service delivery to meet migrants' health needs; disaggregating health information by gender, age and origin and by socioeconomic and migratory status; encouraging health and migration knowledge production, including both quantitative and qualitative studies; documenting and disseminating best practices and lessons learnt in addressing migrants' health needs in countries of origin or return, transit and destination; and disseminating good practices such as migrant-friendly hospitals to other regions of the globe
    - **capacity building**: sensitizing and training relevant policy-makers and health stakeholders involved with migrants' health in countries of origin or return, transit and destination; promoting increased cultural, religious, linguistic and gender sensitivity associated with migrants' health among health service providers, and training health professionals in addressing the health aspects associated with population movements; creating a network of collaborating centres, academic institutions and other key partners for

DRAFT

furthering research into migrants' health and for enhancing capacity for technical cooperation; and training health professionals about diseases and pathologies that prevail in the country of origin or return

- **service delivery:** initiating or reinforcing migrant-friendly public health services and health care delivery methods for migrants with special needs; strengthening health promotion and disease prevention initiatives to reach out to migrants in the community; establishing minimum standards of health care for all vulnerable migrant groups (particularly women, children, undocumented or irregular migrants, asylum seekers, refugees and victims of human trafficking); and publicizing existing services.

23. The Executive Board discussed an earlier version of this report at its 122nd session in January 2008. It also extensively discussed a draft resolution proposed by several Member States, before adopting resolution EB122.R5.

DRAFT

RESOLUTION 11.9: Health of Migrants

Extract from Executive Board Resolution, EB122.R5:

The Executive Board, having considered the report on health of migrants, RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on health of migrants;

Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);

Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;

Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;

Recognizing that health outcomes can be influenced by the multiple dimensions of migration;

Noting that some groups of migrants experience increased health risks;

Recognizing the need for additional data on migrants' health and their access to health care to substantiate evidence based policies;

Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;

Mindful of the role of health in promoting social inclusion;

DRAFT

Acknowledging that the health of migrants is an important public health matter both for Member States and for the work of the Secretariat;

Noting that Member States have need to formulate and implement strategies for improving the health of migrants;

Noting that policies addressing migrants' health should be sensitive to the specific health needs of women, men and children;

Recognizing that health policies can contribute to development and to achievement of the Millennium Development Goals,

1. CALLS UPON Member States:
   (1) to promote migrant-sensitive health policies;
   (2) to promote equitable access to health promotion and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing the health of migrants;
   (3) to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
   (4) to better identify the gaps in service delivery in order to improve the health of all populations, including migrants;
   (5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
   (6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
   (7) to train health professionals to deal with the health issues associated with population movements;
   (8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
   (9) to promote strengthening of health systems in developing countries;
   (10) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:
   (1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;
   (2) to explore policy options and approaches for improving the health of migrants;

DRAFT

(3) to analyse the major challenges to health associated with migration;

(4) to support the development of regional and national assessments of migrants' health status and access to health care;

(5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;

(6) to help collect and disseminate data on migrants' health;

(7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies;

(8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;

(9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;

(10) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

DRAFT

For more information:

WHO Websites:

- Closing statement, Conference on Health and Migration in the European Union Lisbon, Portugal, 28 September 2007, by Margaret Chan: http://www.who.int/dg/speeches/2007/20070928_lisbon/en/index.html

Non-WHO Websites:

- EUPHA (European Public Health Association) Section on Migrant Health: http://www.eupha.org/html/menu5_7.html
- EU Migrant and Ethnic Health Observatory: http://www.meho.eu.com/
- ICN, Health services for migrants, refugees and displaced persons: http://www.icn.ch/psmigrants00.htm
- Conference on Health and Migration, Lisbon, Sept 2007: http://www.hmelisbon2007.com/site.asp?ID=2&IDIOMA=2

DRAFT

*11.10 Strategies to reduce the harmful use of alcohol

Extract from Document A61/13 (Report by Secretariat):

1. Harmful use of alcohol[41] is one of the main factors contributing to premature deaths and avoidable disease burden worldwide and has a major impact on public health. Although there are regional, national and local differences in levels, patterns and context of drinking, in 2002 the harmful use of alcohol was estimated to cause about 2.3 million premature deaths worldwide (3.7% of global mortality) and to be responsible for 4.4% of the global burden of disease, even when protective effects of low and moderate alcohol consumption on morbidity and mortality have been taken into consideration.
2. Harmful use of alcohol encompasses several aspects of drinking. One is the volume drunk over time. The strongest drinking-related predictor of many chronic illnesses is the cumulated amount of alcohol consumed over a period of years. Other factors include the pattern of drinking, in particular occasional or regular drinking to intoxication; the drinking context, which may increase the risks of intentional and unintentional injuries and of transmission of certain infectious diseases; and the quality of the alcoholic beverage or its contamination with toxic substances such as methanol.
3. Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. For some diseases, such as breast cancer, there is no evidence of a threshold effect in the relationship between the risk and level of alcohol consumption. A significant proportion of the disease burden attributable to harmful drinking is determined by unintentional and intentional injuries, including those due to road traffic crashes, and suicides. Fatal alcohol-attributable injuries tend to occur in relatively young people. Some vulnerable or at-risk groups and individuals have increased susceptibility to the toxic, psychoactive and dependence-producing properties of alcohol.
4. Public health problems caused by harmful use of alcohol are considerable in countries with different levels of development and effectiveness of health systems. Globally, among 20 selected risk factors to health, harmful use of

[41] In line with resolution WHA58.26 and in the context of the phrase "harmful use of alcohol", in this document the word harmful refers only to the negative public health effects of consumption of alcoholic beverages without prejudice to religious beliefs and cultural norms in any way.

DRAFT

alcohol is the leading cause of death and disability in developing countries with low mortality, the third among the leading risk factors in developed countries, after tobacco and blood pressure, and eleventh in developing countries with high mortality rates. Awareness is growing of the impact of harmful use of alcohol on the burden of infectious diseases, including sexually-transmitted infections and HIV infection, through association with unsafe sexual behaviour and interference with effective treatment regimens and procedures.

5. Harmful drinking among young people and women is an increasing concern across many countries. Drinking to intoxication and heavy episodic drinking are frequent among adolescents and young adults, and the negative impact of alcohol use is greater in younger age groups of both sexes. The range of prenatal damage includes fetal alcohol syndrome and various physical defects and neurobiological deficits that impair development and social functioning. Harmful drinking effects not only those who drink, but also others and has consequences for society. There is growing evidence on alcohol's contribution to acute injuries associated with violence and traffic crashes involving pedestrians. The public health impact of alcohol-related road crashes could become even more marked with the rapid growth in the number of cars in many parts of the world. Fatal mass poisonings following the drinking of illegally or informally produced alcoholic beverages have been reported from several countries, but globally the public health impact of consuming non-commercially produced alcoholic beverages remains to be determined.
6. Harmful drinking is associated with numerous social consequences, such as crimes, violence, unemployment and absenteeism. It generates health-care and societal costs. Notwithstanding methodological problems of measurement, it represents an enormous social and economic burden: the global cost of the harmful use of alcohol in 2002 has been estimated to be between US$ 210 000 million and US$ 665 000 million. The health and social consequences tend to hurt less advantaged social groups most and contribute to disparities in health between and within countries.
7. The burden attributable to alcohol is to a large extent avoidable, and there is much evidence for the effectiveness, including cost-effectiveness, of different strategies and interventions to reduce alcohol-related harm. Since 2005 the Secretariat has strengthened its work in this area at global and regional levels, and undertaken a broad and extensive consultation process involving all

DRAFT

WHO regions, Member States and other stakeholders on public health impact of harmful use of alcohol. Furthermore, the Expert Committee on Problems Related to Alcohol Consumption[42] has reviewed the available evidence on the scale of the problem and the effectiveness of different policy options, and made recommendations that have implications for WHO's programmes.[43] The Sixtieth World Health Assembly discussed evidence-based strategies and interventions to reduce alcohol-related harm[44] and an appropriate frame for global activities, and decided that an item entitled "Strategies to reduce the harmful use of alcohol" and related documents discussed at the Health Assembly should be included in the agenda of the Executive Board at its 122nd session, and requested the Director-General, in the interim, to continue her work on this matter.[45] As part of the Secretariat's work on this matter and pursuant to the Health Assembly's decision, an informal consultation for Member States was organized (Geneva, 3 December 2007).

STRATEGIES AND POLICY ELEMENT OPTIONS TO REDUCE ALCOHOL-RELATED HARM[46]

8. The public health problems caused by the harmful use of alcohol are multidimensional and complex, with significant differences in consumption levels, drinking patterns and drinking contexts between countries and regions. Various strategies and policy element options can be chosen, depending on regional circumstances, public health problems and needs of individual countries. Priority areas for action should focus on prevention of harmful drinking and should be based on the best available evidence. To be effective, strategies and policy element options should address levels, patterns and context of alcohol consumption through a combination of measures that target the population at large, vulnerable groups, such as young people and pregnant women, affected individuals and particular problems such as drink-driving and alcohol-related violence. Alcohol policies or action plans to reduce alcohol-related harm should take into account several major issues, such as the strength of evidence, cultural

[42] WHO Technical Report Series No. 944, 2007.
[43] See document EB121/10.
[44] Document WHASS1/2006–WHA60/2007/REC/3, summary record of the seventh meeting (section 3), eighth meeting and fourteenth meeting (section 2) of Committee A at the Sixtieth World Health Assembly, in press.
[45] Decision WHA60(10).
[46] These strategies and policy element options were highlighted during the consultation process organized by the Secretariat; the list is not exhaustive and some policy element options might not be applicable in all Member States (that is, those with a total ban on alcohol).

DRAFT

sensitivity, adaptation to local needs, and contexts, ensuring a sustainable and intersectoral approach, and provision for adequate monitoring and evaluation.

9. **Raising awareness and political commitment**. The actions needed to reduce harmful use of alcohol call for sustained and determined efforts by all relevant partners, as appropriate. Written alcohol policies or strategies can facilitate and clarify the contributions and division of responsibilities of the different partners who must be involved at different levels. An action plan at country and, when appropriate, subnational and municipal levels with clear objectives, strategies and targets is required. Regular reports on the harmful use of alcohol at international, national, regional and local levels need to be available to policy-makers, stakeholders and a wide public audience. Building a strong base of public awareness and support can also help to secure the necessary continuity and sustainability of alcohol policies.

10. **Health-sector response**. Health-sector preventive measures against hazardous and harmful alcohol consumption, such as screening and brief interventions, have proven to be effective and cost-effective in reducing alcohol consumption and alcohol-related harm. Early identification and effective treatment in health-care settings of alcohol-use disorders, also in patients with co-morbid conditions, can reduce associated morbidity and mortality and improve the well-being of affected individuals and their families. Treatment is most effective when supported by sound policies and health systems and integrated within a broader preventive strategy. Health-care providers should concentrate on clients' health improvement and satisfaction through evidence-based and cost-effective interventions, and governments, in improving health systems, should take into consideration services for alcohol-use disorders and interventions for hazardous and harmful use of alcohol. As the main providers of health care, the many millions of health workers worldwide can contribute substantially to reducing and preventing harmful use of alcohol.

11. **Community action to reduce the harmful use of alcohol**. Community-based action, with appropriate engagement of different stakeholders, can effectively reduce the harmful use of alcohol. Community actions are particularly important in settings where unrecorded alcohol consumption is high and/or where social consequences such as public drunkenness, mistreatment of children, violence against intimate partners and sexual violence are prevalent. Community actions can increase recognition of alcohol-related harm at the community level, reduce

DRAFT

the acceptability of public drunkenness, bolster other policy measures at the community level, enhance partnerships and networks of community agencies and nongovernmental organizations, provide care and support for affected individuals and their families, and mobilize the community against the selling and consumption of illicit and potentially contaminated alcohol.

12. **Drink-driving policies and countermeasures**. Strategies that aim to reduce the harm associated with drink-driving can be broadly classified as follows:
    - deterrence, or direct measures that aim to reduce the likelihood of drink-driving occurring
    - indirect measures that aim to reduce the likelihood of drink-driving by reducing alcohol consumption
    - measures that create a safer driving environment in order to reduce the consequences and level of severity associated with impaired driver crashes.

    A substantial body of research evidence exists that introducing a low limit for blood alcohol concentration reduces the harm. Young drivers are at particular risk of death from alcohol-related traffic crashes, and many countries have lowered this limit for new and/or young drivers. The success of legislation as a deterrent, and reducing the incidence of drink-driving and its consequences, largely depends on its enforcement and the severity of penalties imposed on those caught driving over the limit. Consistent enforcement by police departments using random, targeted or selective breath-testing is essential and should be supported by sustained publicity and awareness campaigns.

13. **Addressing the availability of alcohol**. Regulating production and distribution of alcoholic beverages is an effective strategy to reduce harmful use of alcohol and in particular to protect young people and other vulnerable groups. Many countries have some restrictions on the sale of alcohol. These restrictions cover the age of consumers, the type of retail establishments that can sell alcoholic beverages, and licensing, with limits on hours and days of sale and regulations on vendors and the density of outlets. However, in some developing countries the informal markets are the main source of alcohol and formal controls on sale may be of less relevance until a better system for controls and enforcement is in place.

14. **Addressing marketing of alcoholic beverages**. Young people who have chosen to drink alcoholic beverages and who drink regularly are an important market segment for alcohol producers. It is very difficult to target young adult

DRAFT

consumers without exposing cohorts of adolescents under the legal age to the same marketing practices. Controls or partial bans on volume, placement and content of alcohol advertising are important parts of a strategy, and research results underline the need for such controls or bans, in particular to protect adolescents and young people from pressure to start drinking. Marketing practices that appeal to children and adolescents could be seen as particular policy concerns.

15. **Pricing policies**. Price is an important determinant of alcohol consumption and, in many contexts, of the extent of alcohol-related problems. Considerable evidence has accumulated to support the use of tax changes as a means of influencing price. High tax rates may not be the first choice of policy in countries where alcohol-related problems are less important or there is a considerable informal market, and interventions directed at particular subpopulations may be more cost-effective. Even in such countries, decreases in prices of alcoholic beverages or an increase in disposable income without appropriate adjustment in those prices could counteract such policies. A particular concern emerges when alcoholic drinks are cheaper than non-alcoholic alternatives such as bottled water. It is also worth keeping in mind that tax is only one component of the price of alcoholic beverages and tax changes may not always be reflected in changes in the retail price. Similarly, vendors or manufacturers may attempt to encourage demand by price promotions.
16. **Harm reduction**. Directly focusing on reducing the negative consequences of drinking and alcohol intoxication can be an effective strategy in specific contexts. A range of interventions to reduce alcohol-related harm in and around licensed premises has been developed. Interventions that focus on changing the night-life environment can reduce the harmful consequences of drinking in and around these settings, without necessarily altering overall consumption levels. The impact of these measures is greatly enhanced when there is active and ongoing enforcement of laws and regulations prohibiting sale of alcohol to intoxicated customers and policing of the streets at night. The evidence base for harm-reduction approaches, however, is not yet as well established as that for regulating the availability and demand for alcohol beverages.
17. **Reducing the public health impact of illegally and informally produced alcohol**. From a public health perspective, illegally and informally produced alcohol can create an additional negative health effect if the beverage contains

DRAFT

methanol or other contaminants and its production and distribution are under less control than legally produced and sold alcohol. Evidence for the effectiveness of measures to counteract the public health impact of the consumption of illegally produced alcohol is weak, but points towards a combination of community mobilization and enforcement and control. The feasibility and effectiveness of countermeasures will be influenced by the fact that the purchasing power of those who buy informally produced alcohol often is extremely low.

A WAY FORWARD

18. National policies and action plans with defined objectives and targets have to be developed, implemented and reinforced by appropriate national institutional frameworks. National efforts can produce better results when they are supported by regional and global awareness campaigns, advocacy, research and capacity building. Public health objectives should be paramount in defining and consolidating appropriate responses at different levels. Joint appropriate and coordinated actions of different agencies and stakeholders are needed in raising awareness and political commitment to reduce public health problems caused by harmful use of alcohol.
19. Adequate mechanisms for assessment, reporting and evaluation are necessary for monitoring progress at different levels and strengthening the evidence base for strategies that reduce alcohol-related harm in different cultural contexts. An important element is surveillance of alcohol-related harm coupled with the improvement of global and regional information systems on alcohol and health and the development of relevant technical tools, based on comparable data and agreed definitions. Regularly-produced status reports on alcohol consumption and related harm could be valuable for monitoring harmful use of alcohol and policy responses worldwide.
20. The capacity of national institutions to undertake situation assessments and prepare, implement and evaluate strategies and programmes to reduce public health problems caused by harmful use of alcohol can be strengthened, when required, by appropriate technical support and relevant technical tools. Special efforts are needed to formulate a comprehensive health-care sector response to alcohol-related problems, with particular emphasis on primary health care interventions.

DRAFT

21. Compiling and disseminating good practices for reducing the harmful use of alcohol at community and national levels can facilitate development of adequate and effective responses. Further international research on alcohol-related harm and on the effectiveness and cost-effectiveness of different strategies is needed, particularly in low-income and middle-income countries, in order to strengthen the evidence base regarding different cultural contexts. Also, research on the impact of the harmful use of alcohol on HIV-related mortality and morbidity, the public health impact of the consumption of illegally or informally produced alcoholic beverages and the interaction with other psychoactive substances used is especially important.
22. Reducing the public health problems caused by the harmful use of alcohol at the international level requires coordination and appropriate participation of different international stakeholders. Leadership is needed for building consensus around values and appropriate strategies and interventions. WHO is in a strong position to play a significant role in developing and supporting a global framework to complement regional and national actions to reduce the harmful use of alcohol.
23. The Executive Board at its 122nd session in January 2008 discussed an earlier version of this report and adapted resolution EB122.R2.

DRAFT

RESOLUTION 11.10: Reducing The Harmful Effects Of Alcohol

Extract from Executive Board Resolution, EB122.R2:

The Executive Board, having considered the report on strategies to reduce the harmful use of alcohol, RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on strategies to reduce the harmful use of alcohol and the further guidance on strategies and policy element options therein;

Reaffirming resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse and WHA57.16 on health promotion and healthy lifestyles;

Recalling resolution WHA58.26 on public-health problems caused by harmful use of alcohol and decision WHA60(10);

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol;

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption and acknowledging that effective strategies and interventions that target the general population, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

Mindful that such strategies and interventions must be implemented in a way that takes into account different national, religious and cultural contexts, including national public health problems, needs and priorities, and differences in Member States' resources, capacities and capabilities;

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence, and possible links to certain communicable diseases, thereby adding to the disease burden, in both developing and developed countries;

DRAFT

Mindful that international cooperation in reducing public-health problems caused by the harmful use of alcohol is intensifying, and of the need to mobilize the necessary support at global and regional levels,

1. URGES Member States:
   (1) to collaborate with the Secretariat in developing a draft global strategy on harmful use of alcohol based on all evidence and best practices, in order to support and complement public health policies in Member States, with special emphasis on an integrated approach to protect at-risk populations, young people and those affected by harmful drinking of others;
   (2) to develop, in interaction with relevant stakeholders, national systems for monitoring alcohol consumption, its health and social consequences and the policy responses, and to report regularly to WHO's regional and global information systems;
   (3) to consider strengthening national responses, as appropriate and where necessary, to public health problems caused by harmful use of alcohol, on the basis of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm generated in different contexts;
2. REQUESTS the Director-General:
   (1) to prepare a draft global strategy to reduce harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options, taking into account different national, religious and cultural contexts, including national public health problems, needs and priorities, and differences in Member States' resources, capacities and capabilities;
   (2) to ensure that the draft global strategy will be composed of a set of proposed measures recommended for states to implement at the national level taking into account the national circumstances of each country;
   (3) to include full details of ongoing and emerging regional, subregional and national processes as vital contributions to a global strategy;
   (4) to collaborate and consult with Member States as well as with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;

DRAFT

(5) to submit to the Sixty-third World Health Assembly, through the Executive Board, a draft global strategy to reduce harmful use of alcohol.

For more information:

WHO Websites:

- Alcohol drinking: http://www.who.int/topics/alcohol_drinking/en/
- Country profiles (divided by WHO Regions): http://www.who.int/substance_abuse/publications/globalstatusreportalcoholprofiles/en/index.html
- Substance abuse (including alcohol): http://www.who.int/topics/substance_abuse/en/ and http://www.who.int/substance_abuse/en/
- WHO expert committee on problems related to alcohol consumption: http://www.who.int/substance_abuse/expert_committee_alcohol/en/index.html
- WHO EURO, alcohol drinking: http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=alcohol_drinking

Non-WHO Websites:

- UK DoH, Alcohol and health: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/AlcoholMisuseGeneralInformation/DH_4062199
- UK Institute of Alcohol Studies factsheet on alcohol and health: http://www.ias.org.uk/resources/factsheets/health.pdf

DRAFT

*11.11 Climate change and health

Extract from Document A61/14 (Report by Secretariat):

1. There is now a strong, global scientific consensus that warming of the climate system is unequivocal,[47] and is caused by human activity, primarily the burning of fossil fuels which releases greenhouse gases into the atmosphere. Already, evidence from around the world shows that global warming is changing rainfall and storm patterns, and disrupting the balance of natural systems that supply the necessities of life.
2. WHO has, for several years, stressed that the health risks posed by climate change are significant, distributed throughout the globe, and difficult to reverse. Recent changes in climate have had diverse impacts on health, such as the death of more than 44 000 people during the heat wave in Europe in 2003. Climate-sensitive risk factors and illnesses are currently among the most important contributors to the global burden of disease; these include undernutrition (estimated to kill 3.7 million people per year), diarrhoea (1.9 million) and malaria (0.9 million). Such conditions and other health outcomes will be increasingly affected by accelerating climate change through its adverse effects on food production, water availability and the population dynamics of vectors and pathogens; already, for example, evidence shows that higher temperatures are increasing the risk of malaria transmission in the East African highlands.

Summary

3. Climate change will affect, in profoundly adverse ways, some of the most fundamental determinants of health: food, air and water. The warming of the planet will be gradual, but the increasing frequency and severity of extreme weather events, such as intense storms, heat waves, droughts and floods, will be abrupt and the consequences will be acutely felt. The earliest and most severe threats are to developing countries, with negative implications for the achievement of the health-related Millennium Development Goals and for health equity. It is therefore essential to formulate a clear response in order to protect human health and ensure that it is placed at the centre of the climate debate.

[47] Intergovernmental Panel on Climate Change, Fourth Assessment Report. Climate change 2007: synthesis report. Summary for policymakers. Geneva, Intergovernmental Panel on Climate Change, November 2007 (unedited copy).

DRAFT

HEALTH ISSUES

4. The health sector, at international, national and subnational levels, has a responsibility, political leverage and staff with many of the necessary skills to protect the public from climate-related threats to health. Health professionals bring an understanding of primary prevention (analogous to strategies to mitigate climate change[48]) and secondary prevention (analogous to measures for adapting to climate change[49]) to the discussion of how to reduce and prevent climate-related disease, injury and death. Key concepts that should be considered in designing responses include the following.

5. **Climate change threatens public health security**. Global warming is expected to pose direct threats to health by causing more severe storms, floods, droughts and fires, with consequent disruptions in water and food supplies and medical and other services. Higher temperatures will change the distribution, and increase the burden, of various vector-borne, food-borne and water-related infectious diseases. The worsening of air quality, particularly owing to ozone pollution, increases the prevalence of asthma and respiratory infections, the number of admissions to hospital, and days of work and schooling lost. Meeting increasing energy demands by greater use of fossil fuels will tend to increase the number of cases of these air pollution-related illnesses and all-cause and all-age premature deaths. Greater frequency and intensity of heat waves will increase mortality and the incidence of heat stress and heat stroke. Evidence shows that this is already occurring.

6. **Health impacts will be disproportionately greater in vulnerable populations**. Globally, people at greatest risk include the very young, the elderly, and the medically infirm. Low-income countries and areas where undernutrition is widespread, education is poor, and infrastructures are weak will have most difficulty adapting to climate change and related health hazards. Vulnerability is also determined by geography, and is higher in areas with a high endemicity of climate-sensitive diseases, water stress, low food production and isolated populations. The populations considered to be at greatest risk are those living in small-island developing states, mountainous regions, water-stressed areas, mega cities and coastal areas in developing countries (particularly the large

[48] Mitigation in this context means action to reduce human effects on the climate system: principally strategies to reduce greenhouse gas emissions.

[49] Adaptation in this context means adjustment in natural or human systems in response to actual or expected climatic stimuli or their effects, which moderates harm or exploits beneficial opportunities.

DRAFT

urban agglomerations in delta regions in Asia), and also poor people and those unprotected by health services. A major concern is the fact that some African countries have a high burden of climate-sensitive diseases and poor public health capability to respond; the effects of climate change on socioeconomic development will seriously undermine health and well-being of people in such countries.

7. **Mitigating the effects of climate change can have direct and immediate health benefits**. A number of proposed mitigation strategies may improve health. For example, lessening the reliance on coal-fired generation of power will reduce air pollution, and associated respiratory and cardiopulmonary disease and death. Providing opportunities for the use of active transport (bicycling and walking) can also reduce levels of ambient air pollution, traffic-related injury and death, and obesity rates. Production and transport of food are major emitters of greenhouse gases.
8. **Adaptation is needed because some degree of climate change is inevitable, even if greenhouse gas emissions were abruptly capped. Failure to respond will be costly in terms of disease, health-care expenditure and lost productivity**. Estimated direct and indirect health-care costs and lost income due to several environmental illnesses (e.g. those caused by air pollution) often match or exceed the expenditure needed to tackle the environmental hazard itself.

ACTIONS

9. The overarching goals for the international response to protect health from climate change are: (a) to ensure that concerns about public health security are placed at the centre of the response to climate change; (b) to implement adaptive strategies at local, national and regional levels in order to minimize impacts of climate change on the health of human populations; and (c) to support strong actions to mitigate climate change and to avoid further dramatic and potentially disastrous impacts on health. These goals can be achieved by working through existing public health frameworks with the following specific objectives.
10. **Raise awareness of the need to ensure public health security by acting on climate change**. Strong, evidence-based and consistent advocacy by the global health community will be needed to raise awareness that global public health needs to be protected from climate change. Such awareness raising will

DRAFT

call for health-sector professionals to show leadership in supporting rapid and comprehensive actions, promoting mitigation and adaptation strategies that both improve health now and reduce future impacts of climate change. The case for public health security should be made more clearly in national and international processes that guide policy and resources for work on climate change, such as preparation of National Communications and National Adaptation Programmes of Action, and the global Nairobi work programme on impacts, vulnerability and adaptation to climate change, under the United Nations Framework Convention on Climate Change. WHO can support this objective through its own advocacy within and outside the United Nations system, and by providing guidance to Member States' health sectors on how to engage more effectively in the above processes.

11. **Strengthen public health systems to cope with the threats posed by climate change**. Increased investment in public health systems is already necessary in order to meet the health-related Millennium Development Goals, whose achievement will be further compromised by the impact of climate change. For this reason, additional system strengthening and forward planning will be required. Within this broad context, at national level the health sector should: (a) assess the potential impacts of climate change on health; (b) review the extent to which existing health systems can cope with the additional threat posed by climate changes, and (c) develop and implement adaptation strategies to strengthen key functions that already protect against climatic risks. This approach will need to encompass 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, from provision of clean water and sanitation, to enhancing the welfare of women. A common theme must be ensuring health equity and giving priority to protecting the health security of particularly vulnerable groups. WHO can provide technical support for building capacity to assess vulnerability and plan adaptive measures, and can mobilize and guide international support for the necessary strengthening of public health systems.

12. **Enhance capacity to deal with public health emergencies**. There is a particular need to strengthen systems to be able to respond to acute shocks associated with climate variability, including the health consequences of natural disasters, and more frequent, severe and wide-ranging epidemics. WHO can

DRAFT

assist this effort through existing international programmes on health action in crises, and disease surveillance, reporting and response.

13. **Promote health development**. National and subnational health agencies can promote health through assessment of the health implications of decisions taken in other sectors, such as urban planning, transport, energy supply, food production, land use and water resources. In this way, they can support those decisions that provide opportunities for improving health and at the same time reduce emissions of greenhouse gases that cause climate change; these opportunities include new investment in sustainable transport in developed and rapidly developing countries and in clean domestic energy in developing nations. WHO's role could be to provide technical guidance and adapt tools (such as cost-benefit analysis and health impact assessment) for global and regional assessments of the implications for health of policies in sectors such as energy, transport and water and sanitation.
14. **Enhance applied research on health protection from climate change**. Better evidence is needed of the effectiveness and efficiency of public health measures to protect health from climate change. Such activities require systematic, interdisciplinary applied research in Member States. WHO can assist by working with research bodies throughout the world to define and promote a common research agenda, and facilitating information exchange among countries.
15. **Monitor and evaluate delivery**. National and subnational agencies should improve identification and monitoring of the health status of vulnerable groups, and evaluate the effectiveness of interventions aiming to protect health better from climate change. WHO can support this work through technical guidance in many areas including design of indicators, and working closely with existing international mechanisms for monitoring progress towards attainment of the health-related Millennium Development Goals.
16. **Foster cross-disciplinary partnerships**. In order to ensure wide-ranging and effective mitigation and adaptation, Member States should build partnerships at the national and subnational levels, exploiting the expertise of government agencies, intergovernmental and nongovernmental organizations, and community, industry and professional groups for health protection. WHO can support this process at national and international levels through further

DRAFT

development of the multi-sector and cross-disciplinary "healthy settings" approach (e.g. healthy homes, schools, public spaces and work places).

17. An earlier version of this report was considered by the Executive Board at its 122nd session. The Board considered a draft resolution proposed by several Member States and adopted resolution EB122.R4.

DRAFT

RESOLUTION 11.11: Protecting Health From Climate Change

Extract from Executive Board Resolution, EB122.R4:

The Executive Board, having considered the report on climate change and health, RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Recalling resolution WHA51.29 on the protection of human health from risks related to climate change and stratospheric ozone depletion and acknowledging and welcoming the work carried out so far by WHO in pursuit of it;

Recognizing that, in the interim, the scientific evidence of the effect of the increase in atmospheric greenhouse gases, and of the potential consequences for human health, has considerably strengthened;

Noting with concern the recent findings of the Intergovernmental Panel on Climate Change that the effects of temperature increases are already being observed on some aspects of human health; that the net global effect of projected climate change on human health is expected to be negative, especially in developing countries, small island developing States and vulnerable local communities which have the least capacity to prepare for and adapt to such change, and that exposure to projected climate change could affect the health status of millions of people, through increases in malnutrition, in death, disease and injury due to extreme weather events, in the burden of diarrhoeal disease, in the frequency of cardiorespiratory diseases, and through altered distribution of some infectious disease vectors;

Noting further that climate change could jeopardize achievement of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the Secretariat and Member States to improve public health and reduce health inequalities globally;

Recognizing the importance of addressing in a timely fashion the health impacts resulting from climate change due to the cumulative effects of emissions of greenhouse gases, and further recognizing that solutions to the health impacts of climate change should be seen as a joint responsibility of all States;

Recognizing the need to assist Member States in assessing the implications of climate change for health and health systems in their country, in identifying

DRAFT

appropriate and comprehensive strategies and measures for addressing these, in building capacity in the health sector to do so and in working with government and nongovernmental partners to raise awareness of the health impacts of climate change in their country and take action to address them;

Further recognizing that strengthening health systems to enable them to deal with both gradual changes and sudden shocks is a fundamental priority in terms of addressing the direct and indirect effects of climate change for health,

1. REQUESTS the Director-General:
   (1) to continue to draw to the attention of the public and policy-makers the serious risk of climate change to global health security and to the achievement of the health-related Millennium Development Goals, and to work with FAO, WMO, UNDP, UNEP, the United Nations Framework Convention on Climate Change secretariat, and other appropriate organizations of the United Nations, in the context of United Nations reform initiatives, and with national and international agencies, to ensure that these health impacts and their resource implications are understood and can be taken into account in further developing national and international responses to climate change;
   (2) to engage actively in the UNFCCC Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change, in order to ensure its relevance to the health sector, and to keep Member States informed about the work programme in order to facilitate their participation in it as appropriate and access to the benefits of its outputs;
   (3) to continue close cooperation with appropriate United Nations organizations, other agencies and funding bodies, and Member States, to develop capacity to assess the risks from climate change for human health and to implement effective response measures, by promoting further research and pilot projects in this area, including work on:
      – health vulnerability to climate change and the scale and nature thereof;
      – health protection strategies and measures relating to climate change and their effectiveness, including cost-effectiveness;
      – the health impacts of potential adaptation and mitigation measures in other sectors such as water resources, land use, and transport, in particular where these could have positive benefits for health protection;

DRAFT

- decision-support and other tools, such as surveillance and monitoring, for assessing vulnerability and health impacts and targeting measures appropriately;
- assessment of the likely financial costs and other resources necessary for health protection from climate change;

(4) 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, including practical tools and methodologies and mechanisms for facilitating exchange of information and best practice and coordination between Member States, and to present a draft workplan to the Executive Board at its 124th session.

DRAFT

For more information:

WHO Communication Officers:

John Rainford
Telephone: +41 22 791 3982
Mobile: +41 79 516 3709
rainfordj@who.int

Sari Setiogi
Telephone: +41 22 791 3576
Mobile: +41 79 701 9467
setiogis@who.int

Nada Osseiran
Telephone: +41 22 791 4475
Mobile: +41 79 637 6963
osseirann@who.int

WHO Websites:

- Global environmental change: http://www.who.int/globalchange/en/
- World Health Day: http://www.who.int/world-health-day/en/
- WHO EURO, Climate: http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=climate
- cCASHh: 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.epha.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
- World Development Movement climate change campaign: http://www.wdm.org.uk/campaigns/climate/index.htm
- Stop Climate Chaos: http://www.stopclimatechaos.org/

DRAFT

11.12 Monitoring achievement of the health-related Millennium Development Goals

Extract from Document A61/15 (Report by the Secretariat):

1. At the mid-point in the countdown to 2015, the target date set by the United Nations Millennium Declaration, there are several examples of success. However, great inequalities still exist within and between countries, and current trends suggest that many low-income countries will not reach the Millennium Development Goal targets. This report sets out current progress towards the health-related Goals and targets. It outlines WHO's role in monitoring progress, and in supporting national and international efforts to overcome key policy and operational constraints.
2. An earlier version of this report was considered by the Executive Board at its 122nd session in January 2008. The Board agreed that the report should be debated fully by the Health Assembly.[50]

CURRENT STATUS AND ACHIEVEMENTS

Millennium Development Goal 1: Eradicate extreme poverty and hunger

3. Much of childhood mortality is attributable to undernutrition, which exacerbates the impact of diseases such as malaria, diarrhoea and acute respiratory infections. While the global prevalence of underweight (low weight for age) has declined since 1990 from 43% to 27%, 143 million children under five years old remain affected. Most of these children live in south Asia, where two out of every five children are underweight. Prevalence is lower in sub-Saharan Africa, at around 28%, but progress in reducing this figure has been particularly slow.
4. Stunting (low height for age, chronic undernutrition) and wasting (low weight for height, acute undernutrition) are more precise measures of poor nutrition than underweight. WHO estimates that, in 2005, 178 million children in developing countries were stunted and 55 million wasted. The prevalence of stunting is highest in south Asia and sub-Saharan Africa.

Millennium Development Goal 4: Reduce child mortality

5. Major progress has been made towards achieving Goal 4, a two-thirds reduction in the mortality rate among children under five by 2015, in all regions *except*

[50] See document EB122/2008/REC/2, summary record of the ninth meeting, section one.

DRAFT

for sub-Saharan Africa, which now accounts for around half of the 9.7 million deaths that occur among children under five every year. The under-five mortality rate in sub-Saharan Africa is estimated at 160 per 1000 live births compared with 83 in south Asia, 29 in east Asia, and 27 in Latin America in 2006. Just four of 46 sub-Saharan African countries are on track to achieve Goal 4. However, lessons can be learnt from several countries including Bangladesh, Eritrea, Ethiopia, Madagascar, Malawi, Mozambique, Nepal, Niger, and United Republic of Tanzania, where striking declines in the under-five mortality rate have been observed in recent years.

6. The slowest progress in reducing child mortality continues to be in countries with high prevalence of HIV or those affected by conflicts. The coverage of services that can be delivered by outreach, such as immunization, vitamin A and insecticide-treated bed-nets, has shown encouraging trends. In addition, trends for early and exclusive breastfeeding are positive. According to estimates based on the latest data, measles vaccination coverage has reached 80% globally and 72% in sub-Saharan Africa; between 2000 and 2006, measles-specific mortality declined by 68% globally and by 91% in sub-Saharan Africa. However, those interventions requiring a functional health system (prevention and treatment of neonatal disorders, diarrhoea, pneumonia, malaria and malnutrition) are having less impact. Pneumonia, for example, continues to kill more children worldwide than AIDS, malaria and measles combined. Although about half of all children with pneumonia are taken to appropriate health-care providers, this proportion has hardly changed since 2000 so that many children do not receive effective treatment. Diarrhoeal diseases cause a further 1.6 million child deaths each year but only about half of children with diarrhoea receive the recommended oral rehydration therapy with continued feeding.

Millennium Development Goal 5: Improve maternal health

7. Slower progress has been made towards Goal 5, the reduction in the maternal mortality ratio by three quarters by 2015. More than 500 000 women died of causes related to maternity in 2005, with around half the deaths occurring in sub-Saharan Africa and one third in south Asia. Maternal mortality ratios for countries in sub-Saharan Africa are the highest in the world at 920 per 100 000 live births compared with 8 per 100 000 in industrialized countries. This ratio translates into a woman's lifetime risk of maternal death of 1 in 22 in Africa.

DRAFT

The single leading cause of maternal death is haemorrhage, which causes one maternal death in three in Africa.

8. Progress in reducing this preventable cause of death has been slow. While middle-income countries have achieved decreases in maternal mortality since 1990, declines in sub-Saharan Africa have been negligible. No region has achieved the necessary 5.5% annual decline needed to meet the Goal target, although east Asia came close with a 4.2% annual decline.

9. A well-functioning health system is a prerequisite for significant improvements in maternal health. Globally, coverage of skilled delivery attendance has increased over the past decade and around 60% of births in the developing world are attended by a doctor, nurse or midwife, but progress has been especially slow in sub-Saharan Africa and, in both the African and South-East Asia regions, under half of deliveries take place with a skilled attendant present.

Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases

10. **HIV/AIDS**. Progress in access to antiretroviral treatment in low- and middle-income countries has been dramatic in recent years: from about 240 000 recipients in 2001 to 2.1 million in 2006. But coverage is still inadequate: in sub-Saharan Africa, about one quarter of the 4.8 million people who need antiretroviral treatment currently have access to it. The proportion of children who need and receive antiretroviral treatment has also increased rapidly, but coverage is even lower (15%) than for adults. In low- and middle-income countries, the proportion of HIV-positive pregnant women receiving antiretroviral treatment for prevention of mother-to-child transmission of HIV was still as low as 11%. There have been some declines in the incidence of HIV infection which can be attributed to behavioural change and may indicate the growing impact of preventive interventions. However, there are still an estimated 1.7 million new infections per year in Africa and there remains an urgent need to rethink and expand evidence-informed prevention work.

11. For **malaria**, use of insecticide-treated bed-nets has progressed from a low baseline. In 20 African countries with data for 2000 and 2005, their use increased from 2% to 13% among children under five, and in 16 countries their use tripled. Although the policy shift to more effective antimalarials (including artemisinin-based combination therapies) has been swift, only one third of children under five with fever in Africa receive any antimalarial treatment. Recent high-

DRAFT

level initiatives are now attempting to redress the low coverage of effective interventions.

12. For **tuberculosis**, since 2005 the number of new cases per capita has been falling, albeit slowly, in *all* regions including Africa—thus meeting Goal 6, target 8. While other regions are on track to halve prevalence and death rates by 2015, and while rates have stabilized in Africa since 2003, the rate of decline in Africa is insufficient to reach the 50% target set by the Health Assembly. In Africa, rapid increases in treatment success (74% in 2004) and case detection (50% in 2005) are urgently required.

Millennium Development Goal 7: Ensure environmental sustainability

13. The health, economic and social repercussions of open defecation, poor hygiene and lack of safe drinking-water are well documented. Together they contribute to about 88% of the deaths due to diarrhoeal diseases—more than 1.5 million—in children under five years old. Infestation with intestinal worms caused by open defecation affects hundreds of millions of predominantly school-aged children, resulting in reduced physical growth, weakened physical fitness and impaired cognitive functions. Poor nutrition contributes to these effects. Currently, an estimated 1.6 billion people will need access to improved sanitation over the period 2005–2015 to meet Goal 7, target 10. Yet if trends since 1990 continue, the world is likely to fall short of the target by almost 600 million people. In sub-Saharan Africa, the number of people without access to sanitation actually increased from 335 million in 1990 to 440 million at the end of 2004. This number may increase even further if trends do not improve.

Millennium Development Goal 8: Develop a global partnership for development

14. While there have been improvements in some areas such as antiretroviral drugs, assessments of health service delivery in many countries show that a significant proportion of the population still have inadequate access to essential drugs on a sustainable basis. This is due either to physical, economic or sociocultural barriers, or to weaknesses in the health system in terms of ensuring a continuous supply of essential drugs, problems which must be addressed in order to achieve Goal 8, target 17.

DRAFT

Monitoring progress

15. Monitoring progress in terms of the health-related Goals' indicators is a well-established process coordinated by the United Nations Statistics Division. WHO participates in the Inter-Agency and Expert Group on MDG Indicators. Each year an annual progress report is produced based on the statistics provided by organizations in the United Nations system and countries. The coordination between all relevant United Nations bodies avoids unnecessary duplication of requests to countries for data and ensures harmonization of statistics. In close collaboration with UNICEF and UNAIDS, WHO provides health statistics on HIV/AIDS, tuberculosis, malaria, child mortality and child nutrition, water and sanitation, and indoor air pollution.
16. In addition, WHO reports the most recent estimates for statistics related to the Goals in its annual publication *World health statistics* which is issued in May each year and includes all relevant health indicators and additional indicators including causes of death, coverage of interventions, risk factors, and health systems. Hitherto, further analyses and detailed reporting on progress towards the health-related Millennium Development Goals have been limited to occasional publications or sections of reports.
17. In addition to supporting the United Nations reporting system, WHO plans to strengthen its core function of monitoring the health situation and trends in the world by establishing a global health observatory. The observatory will build on existing data and work on information within WHO, collaborate closely with partners, and issue analytical reports on high-priority topics, such as women and health and health in Africa, through special publications and an integrated web portal.
18. A major function of the observatory will be to monitor progress towards attaining the health-related Goals. Its analytical work will go beyond the joint United Nations monitoring process. Equity will receive special attention, including analyses of the extent to which the poorest countries are making progress, gender-specific trends and geographical differences within countries. It will also pay more attention to cause-specific mortality trends. In addition, it will monitor global health initiatives focusing on the Goals and evaluate the impact of various initiatives that aim to expand health services. The global health observatory's work elements will be introduced step-wise and work on monitoring progress

DRAFT

towards attaining the Millennium Development Goals is expected to expand gradually during 2008.

OVERCOMING CHALLENGES AND CONSTRAINTS: AN OVERVIEW OF THE CURRENT LANDSCAPE

19. Recent initiatives recognize that expanding health services requires a far more coherent approach: objectives cannot be achieved without adequate investment in the systems that deliver better health, and health should be embedded in broader social and economic development planning and a multisectoral response; countries need long-term predictable aid from external donors; domestic and international contributors need to see a clear link between financing and results; and mechanisms are badly needed that will hold all partners accountable for their performance against international agreements.
20. Practical expressions of this growing consensus include: agreement on key technical strategies such as the WHO, UNICEF and World Bank framework for achieving the health-related Millennium Development Goals in Africa prepared at the invitation of the African Union; WHO's framework for action on strengthening health systems to improve health outcomes;[51] the work to follow up the High-Level Forum on the Health Millennium Development Goals; the GAVI Alliance's expansion of support for health systems; the new agreement at the recent board meeting of the Global Fund to Fight AIDS, Tuberculosis and Malaria on modalities for health systems support and conditions for more programmatic funding (national strategy applications); the 2007 commitment of the G8 countries at the G8 Summit (Heiligendamm, Germany, June 2007) to scaling up of health interventions in Africa; and, most recently, several closely related bilaterally-championed initiatives—the International Health Partnership and the global campaign for the achievement of Goals 4, 5 and 6 and the recently announced Catalytic Initiative to Save One Million Lives.
21. Official development assistance for health globally has doubled in recent years from US$ 6000 million in 2000 to US$ 12 000 million in 2005. Major new resources have been committed—mostly towards the achievement of the health-related Goals, focusing on particular diseases (notably AIDS, tuberculosis and malaria) and interventions such as immunization. The Global Fund to Fight

[51] *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.* Geneva, World Health Organization, 2007.

DRAFT

AIDS, Tuberculosis and Malaria and the GAVI Alliance have attracted much of these new resources. The organizations in the United Nations system and World Bank are also committing significant investments to health. However, recent analysis by WHO shows that levels of flexible financing under the direct control of national governments have risen much more slowly.

22. As many donor governments and development banks have shifted towards budget or sector support, decreasing their involvement in specific sectors, new partners have emerged in the health sector. The foundations (particularly the Bill & Melinda Gates Foundation), global funds (particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria) and categorical bilateral programmes (particularly the United States of America's President's Emergency Plan for AIDS Relief) can now play a dominant role in external health sector funding in some countries. Innovative sources of finance (e.g. the International Finance Facility for Immunization and UNITAID) are tapping new sources of finance. Plans for advance market commitments promise new resources and a stimulus for research and development. Although these increases are welcome, significant gaps still exist and the current pattern of external assistance can be unpredictable at country level, making it difficult for governments to finance vital recurrent costs and make long-term plans for expanding the reach of some vital health interventions.

23. Global partnerships have been successful in raising the profile of critical issues, promoting interagency work and involving civil society and the private sector. However, there are now between 75 and 100 global health partnerships and initiatives; the global health environment has become increasingly fragmented and transaction costs faced by governments have increased. In addition, the capacity for supporting governments to expand programmes has not kept pace with the increases in resources and political attention for global health. In the field of AIDS, efforts have been made to promote a single framework—the "Three Ones" principle—in order to capture issues of governance, technical strategies and a single framework for monitoring and evaluation, which provides valuable lessons in general. The need for a common framework for monitoring performance and evaluation for the scaling up of health interventions has been recognized and international partners and countries are working together to develop and operationalize such a framework.

DRAFT

Scaling up: the way forward

24. Accelerating progress requires not only significant increases in the level of investment and political commitment to health, but also attention to fundamental issues of implementation.

Building the systems that create better health is important both within and beyond the health sector

25. Progress towards the health-related Millennium Development Goals cannot be sustained without adequate investment in health systems (in financing, human resources, information, procurement and logistics, governance and service delivery).
26. The Goals are interdependent and progress towards attainment of the health-related Goals relies on achievements in relation to the others. More rapid progress—particularly in relation to prevention of HIV/AIDS, but equally with regard to other infectious and noncommunicable diseases—requires a multi-sectoral response.

Weak national capacity remains an obstacle to progress: there are clear priorities for capacity-building

27. A shortage of well-trained health workers is a constraint in most African countries. Strategies are needed to increase their numbers; to adjust the mix of skills to changing circumstances and tasks (task shifting); to increase retention of health personnel through better incentives and improvements in the work environment; and to tackle the issue of migration of such workers. Capacity is also needed for data collection and analysis in order to enable countries to track progress accurately.
28. In order to achieve the health-related Millennium Development Goals in Africa greater attention will need to be paid to populations living in circumstances where the State, for a wide variety of reasons, is unable to respond fully to the health needs of its people. Work in such fragile States will in turn require the United Nations to have the capacity to support governments and other development partners.
29. Capacity-building cannot focus or rely on the public sector alone. Greater cooperation between the State and civil society is essential to success. In order to make progress in areas such as service delivery, effective networks of public,

DRAFT

private, voluntary, community and faith-based civil organizations will need to be created.

If financing commitments made by national governments and their development partners were fully honoured, many of the resource gaps in the sector could be filled

30. Donors' aid for health in Africa has increased significantly but still lags behind stated intentions. Moreover, the volume of resources that can be used flexibly by governments to build health-delivery systems has risen far less rapidly than have the resources available for specific diseases and technical cooperation.
31. National leaders should also be urged to meet agreed commitments with regard to spending on health (as set out, for example, in the Abuja Declaration by Heads of State and Government of African countries, 2000). Domestic policies for health financing should aim to decrease reliance on out-of-pocket payments and, using pooling of risk (either through tax-based or social insurance systems), help people to avoid catastrophic levels of expense when they fall ill.

Progress in achieving the health-related Millennium Development Goals in Africa is constrained by fragmentation and inefficiencies in the international response: putting the Paris Declaration on Aid Effectiveness (2005) into practice

32. While resource gaps remain, there is no need for new mechanisms, initiatives or channels of funding. Rather, support is needed for existing coordination mechanisms. These mechanisms include those at global and regional levels in which eight global health agencies are involved as part of their support for the International Health Partnership and related initiatives including the Harmonization for Health in Africa action framework.
33. Coordination at country level is essential. The idea of the "Three Ones" principle, that is, one national plan, one coordination mechanism and one monitoring and evaluation plan, which was developed for HIV/AIDS, is equally applicable in other areas of health. Work has begun to prepare criteria for determining what constitutes a sound health sector strategy and plan, and to agree a common approach to monitoring and evaluation. Among other things, ways will be explored of creating more effective links between the responses to HIV/AIDS and those in other areas of health.

DRAFT

34. Lessons learnt in strengthening coordination in the health sector will inform the third High-Level Forum on Aid Effectiveness, to be held in Accra from 2 to 4 September 2008.

Volatility in external resources makes it difficult to plan and manage the scaling up of health services: measures to increase predictability of aid at the country level are therefore critical

35. Much needs to be done to increase the predictability of health-sector financing so that finance ministries can budget with greater confidence for recurrent costs—particularly those for medicines and salaries. More robust compacts between governments and their development partners, agreements that align external financing around national results-based strategic plans that focus on the Millennium Development Goals, can provide the basis for mutual accountability and for securing long-term predictable financing from multiple sources. Mechanisms that promote a link between funding and performance while enhancing predictability, such as the "MDG contracts" proposed by the European Commission and others, merit support.

DRAFT

For more information:

WHO Communication Officers:

Child and adolescent health

Olivia Lawe-Davies
Telephone: +41 22 791 1209
lawedavieso@who.int

Gender and women's health

Sophie Berlamont
Telephone: +41 22 791 5543
berlamonts@who.int

Maternal, newborn and child health

Tunga Namjilsuren
Telephone: +41 22 791 1073
namjilsurent@who.int

Safe pregnancy

Marie Agnes Heine
Telephone: +41 22 791 2710
Mobile: +41 79 449 5784
heinem@who.int

HIV/AIDS

Valeri Abramov
Telephone: +41 22 791 2543
abromovv@who.int

Malaria

Valentina Buj
Telephone: +41 22 791 5071
bujv@who.int

Pru Smith (Roll Back Malaria Partnership)
Telephone: +41 22 791 4586
Mobile: +41 79 731 3569
smithp@who.int

DRAFT

Tuberculosis

Judith Mandelbaum-Schmid (Stop TB Partnership)
Telephone: +41 22 791 2967
Mobile: +41 79 254 6835
schmidj@who.int

Glenn Thomas
Telephone: +41 22 791 3983
Mobile: +41 79 509 0677
thomasg@who.int

WHO Websites:

- Health and the Millennium Development Goals: http://www.who.int/mdg/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

DRAFT

11.13 Counterfeit medical products

Extract from Document A61/16 (Report by the Secretariat):

1. Counterfeiting medical products, from their manufacture to their supply to patients, is a serious crime that puts human lives at risk and undermines the credibility of health systems. Counterfeit medical products jeopardize progress achieved in public health and threaten the effectiveness of major initiatives aimed at priority diseases.
2. Resolutions WHA41.16 and WHA47.13 on the rational use of drugs, and resolution WHA52.19 on the revised drug strategy recognize the threat posed by counterfeit medical products and requested the Director-General to support Member States in their efforts to combat the manufacture, trade and use of counterfeit medical products. In response to these requests, the Secretariat has organized international consultations, intensified collaboration with Member States and other organizations, and issued guidelines for the development of measures to combat counterfeit drugs.[52]
3. The context in which anti-counterfeiting strategies are implemented has changed markedly over the past decade. Intensified international commerce, the rapid expansion of the Internet and its commercial use, the widespread use of "free zones" in international trade, and the increasingly easy access to sophisticated technologies such as those for printing and manufacturing, have made it more difficult for governments and other concerned parties to combat counterfeiters of medical products effectively.
4. The extent of counterfeiting is impossible to quantify. However, the number of incidents detected in 2007 increased to over 1500 (that is on average more than four cases a day), roughly a 20% increase with respect to 2006 and a 10-fold increase compared with 2000. These increases reflect improved detection and reporting capacity, but also indicate that the problem is growing in numbers.
5. Counterfeiting affects all medical products: from medicines and pharmaceutical ingredients to medical devices and diagnostics. The consequences of their use can be extremely dramatic, as even the smallest cases concern at least one production batch, which amounts to thousands of tablets. In 2006, a counterfeit pharmaceutical excipient caused more than 100 deaths in Panama. A collaborative study conducted in 1999–2006 by the WHO Regional Office for

[52] Document WHO/EDM/QSM/99.1.

DRAFT

the Western Pacific, the International Criminal Police Organization (INTERPOL) and other stakeholders has shown that about half the samples of antimalarial medicines collected in the Mekong subregion contained no or insufficient amounts of active substances.[53]

6. In addition to direct harm to patients and therapeutic failure, the presence of counterfeit medical products weakens public confidence in the entire health system, affecting the reputation of manufacturers, wholesalers, pharmacists, doctors, private organizations and government institutions alike.

7. Counterfeit medical products have been detected in most of WHO's Member States and in all its regions. Cases have involved widely-used medicines such as atorvastatin and paracetamol, limited-use medicines such as growth hormone, paclitaxel, and filgrastim, erectile dysfunction medicines, and medical devices such as contact lenses, condoms, surgical mesh, and diagnostic test strips used by diabetic patients to monitor their blood glucose concentrations. Both expensive products and cheap ones, generic and branded products are being counterfeited with the result that they appear in community pharmacies and hospitals, as well as other less-regulated settings.

8. Although organized crime and individuals acting alone have been associated with the manufacture of, and trade in, counterfeit medical products, in most cases counterfeit products appear to have been internationally traded between previously unconnected groups or individuals. This fact puts an equal responsibility on importing and exporting countries.

9. Many factors of varying importance between Member States contribute to creating an environment in which manufacture of, and trade in, counterfeit medical products can thrive:
   - governments' unwillingness to recognize the existence or gravity of the problem
   - inadequate legal framework and penalties
   - weak administration and coordination, with measures not focused on fighting counterfeiting
   - ineffective control of manufacturing, import and distribution of medical products

[53] Newton PN et al. A collaborative epidemiological investigation into the criminal fake artesunate trade in south-east Asia. *PLoS Medicine*, 2008, 5:e32 (http://medicine.plosjournals.org/perlserv/?request=getdocument&doi=10.1371/journal.pmed.0050032, accessed 10 March 2008).

DRAFT

- ineffective collaboration among bodies and institutions, such as health authorities, police, customs and the judiciary, involved in regulation, control, investigation and prosecution
- ineffective collaboration and exchange of information between public and private sector
- insufficient international collaboration and exchange of information.

10. Besides the ubiquitous corruption, several other socioeconomic factors, many of which are specific to some countries or particular areas inside a country, undermine efforts against counterfeiting:
    - national drug policies that prioritize economic over public health aspects of medicine manufacturing, with the result that exporting takes priority over compliance with good manufacturing practices
    - extreme fragmentation of distribution channels involving an unnecessarily large number of transactions, thereby increasing the opportunities for counterfeiters to infiltrate the normal distribution system
    - existence of "extraterritorial" trade zones which largely escape from regulatory and enforcement oversight and goods and their accompanying documentation can be manipulated
    - inadequate access to health services and reliable pharmaceutical supply channels that creates opportunities for "informal operators" who establish "informal supply systems" purportedly to meet populations' real needs
    - absence of or insufficient social security coverage in countries that do not regulate prices; the resulting search by patients for better prices often leads to fierce competition among vendors and opens opportunities for counterfeiters who can offer unbeatable prices
    - illiteracy and poverty, which put patients at a particular disadvantage
    - unregulated Internet trade, where unscrupulous sellers can hide their identity and the true origin of traded medical products
    - third-party manufacturing, which, if not properly and carefully supervised, may lead to the unauthorized use of manufacturing techniques and packaging materials.
11. Against this background, WHO in 2006 launched the International Medical Products Anti-Counterfeiting Taskforce (IMPACT). Based on the principles enshrined in the Declaration of Rome (18 February 2006),[54] this taskforce aims to coordinate action

[54] http://www.who.int/entity/medicines/services/counterfeit/RomeDeclaration.pdf.

DRAFT

across and between countries in order to halt the production, movement and commerce – both between traders and with consumers – of counterfeit medical products around the globe. It brings together all the major anti-counterfeiting bodies,[55] including international organizations, nongovernmental organizations, drug regulatory authorities, enforcement authorities, associations representing pharmaceutical manufacturers, wholesalers, health professionals and patients.

Five areas of action

12. The common agreement that (a) combating counterfeit medical products requires the coordinated effort of all the public and private stakeholders who are concerned and competent for addressing the different aspects of the problem and (b) effective coordination and cooperation at the international level are essential for regional and national strategies to be more effective was instrumental in the establishment of IMPACT.
13. The Taskforce has identified five areas where action is needed in order to combat counterfeit medical products effectively. Accordingly, five working groups have been created, covering: legislative and regulatory infrastructure, regulatory implementation, enforcement, technology, and communication.
14. The Taskforce has developed "Principles and elements for national legislation against counterfeit medical products".[56] The text will be disseminated and promoted during 2008 in order to provide support to countries that want to strengthen their legislative infrastructure. IMPACT has also developed recommendations for strengthening WHO's Good Distribution Practices,[57] and has submitted them for consideration and appropriate action to WHO's Expert Committee on Specifications for Pharmaceutical Preparations.
15. A guide to investigating counterfeiting of medical products and other pharmaceutical crimes has been prepared for IMPACT by the Permanent Forum

[55] IMPACT stakeholders include representatives from the following organizations: INTERPOL, Organisation for Economic Co-operation and Development, World Customs Organization, World Intellectual Property Organization, World Trade Organization, European Commission, Council of Europe, United States Pharmacopoeia, Commonwealth Secretariat, Association of Southeast Asian Nations Secretariat, International Federation of Pharmaceutical Manufacturers and Associations, International Generic Pharmaceuticals Alliance, World Self-Medication Industry, Asociación Latinoamericana de Industrias Farmacéuticas, International Federation of Pharmaceutical Wholesalers, European Association of Pharmaceutical Full-line Wholesalers, International Pharmaceutical Federation, International Council of Nurses, World Medical Association, the Pharmaceutical Security Institute, Pharmaciens sans frontiers, ReMeD and International Alliance of Patients' Organizations.

[56] http://www.who.int/entity/impact/events/FinalPrinciplesforLegislation.pdf.

[57] http://www.who.int/entity/impact/events/IMPACT-ACTechnologiesv3LIS.pdf.

DRAFT

on International Pharmaceutical Crime. The guide will be used in courses for the training of regulatory and enforcement officers. The two complementary goals that IMPACT wants to pursue with its training courses are: to provide training and to contribute to creating the conditions for improved collaboration between health and enforcement authorities in this very specific area.

16. IMPACT has drawn up a communication strategy for creating awareness of the risks created by counterfeit medical products in the supply systems, supporting policy objectives and increasing commitment of those who can influence change. Model materials have been prepared to create awareness among, and foster cooperation of, health professionals. Other materials aimed at enforcement officers are being developed.

17. IMPACT has published a summary assessment of existing technologies used to protect medical products.[58] Meetings have been organized for technology developers, manufacturers and wholesalers of pharmaceutical and medical devices, and regulatory authorities in order to facilitate exchange of information and discuss cost, feasibility, specific country needs, and regulatory implications of the use of different technologies.

18. WHO, INTERPOL and the Association of Southeast Asian Nations Secretariat have launched a collaborative project for regulatory and enforcement authorities of all countries in the Mekong subregion: Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. The project aims to disrupt the manufacture and trade of counterfeit antimalarial agents and antibiotics through intensified cross-border collaboration.

Plans for the future

19. The Taskforce's work plans for 2008 are based on the recommendations provided by IMPACT's stakeholders at its second general meeting (Lisbon, 12–13 December 2007). The planned actions include:
    - disseminating and promoting existing documents in order to build on consensus and convince decision-makers at all levels of the need to strengthen national capacity to combat counterfeit medical products;
    - finalizing technical documents started in 2007, including those on the regulation of packaging materials, strategies for sampling and testing, information gathering for the assessment of national situations, and

[58] WHO Technical Report Services, No. 937, 2006.

DRAFT

extending the web-based availability of the Rapid Alert System developed by the WHO Regional Office for the Western Pacific to all regions;

- designing a comprehensive approach to preventing the sale of counterfeit medical products through the Internet that will cover legislative and regulatory measures, investigative and enforcement aspects, collaboration with Internet service providers and electronic trade platforms, and initiatives to warn Internet users of the risk;
- creating initiatives that focus on the specific needs and problems related to counterfeit medical products in sub-Saharan Africa.

20. WHO's role in IMPACT is to work with Member States in order to mobilize all relevant sectors of the international community in support of common strategies against counterfeiting of medical products in line with the Organization's fundamental principles of promoting and protecting public health. This objective will be attained through strategic alliances with other international organizations and stakeholders, promotion of appropriate legal frameworks, effective exchange of information, involvement of health professionals, and building appropriate technical capacity at all levels.

DRAFT

For more information:

WHO Communication Officers:

Patient safety

Agnès Leotsakos
Telephone: +41 22 791 2567
Mobile: +41 79 500 6504
leotsakosa@who.int

Pharmaceuticals, health technologies

Daniela Bagozzi
Telephone: +41 22 791 4544
Mobile: +41 79 475 5490
bagozzid@who.int

WHO websites:

- Pharmaceutical Products: http://www.who.int/topics/pharmaceutical_products/en/
- Counterfeit Medicines Factsheet: http://www.who.int/mediacentre/factsheets/fs275/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

DRAFT

20. Outcome of the second session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control

Extract from Document A61/34 (Report by the Secretariat)

1. The second session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control was held from 30 June to 6 July 2007, in Bangkok, under the presidency of Ambassador Juan Martabit (Chile). Twenty-three international intergovernmental organizations and 49 nongovernmental organizations were accredited as observers. As of 29 February 2008, there were 152 Parties to the Convention.

2. The Conference of the Parties adopted a number of decisions,[59] on matters ranging from the development of various guidelines for the implementation of the Convention to budgetary and organizational issues and the decision on its date and venue of the third session.

3. The Conference decided to establish an intergovernmental negotiating body open to all Parties to draft and negotiate a protocol on illicit trade in tobacco products, which would build upon and complement the provisions of Article 15 of the Convention.[60] That Body commenced its work by convening its first session, held from 11 to 16 February 2008, in Geneva.

4. The Conference of the Parties adopted the first guidelines for implementation of the Convention, namely those on Article 8 (Protection from exposure to tobacco smoke),[61] and also requested the working group on the elaboration of guidelines for the implementation of Articles 9 and 10 (Regulation of the contents of tobacco products, and Regulation of tobacco product disclosures) to continue its work and to submit a progress report to the third session of the Conference of the Parties.[62]

5. The Conference of the Parties also established four new working groups to elaborate guidelines on the implementation of various articles of the Framework Convention, namely on Articles 5.3 on protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry, Article 11 (Packaging and labelling of tobacco products),

---

[59] All decisions taken by the Conference of the Parties at its second session are contained in document A/FCTC/COP/2/DIV/9.

[60] Decision FCTC/COP2(12).

[61] Decision FCTC/COP2(7).

[62] Decision FCTC/COP2(14).

DRAFT

Article 12 (Education, communication, training and public awareness)[63] and Article 13 (Tobacco advertising, promotion and sponsorship).[64] The working groups are to present draft guidelines or a progress report for consideration by the Conference of the Parties at its third session.

6. The Conference of the Parties further decided to mandate the study group on economically sustainable alternatives to tobacco growing to continue its work and submit a report to the Conference at its third session.[65] The Conference also requested the Convention Secretariat to prepare a report on Article 14 of the Framework Convention (Demand reduction measures concerning tobacco dependence and cessation)[66] and, with regard to the reporting instrument, to revise the format of the questionnaire for Group 1 questions and to draft the Group 2 questions, for consideration by the Conference at its third session.[67]

7. The Conference of the Parties adopted the budget and workplan for the period 2008–2009[68] as well as a decision on financial resources and mechanisms of assistance,[69] and decided that the third session of the Conference of the Parties will be held in South Africa in the last quarter of 2008, the dates and venue to be confirmed by the Bureau.[70] The Conference was also informed that, in accordance with relevant decisions,[71] the Convention Secretariat had been established within WHO. Dr Haik Nikogosian was appointed as the Head of the Convention Secretariat. Lastly, the Conference elected officers to constitute the Bureau for its third session, under the presidency of Dr Hatai Chitanondh (Thailand).

---

63 Also contained in decision FCTC/COP/2(14).
64 Decision FCTC/COP2(8).
65 Decision FCTC/COP2(13).
66 Also contained in decision FCTC/COP2(14).
67 Decision FCTC/COP2(9).
68 Decision FCTC/COP2(11).
69 Decision FCTC/COP2(10).
70 Decision FCTC/COP2(15).
71 Decisions FCTC/COP1(10) and FCTC/COP1(12) and resolution WHA59.17.

DRAFT

For more information:

WHO Communication Officer:

Tobacco

Alison Clements-Hunt
Telephone: +41 22 791 5539
Mobile: +41 79 477 2633
clementshunta@who.int

WHO websites:

- Framework Convention on Tobacco Control: http://www.who.int/gb/fctc/
- Tobacco Free Initiative (TFI): http://www.who.int/tobacco/en/
- Tobacco (generally): http://www.who.int/topics/tobacco/en/

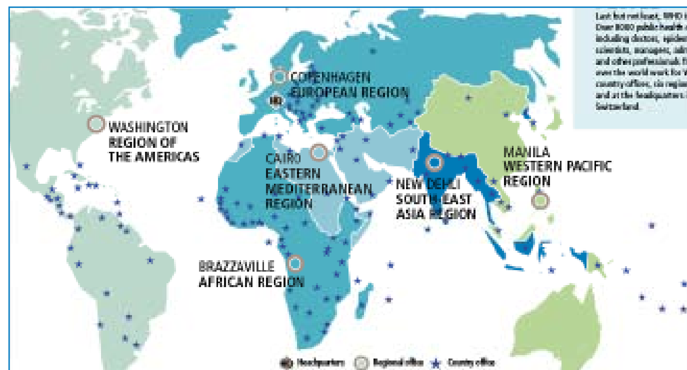
Non-WHO websites:

- Centre for Tobacco Control Research: http://www.ctcr.stir.ac.uk/
- Doctors and Tobacco: Tobacco Control Resource Centre: http://www.doctorsandtobacco.org/
- BMA's Tobacco Fact File: http://www.tobaccofactfile.org/
- GLOBALink, Global tobacco control: http://www.globalink.org/

DRAFT

ANNEX 1. STRUCTURE OF WHO

Six Regional Offices



DRAFT

Regional Office for the Eastern Mediterranean (EMRO):
Abdul Razzak Al Sanhouri Street
P O Box 7608
Nasr City, Cairo 11371
Egypt
Tel: +202 2276 50 00
Fax: +202 2670 24 92 or 24 94
Email: postmaster@emro.who.int

Regional Director: *Dr Hussain Abdel-Razzak Al Gezairy*

- Afghanistan
- Bahrain
- Djibouti
- Egypt
- Iran (Islamic Republic of)
- Iraq
- Kuwait
- Lebanon
- Libyan Arab Jamahiriya
- Morocco
- Oman
- Pakistan
- Qatar
- Saudi Arabia
- Somalia
- Sudan
- Syrian Arab Republic
- Tunisia
- United Arab Emirates
- Yemen

Regional Office for the Western Pacific (WHPRO):
P O Box 2932
1000 Manila
Philippines
Tel: +63 2 528 8001
Email: postmaster@wpro.who.int

Regional Director: *Dr Shigeru Omi*

- Australia
- Brunei Darussalam
- Cambodia
- China
- 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

DRAFT

Regional Office for Europe (EURO):

8 Scherfigsvej
DK-2100 Copenhagen 0
Denmark

Tel: +45 39 171 717
Fax: +45 39 171 818
Email: postmaster@euro.who.int

Regional Director: *Marc Danzon*

- Albania
- Andorra
- Armenia
- Austria
- Azerbaijan
- Belarus
- Belgium
- Bosnia and Herzegovina
- Bulgaria
- Croatia
- Cyprus
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Georgia
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Israel
- Italy
- Kazhakstan
- Kyrgyzstan
- Latvia
- Lithuania
- Luxembourg
- Malta
- Monaco
- Montenegro
- Netherlands
- Norway
- Poland
- Portugal
- Republic of Moldova
- Romania
- Russian Federation
- San Marino
- Serbia
- Slovakia
- Slovenia
- Turkmenistan
- Ukraine
- United Kingdom
- Uzbekistan

DRAFT

Regional Office for the Americas (PAHO):

525, 23rd Street, N.W.
Washington, DC 20037
USA

Tel: +00 1 202 974 3000
Fax: +00 1 202 974 3663
Email: postmaster@paho.org

Regional Director: *Dr Mirta Roses*

- Antigua and Barbuda
- Argentina
- Bahamas
- Barbados
- Belize
- Bolivia
- Brazil
- Canada
- Chile
- Colombia
- Costa Rica
- Cuba
- Dominica
- Dominican Republic
- Ecuador
- El Salvador
- Grenada
- Guatemala
- Guyana
- Haiti
- Honduras
- Jamaica
- Mexico
- Nicaragua
- Panama
- Paraguay
- Peru
- Saint Kitts and Nevis
- Saint Lucia
- Saint Vincent and the Grenadines
- Suriname
- Trinidad and Tobago
- United States of America
- Uruguay
- Venezuela (Bolivarian Republic of)

Regional Office for South-East Asia (SEARO):

World Health House
Indraprastha Estate
Mahatama Gandhi Marg
New Delhi 110 002
India

Tel: +91 11 2337 0804
Fax: +91 11 2337 9507

Regional Director: *Dr Samlee Plianbangchang*

- Bangladesh
- Bhutan
- Democratic People's Republic of Korea
- India
- Indonesia
- Maldives
- Myanmar
- Nepal
- Sri Lanka
- Thailand
- Timor-Leste

DRAFT

Regional Office for Africa (AFRO):

Cité du Djoue, P O Box 06
Brazzaville
Congo

Tel: +242 839 100 /
+47 241 39100
Fax: +242 839 501 /
+47 241 395018

Regional Director: *Dr L Sambo*

- Algeria
- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Central African Republic
- Chad
- Comoros
- Congo
- Côte d'Ivoire
- Democratic Republic of the Congo
- Equatorial Guinea
- Eritrea
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
- Seychelles
- Sierra Leone
- South Africa
- Swaziland
- Togo

DRAFT

BOX 1 COMPOSITION OF THE EXECUTIVE BOARD

Members entitled to designate a person to serve on the Board, by WHO Region, with term of office.

AFRICA

- Liberia 2005-2008 : Dr W.T. Gwenigale, Minister of Health and Social Welfare, Monrovia
- Madagascar 2005-2008 : Dr R.R. Jean Louis, Ministre de la Santé et du Planning familial, Antananarivo
- Malawi 2007-2010 : Professor F. Salaniponi, Director, National Tuberculosis Programme, Lilongwe
- Mali 2006-2009 : Dr Z.M. Youba, Ministre de la Santé, Bamako Koulouba
- Namibia 2005-2008 : Dr K. Shangula, Permanent Secretary, Ministry of Health and Social Services, Windhoek
- Rwanda 2005-2008 : Dr J.D. Ntawukuliryayo, Ministre de la Santé publique, Kigali
- Sao Tomé and Principe 2007-2010 : Dr J.M. de Carvalho, Directeur des Soins de Santé, Ministère de la Santé, Sao Tomé

AMERICAS

- Bahamas 2007-2010 : Dr M. Dahl-Regis, Chief Medical Officer, Ministry of Health, Nassau New Providence
- El Salvador 2006-2009 : Dr J.G. Maza Brizuela, Ministro de Salud, San Salvador
- Mexico 2005-2008 : Mr. M. Bailón González, Director General de Relaciones Internacionales, Secretaría de Salud, Mexico DF
- Paraguay 2007-2010 : Dr O. Martinez Doldan, Ministro de Salud Pública y Bienestar Social, Asunción
- Peru 2007-2010 : Sr. C. Vallejos, Ministro de Salud, Lima
- United States of America 2006-2009 : Dr J. Agwunobi, Assistant Secretary for Health, Department of Health and Human Services, Washington DC

SOUTH-EAST ASIA

- Bhutan 2005-2008 : Dr J. Singay, Minister of Health, Thimphu
- Indonesia 2007-2010 : Dr S.F. Supari, Minister of Health, Jakarta
- Sri Lanka 2006-2009 : Mr N.S. de Silva, Minister of Healthcare and Nutrition, Colombo

DRAFT

EUROPE

- Azerbaijan 2005-2008 : Mr O.K. Shiraliyev, Minister of Health, Baku
- Denmark 2006-2009 : Mr J. Fisker, Director-General, National Board of Health, Copenhagen
- Latvia 2006-2009 : Dr V. Jaksons, Adviser to the Director, Health Statistics and Medical Technologies State Agency, Riga
- Portugal 2005-2008 : Professor J. Pereira Miguel, Director, National Institute of Public Health, Lisbon
- Republic of Moldova 2007-2010 : Dr I. Ababii, Minister of Health, Chisinau
- Slovenia 2006-2009 : Dr B. Voljč, Adviser, The Blood Transfusion Centre of Slovenia, Ljubljana
- Turkey 2006-2009 : Professor S. Aydin, Deputy Under-Secretary, Ministry of Health, Ankara
- United Kingdom of Great Britain and Northern Ireland 2007-2010 : Professor Sir Liam Donaldson, Chief Medical Officer, Department of Health, London

EASTERN MEDITERRANEAN

- Afghanistan 2006-2009 : Dr A.S. Salehi, Director, External Relations Department, Ministry of Public Health, Kabul
- Djibouti 2006-2009 : M. A.A. Miguil, Ministre de la Santé, Djibouti
- Iraq 2005-2008 : Dr A.H.I. Al-Shammari, Minister of Health, Baghdad
- Tunisia 2007-2010 : Dr H. Abdessalem, Directeur général, Unité de la Coopération technique, Ministère de la Santé publique, Tunis
- United Arab Emirates 2007-2010 : Dr A.A. Bin Shakar, Under-Secretary, Ministry of Health, Abu Dhabi

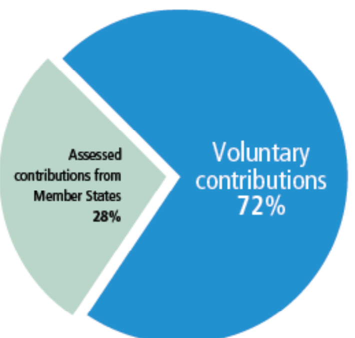
WESTERN PACIFIC

- Japan 2005-2008 : Dr H. Shinozaki, President, National Institute of Public Health, Saitama
- China 2006-2009 : Mr Ren Mingui, Deputy Director-General, Department of International Cooperation, Ministry of Health, Beijing
- New Zealand 2007-2010 : Mr P. Hodgson, Minister of Health, Wellington
- Republic of Korea 2007-2010 : Dr Sohn Myong-sei, Vice-President, Korean Academy of Medical Sciences, Seoul
- Singapore 2006-2009 : Dr B. Sadasivan, Senior Minister of State for Foreign Affairs, Ministry of Foreign Affairs, Singapore

DRAFT

WHO Budget—www.who.int

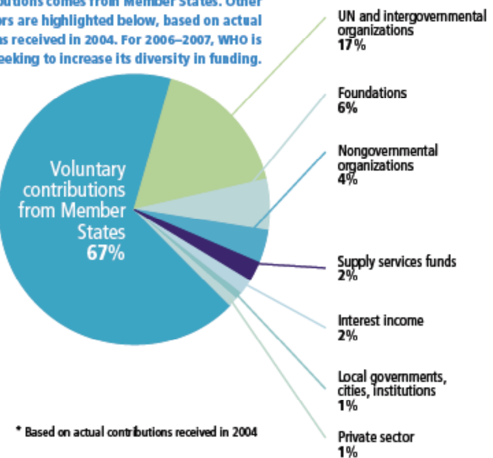
TOTAL RESOURCES 2006—2007



The total WHO budget planned for 2006-2007 is roughly $US 3.3 billion. Of this amount, just over one quarter comes from regular "dues" from WHO's Member States, while more than 70% is money that countries, agencies and other partners give to WHO voluntarily.

SOURCE OF VOLUNTARY CONTRIBUTIONS*

Traditionally, the major source of voluntary contributions comes from Member States. Other contributors are highlighted below, based on actual contributions received in 2004. For 2006–2007, WHO is seeking to increase its diversity in funding.



* Based on actual contributions received in 2004

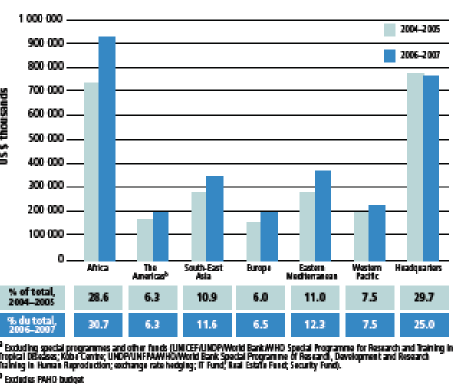
DRAFT

HOW DOES WHO SPEND ITS MONEY?

To achieve results in the four priority areas described in this brochure, the World Health Assembly approved the 2006–2007 budget which divides WHO's spending into four interdependent categories: essential health interventions (such as response to epidemic alerts and reduction of maternal and child mortality); health systems, policies and products (such as the quality of medicines and technologies); determinants of health (such as nutrition and tobacco-use); and effective support for Member States (such as increasing investment in knowledge management and information technology and ensuring staff security).

PROGRAMME BUDGET 2004–2005, 2006–2007, BY OFFICE

all sources of financing[a]



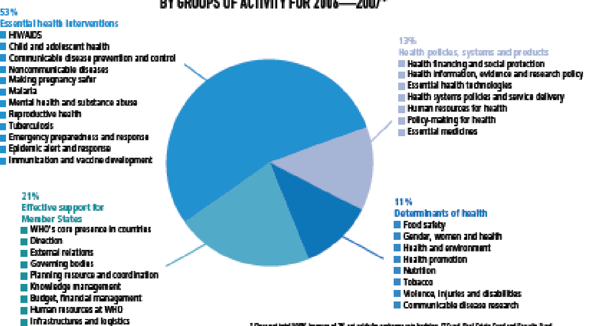
	Africa	The Americas[b]	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters
% of total, 2004–2005	28.6	6.3	10.9	6.0	11.0	7.5	29.7
% du total, 2006–2007	30.7	6.3	11.6	6.5	12.3	7.5	25.0

[a] Excluding special programmes and other funds (UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; Kobe Centre; UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; exchange rate hedging; IT Fund; Real Estate Fund; Security Fund).

[b] Excludes PAHO budget

ESTIMATED EXPENDITURE

BY GROUPS OF ACTIVITY FOR 2006—2007*



* Does not total 100% because of 2% set aside for exchange rate hedging, IT Fund, Real Estate Fund and Security Fund

GEOGRAPHIC DISTRIBUTION

The figure below provides a breakdown between the regions and headquarters by all sources of funding for the periods 2004-2005 and 2006-2007. The figures for the regional level combine the proposed amounts for the country and regional budget of the respective region. In order to get the best health results in countries, WHO spends approximately 75% of its funds in regional and country offices, and approximately 25% at WHO headquarters.

HOW DO WE REPORT ON THE MONEY WE SPEND?

WHO uses results-based management. This means that every two years, WHO sets out what it plans to achieve in the future, how it plans to do it, and what funds are needed to meet these goals.

Progress against these goals is reported to the World Health Assembly. In this way, WHO can report regularly on its achievements, improve the targeting of its funds and be as transparent and accountable as possible to its member countries and donors.

DRAFT

THIS SPACE IS FOR NOTE TAKING.

World Health Communication Associates Ltd
Little Harborne, Church Lane, Compton Bishop,
Somerset BS26 2HD, United Kingdom
Tel. & Fax: +44 (0)1934 732353
e-mail: whca@onetel.net

Draft- not for sale or circulation

DRAFT

World Health Communication Associates Ltd
Little Harborne, Church Lane, Compton Bishop,
Somerset BS26 2HD, United Kingdom
Tel. & Fax: +44 (0)1934 732353
e-mail: whca@onetel.net

Draft- not for sale or circulation