Infact

Challenging corporate abuse
Building grassroots power

Infact Intervention to the 57th Session of the World Health Assembly
Agenda Item 21: Policy for Relations with Nongovernmental Organizations

Thank you for the opportunity to speak on behalf of Infact. Infact and the Network for Accountability of Tobacco Transnationals (NATT) strongly support the intent to enhance NGO participation that underlies the proposed new policy for NGO accreditation and collaboration. The acceleration and expansion of NGO access to the Framework Convention on Tobacco Control (FCTC) negotiations contributed positively to the development of the treaty.

With the adoption of the FCTC a year ago, the World Health Assembly established the first multilateral convention of a global scope that protects public health policy from the commercial interests of an industry whose products or practices cause harm. Part of this victory can be attributed to the positive role played by civil society organizations including NGOs—a fact recognized by many delegations in their statements at last year's WHA.

However, the success of the FCTC is also rooted in measures taken to insulate the treaty negotiations and public health policies included in it from interference by the tobacco industry. With the FCTC and WHA resolution 54.18, the WHO and member states have set the precedent that not all industries are entitled to have a voice in the development of health policy. When profits and health come into conflict, corporations cannot be counted on to protect consumers.

Infact therefore urges WHO Member States to reject the inclusion of groups with industry affiliation or commercial interests in the proposed definition of NGOs. The proposed policy confuses the definition of NGOs by including: "not-for-profit organizations that represent or are closely linked with commercial interests." This move goes against established norms and marks a complete reversal in policy. The current Principles Governing Relations Between the WHO and NGOs restrict admission into official relations to those NGOs which are: "free from concerns which are primarily of a commercial or profit-making nature."

Corporations have long tried to advance their interests by forming pseudo NGOs. This trend has reached dangerous new levels as the Confederation of Food and Drink Industries of the EU (CIAA), and the International Council of Grocery Manufacturers Associations (ICGMA), two influential food industry trade associations whose expressed intent is to promote their products—many of which are junk food—are currently applying for official relations status. The proposal to recognize these so-called "NGOs" clearly illustrates the pitfalls of reversing the current NGO policy, and demonstrates why WHO must, at a minimum, distinguish between NGOs and organizations representing commercial interests.

The proposed new definition of NGO and the inclusion of trade associations such as the CIAA and the ICGMA would make it more difficult for Member State delegates to the EB or the WHA to distinguish between organizations representing the public interest and those representing business interests. If WHO member states choose to include organizations that represent or are closely linked with commercial interests in debate on health issues, their participation should be subject to the WHO's guidelines for interaction with the private sector—and their affiliations must be displayed in a transparent manner to all participants, for example through the use of different color badges for the private sector.

We urge WHO either to keep the old definition of NGOs or to delete the phrase "not-for-profit organizations that represent or are closely linked with commercial interests." The avoidance of conflicts of interest, including in WHO's relations with NGOs, is vital to the organization's integrity and capacity to achieve future breakthroughs in public health. Thank you.

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Comm. A

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Federación Internacional de Sociedades de la Cruz Roja y de la Media Luna Roja
الاتحاد الدولي لجمعيات الصليب الأحمر والهلال الأحمر

WORLD HEALTH ASSEMBLY
57th session

Geneva, 17-22 May 2004

Committee A
Agenda item 12.9
"Family and Health"
Reducing the Impact of Malaria and Measles on Families

Statement by

Bernard Morinière
Medical Epidemiologist

INTERNATIONAL FEDERATION
OF RED CROSS AND RED CRESCENT SOCIETIES

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12.9 Family and Health (malaria and measles)

Statement by
the International Federation of Red Cross and Red Crescent Societies
at the 57th World Health Assembly
Geneva, 17-22 May 2004

Mr. Chairman,
Ladies and gentlemen,

The International Federation of Red Cross and Red Crescent Societies welcomes the opportunity to address this Assembly, and to pledge its support in observance of the tenth anniversary of the International Year of the Family. Children under 5 years of age and pregnant women in malaria endemic areas are at especially high risk of dying. We are committed to join with other partners in efforts to enhance family health and to generate new activities aimed at reducing global mortality from malaria, in combination with immunization activities and other health interventions.

The International Federation, and its more than 45 member National Societies in Africa, recognize the severe burden of disease and death imposed by malaria on children and mothers; the impact of malaria on economic and social development; the availability of cost-effective interventions for treatment and prevention; and the commitment of the Roll Back Malaria partners to mobilize resources and to scale-up control efforts towards achieving the Millennium Development Goals and the targets set for 2005 by the Abuja Malaria Summit.

These objectives are consistent with the Red Cross and Red Crescent Societies' mission to improve the life and health of the most vulnerable individuals and families, and with their capacity to mobilize thousands of community volunteers, to extend the reach of health services towards their intended beneficiaries.

The International Federation at global level, and National Societies at country level, are playing an increasing role as partners in global health alliances against major public health problems, working with national governments and Ministries of Health, and with WHO, UNICEF, the Centers for Disease Control and Prevention, the UN Foundation and other global, regional and local partners. In addition to their traditional role in disaster and outbreak response activities, Red Cross and Red Crescent volunteers have been increasingly engaged in

ongoing disease control programs, including HIV/AIDS, Tuberculosis, Polio Eradication and others. Since 2001, Red Cross and Red Crescent Societies have taken an active part in mass vaccination campaigns against measles, as part of the Africa measles partnership, spearheaded by the American Red Cross. By the end of 2005, more than 200 million African children will have been vaccinated, preventing several hundred thousand measles deaths annually. These renewed efforts in measles control have offered opportunities to accelerate other important interventions, including the mass distribution of insecticide-treated mosquito nets for malaria prevention among children under 5 years and pregnant women. Demonstration projects were conducted with success in selected districts in Ghana in 2002 and in Zambia in 2003. A nationwide campaign is under preparation in Togo for December 2004, combining measles vaccination with nationwide distribution of mosquito nets to eligible households, with participation of Red Cross volunteers for community mobilization before and during the campaign. In partnership with the Togo Ministry of Health, local WHO and UNICEF staff, other NGOs, and with a number of other partners, we look forward to a substantial impact on malaria morbidity as a result of this nationwide partnership effort.

Mr. Chairman,

In January 2004, WHO and UNICEF issued a joint statement calling for combining malaria control activities with immunization activities, when possible, either during Supplementary Immunization Activities (such as measles vaccination campaigns), or on a regular basis through routine immunization services

The International Federation welcomes and supports this policy development. We look forward to working with WHO, governments and other partners to implement the WHO/UNICEF comprehensive strategies for measles mortality reduction and for scaling-up malaria control activities. National Societies of Red Cross and Red Crescent and their volunteers will work with you towards increasing demand for these interventions.

We support the call for strengthening partnerships at the global, regional and national levels. As an international organization with a bridging role, we believe that a broader involvement of NGOs as partners to their respective national governments is crucial to achieving better health for all families. The successful mobilization of civil society and the involvement of communities and families in their own health issues are the very core of our Red Cross and Red Crescent National Societies. Communities can thus sustain essential public health

interventions which will result in improved health for the most vulnerable populations. In this way we can together achieve the desired progress towards the fulfillment of the Millennium Development Goals.

Thank you, Mr. Chairman.

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FIFTY-SEVENTH WORLD HEALTH ASSEMBLY WHA57.17

Agenda item 12.6 22 May 2004

Global strategy on diet, physical activity and health

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA55.23 on diet, physical activity and health;

Recalling *The world health report 2002*,[1] which indicates that mortality, morbidity and disability attributed to the major noncommunicable diseases currently account for about 60% of all deaths and 47% of the global burden of disease, which figures are expected to rise to 73% and 60%, respectively, by 2020;

Noting that 66% of the deaths attributed to noncommunicable diseases occur in developing countries where those affected are on average younger than in developed countries;

Alarmed by these rising figures that are a consequence of evolving trends in demography and lifestyles, including those related to diet and physical activity;

Recognizing the existing, vast body of knowledge and public health potential, the need to reduce the level of exposure to the major risks resulting from unhealthy diet and physical inactivity, and the largely preventable nature of the consequent diseases;

Mindful also that these major behavioural and environmental risk factors are amenable to modification through implementation of concerted essential public-health action, as has been demonstrated in several Member States;

Acknowledging that malnutrition, including undernutrition and nutritional deficiencies, is still a major cause of death and disease in many parts of the world, especially in developing countries, and that this strategy complements the important work of WHO and its Member States in the overall area of nutrition;

Recognizing the interdependence of nations, communities and individuals and that governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages individuals, families and communities to make positive, life-enhancing decisions on healthy diet and physical activity;

WHO resolution file

[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

Recognizing the importance of a global strategy for diet, physical activity and health within the integrated prevention and control of noncommunicable diseases, including support of healthy lifestyles, facilitation of healthier environments, provision of public information and health services, and the major involvement in improving the lifestyles and health of individuals and communities of the health and relevant professions and of all concerned stakeholders and sectors committed to reducing the risks of noncommunicable diseases;

Recognizing that for the implementation of this global strategy, capacity building, financial and technical support should be promoted through international cooperation in support of national efforts in developing countries;

Recognizing the socioeconomic importance and the potential health benefits of traditional dietary and physical activity practices, including those of indigenous peoples;

Reaffirming that nothing in this strategy shall be construed as a justification for the adoption of trade-restrictive measures or trade-distorting practices;

Reaffirming that appropriate levels of intakes for energy, nutrients and foods, including free sugars, salt, fats, fruits, vegetables, legumes, whole grains, and nuts shall be determined in accordance with national dietary and physical activity guidelines based on the best available scientific evidence and as part of Member States' policies and programmes taking into account cultural traditions, and national dietary habits and practices;

Convinced that it is time for governments, civil society and the international community, including the private sector, to renew their commitment to encouraging healthy patterns of diet and physical activity;

Noting that resolution WHA56.23 urged Member States to make full use of Codex Alimentarius Commission standards for the protection of human health throughout the food chain, including assistance with making healthy choices regarding nutrition and diet,

1. ENDORSES the Global Strategy on Diet, Physical Activity and Health annexed herewith;

2. URGES Member States:

(1) to develop, implement and evaluate actions recommended in the strategy, as appropriate to national circumstances and as part of their overall policies and programmes, that promote individual and community health through healthy diet and physical activity, and reduce the risks and incidence of noncommunicable diseases;

(2) to promote lifestyles that include a healthy diet and physical activity and foster energy balance;

(3) to strengthen existing, or establish new, structures for implementing the strategy through the health and other concerned sectors, for monitoring and evaluating its effectiveness and for guiding resource investment and management to reduce the prevalence of noncommunicable diseases and the risks related to unhealthy diet and physical inactivity;

(4) to define for this purpose, consistent with national circumstances:

(a) national goals and objectives,

(b) a realistic timetable for their achievement,

(c) national dietary and physical activity guidelines,

(d) measurable process and output indicators that will permit accurate monitoring and evaluation of action taken and a rapid response to identified needs,

(e) measures to preserve and promote traditional foods and physical activity;

(5) to encourage mobilization of all concerned social and economic groups, including scientific, professional, nongovernmental, voluntary, private-sector, civil society, and industry associations, and to engage them actively and appropriately in implementing the strategy and achieving its aims and objectives;

(6) to encourage and foster a favourable environment for the exercise of individual responsibility for health through the adoption of lifestyles that include a healthy diet and physical activity;

(7) to ensure that public policies adopted in the context of the implementation of this strategy are in accordance with their individual commitments in international and multilateral agreements, including trade and other related agreements, so as to avoid trade-restrictive or trade-distorting impact;

(8) to consider, when implementing the strategy, the risks of unintentional effects on vulnerable populations and specific products;

3. CALLS UPON other international organizations and bodies to give high priority within their respective mandates and programmes to, and invites public and private stakeholders including the donor community to cooperate with governments in, the promotion of healthy diets and physical activity to improve health outcomes;

4. REQUESTS the Codex Alimentarius Commission to continue to give full consideration, within the framework of its operational mandate, to evidence-based action it might take to improve the health standards of foods consistent with the aims and objectives of the strategy;

5. REQUESTS the Director-General:

(1) to continue and strengthen the work dedicated to undernutrition and micronutrient deficiencies, in cooperation with Member States, and to continue to report to Member States on developments made in the field of nutrition (resolutions WHA46.7, WHA52.24, WHA54.2 and WHA55.25);

(2) to provide technical advice and mobilize support at both global and regional levels to Member States, when requested, in implementing the strategy and in monitoring and evaluating implementation;

(3) to monitor on an ongoing basis international scientific developments and research relative to diet, physical activity and health, including claims on the dietary benefits of agricultural products which constitute a significant or important part of the diet of individual countries, so as to enable Member States to adapt their programmes to the most up-to-date knowledge;

(4) to continue to prepare and disseminate technical information, guidelines, studies, evaluations, advocacy and training materials so that Member States are better aware of the cost/benefits and contributions of healthy diet and physical activity as they address the growing global burden of noncommunicable diseases;

(5) to strengthen international cooperation with other organizations of the United Nations system and bilateral agencies in promoting healthy diet and physical activity throughout life;

(6) to cooperate with civil society and with public and private stakeholders committed to reducing the risks of noncommunicable diseases in implementing the strategy and promoting healthy diet and physical activity, while ensuring avoidance of potential conflicts of interest;

(7) to work with other specialized United Nations and intergovernmental agencies on assessing and monitoring the health aspects, socioeconomic impact and gender aspects of this strategy and its implementation and to brief the Fifty-ninth World Health Assembly on the progress of this activity;

(8) to report on the implementation of the global strategy at the Fifty-ninth World Health Assembly.

ANNEX

GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH

(endorsed by resolution WHA57.17)

1. Recognizing the heavy and growing burden of noncommunicable diseases, Member States requested the Director-General to develop a global strategy on diet, physical activity and health through a broad consultation process.[1] To establish the content of the draft global strategy, six regional consultations were held with Member States, and organizations of the United Nations system, other intergovernmental bodies, and representatives of civil society and the private sector were consulted. A reference group of independent international experts on diet and physical activity from WHO's six regions also provided advice.

2. The strategy addresses two of the main risk factors for noncommunicable diseases, namely, diet and physical activity, while complementing the long-established and ongoing work carried out by WHO and nationally on other nutrition-related areas, including undernutrition, micronutrient deficiencies and infant- and young-child feeding.

THE CHALLENGE

3. A profound shift in the balance of the major causes of death and disease has already occurred in developed countries and is under way in many developing countries. Globally, the burden of noncommunicable diseases has rapidly increased. In 2001 noncommunicable diseases accounted for almost 60% of the 56 million deaths annually and 47% of the global burden of disease. In view of these figures and the predicted future growth in this disease burden, the prevention of noncommunicable diseases presents a major challenge to global public health.

4. *The world health report 2002*[2] describes in detail how, in most countries, a few major risk factors account for much of the morbidity and mortality. For noncommunicable diseases, the most important risks included high blood pressure, high concentrations of cholesterol in the blood, inadequate intake of fruit and vegetables, overweight or obesity, physical inactivity and tobacco use. Five of these risk factors are closely related to diet and physical activity.

5. Unhealthy diets and physical inactivity are thus among the leading causes of the major noncommunicable diseases, including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the global burden of disease, death and disability. Other diseases related to diet and physical inactivity, such as dental caries and osteoporosis, are widespread causes of morbidity.

6. The burden of mortality, morbidity and disability attributable to noncommunicable diseases is currently greatest and continuing to grow in the developing countries, where those affected are on average younger than in developed countries, and where 66% of these deaths occur. Rapid changes in

[1] Resolution WHA55.23.

[2] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

diets and patterns of physical activity are further causing rates to rise. Smoking also increases the risk for these diseases, although largely through independent mechanisms.

7. In some developed countries where noncommunicable diseases have dominated the national burden of disease, age-specific death and disease rates have been slowly declining. Progress is being made in reducing premature death rates from coronary artery disease, cerebrovascular disease and some tobacco-related cancers. However, the overall burden and number of patients remain high, and the numbers of overweight and obese adults and children, and of cases, closely linked, of type 2 diabetes are growing in many developed countries.

8. Noncommunicable diseases and their risk factors are initially mostly limited to economically successful groups in low- and middle-income countries. However, recent evidence shows that, over time, patterns of unhealthy behaviour and the noncommunicable diseases associated with them cluster among poor communities and contribute to social and economic inequalities.

9. In the poorest countries, even though infectious diseases and undernutrition dominate their current disease burden, the major risk factors for chronic diseases are spreading. The prevalence of overweight and obesity is increasing in developing countries, and even in low-income groups in richer countries. An integrated approach to the causes of unhealthy diet and decreasing levels of physical activity would contribute to reducing the future burden of noncommunicable diseases.

10. For all countries for which data are available, the underlying determinants of noncommunicable diseases are largely the same. Factors that increase the risks of noncommunicable disease include elevated consumption of energy-dense, nutrient-poor foods that are high in fat, sugar and salt; reduced levels of physical activity at home, at school, at work and for recreation and transport; and use of tobacco. Variations in risk levels and related health outcomes among the population are attributed, in part, to the variability in timing and intensity of economic, demographic and social changes at national and global levels. Of particular concern are unhealthy diets, inadequate physical activity and energy imbalances in children and adolescents.

11. Maternal health and nutrition before and during pregnancy, and early infant nutrition may be important in the prevention of noncommunicable diseases throughout the life course. Exclusive breastfeeding for six months and appropriate complementary feeding contribute to optimal physical growth and mental development. Infants who suffer prenatal and possibly, postnatal growth restrictions appear to be at higher risk for noncommunicable diseases in adulthood.

12. Most elderly people live in developing countries, and the ageing of populations has a strong impact on morbidity and mortality patterns. Many developing countries will therefore be faced with an increased burden of noncommunicable diseases at the same time as a persisting burden of infectious diseases. In addition to the human dimension, maintaining the health and functional capacity of the increasing elderly population will be a crucial factor in reducing the demand for, and cost of, health services.

13. Diet and physical activity influence health both together and separately. Although the effects of diet and physical activity on health often interact, particularly in relation to obesity, there are additional health benefits to be gained from physical activity that are independent of nutrition and diet, and there are significant nutritional risks that are unrelated to obesity. Physical activity is a fundamental means of improving the physical and mental health of individuals.

14. Governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages behaviour changes by individuals, families and communities, to make positive, life-enhancing decisions on healthy diets and patterns of physical activity.

15. Noncommunicable diseases impose a significant economic burden on already strained health systems, and inflict great costs on society. Health is a key determinant of development and a precursor of economic growth. The WHO Commission on Macroeconomics and Health has demonstrated the disruptive effect of disease on development, and the importance for economic development of investments in health.[1] Programmes aimed at promoting healthy diets and physical activity for the prevention of diseases are key instruments in policies to achieve development goals.

THE OPPORTUNITY

16. A unique opportunity exists to formulate and implement an effective strategy for substantially reducing deaths and disease worldwide by improving diet and promoting physical activity. Evidence for the links between these health behaviours and later disease and ill-health is strong. Effective interventions to enable people to live longer and healthier lives, reduce inequalities, and enhance development can be designed and implemented. By mobilizing the full potential of the major stakeholders, this vision could become a reality for all populations in all countries.

GOAL AND OBJECTIVES

17. The overall goal of the global strategy on diet, physical activity and health is to promote and protect health by guiding the development of an enabling environment for sustainable actions at individual, community, national and global levels that, when taken together, will lead to reduced disease and death rates related to unhealthy diet and physical inactivity. These actions support the United Nations Millennium Development Goals and have immense potential for public health gains worldwide.

18. The global strategy has four main objectives:

(1) to reduce the risk factors for noncommunicable diseases that stem from unhealthy diets and physical inactivity by means of essential public health action and health-promoting and disease-preventive measures;

(2) to increase the overall awareness and understanding of the influences of diet and physical activity on health and of the positive impact of preventive interventions;

(3) to encourage the development, strengthening and implementation of global, regional, national and community policies and action plans to improve diets and increase physical activity that are sustainable, comprehensive, and actively engage all sectors, including civil society, the private sector and the media;

[1] *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001.

(4) to monitor scientific data and key influences on diet and physical activity; to support research in a broad spectrum of relevant areas, including evaluation of interventions; and to strengthen the human resources needed in this domain to enhance and sustain health.

EVIDENCE FOR ACTION

19. Evidence shows that, when other threats to health are addressed, people can remain healthy into their seventh, eighth and ninth decades, through a range of health-promoting behaviours, including healthy diets, regular and adequate physical activity, and avoidance of tobacco use. Recent research has contributed to understanding of the benefits of healthy diets, physical activity, individual action and population-based public health interventions. Although more research is needed, current knowledge warrants urgent public health action.

20. Risk factors for noncommunicable disease frequently coexist and interact. As the general level of risk factors rises, more people are put at risk. Preventive strategies should therefore aim at reducing risk throughout the population. Such risk reduction, even if modest, cumulatively yields sustainable benefits, which exceeds the impact of interventions restricted to high-risk individuals. Healthy diets and physical activity, together with tobacco control, constitute an effective strategy to contain the mounting threat of noncommunicable diseases.

21. Reports of international and national experts and reviews of the current scientific evidence recommend goals for nutrient intake and physical activity in order to prevent major noncommunicable diseases. These recommendations need to be considered when preparing national policies and dietary guidelines, taking into account the local situation.

22. **For diet,** recommendations for populations and individuals should include the following:

- achieve energy balance and a healthy weight
- limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and towards the elimination of *trans*-fatty acids
- increase consumption of fruits and vegetables, and legumes, whole grains and nuts
- limit the intake of free sugars
- limit salt (sodium) consumption from all sources and ensure that salt is iodized.

23. Physical activity is a key determinant of energy expenditure, and thus is fundamental to energy balance and weight control. Physical activity reduces risk for cardiovascular diseases and diabetes and has substantial benefits for many conditions, not only those associated with obesity. The beneficial effects of physical activity on the metabolic syndrome are mediated by mechanisms beyond controlling excess body weight. For example, physical activity reduces blood pressure, improves the level of high density lipoprotein cholesterol, improves control of blood glucose in overweight people, even without significant weight loss, and reduces the risk for colon cancer and breast cancer among women.

24. **For physical activity,** it is recommended that individuals engage in adequate levels throughout their lives. Different types and amounts of physical activity are required for different health outcomes:

at least 30 minutes of regular, moderate-intensity physical activity on most days reduces the risk of cardiovascular disease and diabetes, colon cancer and breast cancer. Muscle strengthening and balance training can reduce falls and increase functional status among older adults. More activity may be required for weight control.

25. The translation of these recommendations, together with effective measures to prevent and control tobacco use, into a global strategy that leads to regional and national action plans, will require sustained political commitment and the collaboration of many stakeholders. This strategy will contribute to the effective prevention of noncommunicable diseases.

PRINCIPLES FOR ACTION

26. *The world health report 2002* highlights the potential for improving public health through measures that reduce the prevalence of risk factors (most notably the combination of unhealthy diets and physical inactivity) of noncommunicable diseases. The principles set out below guided the drafting of WHO's global strategy on diet, physical activity and health and are recommended for the development of national and regional strategies and action plans.

27. Strategies need to be based on the best available scientific research and evidence; comprehensive, incorporating both policies and action and addressing all major causes of noncommunicable diseases together; multisectoral, taking a long-term perspective and involving all sectors of society; and multidisciplinary and participatory, consistent with the principles contained in the Ottawa Charter for Health Promotion and confirmed in subsequent conferences on health, promotion,[1] and recognizing the complex interactions between personal choices, social norms and economic and environmental factors.

28. A life-course perspective is essential for the prevention and control of noncommunicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age.

29. Strategies to reduce noncommunicable diseases should be part of broader, comprehensive and coordinated public health efforts. All partners, especially governments, need to address simultaneously a number of issues. In relation to diet, these include all aspects of nutrition (for example, both overnutrition and undernutrition, micronutrient deficiency and excess consumption of certain nutrients); food security (accessibility, availability and affordability of healthy food); food safety; and support for and promotion of six months of exclusive breastfeeding. Regarding physical activity, issues include requirements for physical activity in working, home and school life, increasing urbanization, and various aspects of city planning, transportation, safety and access to physical activity during leisure.

30. Priority should be given to activities that have a positive impact on the poorest population groups and communities. Such activities will generally require community-based action with strong government intervention and oversight.

[1] See resolution WHA51.12 (1998).

31. All partners need to be accountable for framing policies and implementing programmes that will effectively reduce preventable risks to health. Evaluation, monitoring and surveillance are essential components of such actions.

32. The prevalence of noncommunicable diseases related to diet and physical activity may vary greatly between men and women. Patterns of physical activity and diets differ according to sex, culture and age. Decisions about food and nutrition are often made by women and are based on culture and traditional diets. National strategies and action plans should therefore be sensitive to such differences.

33. Dietary habits and patterns of physical activity are often rooted in local and regional traditions. National strategies should therefore be culturally appropriate and able to challenge cultural influences and to respond to changes over time.

RESPONSIBILITIES FOR ACTION

34. Bringing about changes in dietary habits and patterns of physical activity will require the combined efforts of many stakeholders, public and private, over several decades. A combination of sound and effective actions is needed at global, regional, national and local levels, with close monitoring and evaluation of their impact. The following paragraphs describe the responsibilities of those involved and provide recommendations deriving from the consultation process.

WHO

35. WHO, in cooperation with other organizations of the United Nations system, will provide the leadership, evidence-based recommendations and advocacy for international action to improve dietary practices and increase physical activity, in keeping with the guiding principles and specific recommendations contained in this strategy.

36. It will hold discussions with the transnational food industry and other parts of the private sector in support of the aims of this global strategy, and of implementing the recommendations in countries.

37. WHO will provide support for implementation of programmes as requested by Member States, and will focus on the following broad, interrelated areas:

- **facilitating the framing, strengthening and updating of regional and national policies** on diet and physical activity for integrated noncommunicable disease prevention
- **facilitating the drafting, updating and implementation of national food-based dietary and physical activity guidelines**, in collaboration with national agencies and drawing upon global knowledge and experience
- **providing guidance to Member States on the formulation of guidelines, norms, standards and other policy-related measures** that are consistent with the objectives of the global strategy
- **identifying and disseminating information on evidence-based interventions, policies and structures** that are effective in promoting healthy diets and optimizing the level of physical activity in countries and communities

- **providing appropriate technical support** to build national capacity in planning and implementing a national strategy and in tailoring it to local circumstances

- **providing models and methods** so that interventions on diet and physical activity constitute an integral component of health care

- **promoting and providing support for training of health professionals in healthy diets and an active life**, either within existing programmes or in special workshops, as an essential part of their curricula

- **providing advice and support to Member States, using standardized surveillance methods and rapid assessment tools** (such as WHO's STEPwise approach to surveillance of risk factors for noncommunicable diseases), in order to measure changes in distribution of risk – including patterns in diet, nutrition and physical activity – and to assess the current situation, trends, and the impact of interventions. WHO, in collaboration with FAO, will provide support to Member States in establishing national nutrition surveillance systems, linked with data on the content of food items

- **advising Member States on ways of engaging constructively with appropriate industries.**

38. WHO, in close collaboration with organizations of the United Nations system and other intergovernmental bodies (FAO, UNESCO, UNICEF, United Nations University and others), research institutes and other partners, will promote and support research in priority areas to facilitate programme implementation and evaluation. This could include commissioning scientific papers, conducting analyses, and holding technical meetings on practical research topics that are essential for effective country action. The decision-making process should be informed by better use of evidence, including health-impact assessment, cost-benefit analysis, national burden-of-disease studies, evidence-based intervention models, scientific advice and dissemination of good practices.

39. It will work with FAO and other organizations of the United Nations system, the World Bank, and research institutes on their evaluation of implications of the strategy for other sectors.

40. The Organization will continue to work with WHO collaborating centres to establish networks for building up capacity in research and training, mobilizing contributions from nongovernmental organizations and civil society, and facilitating coordinated, collaborative research as it pertains to the needs of developing countries in the implementation of this strategy.

Member States

41. The global strategy should foster the formulation and promotion of national policies, strategies and action plans to improve diet and encourage physical activity. National circumstances will determine priorities in the development of such instruments. Because of the great variations in and between different countries, regional bodies should collaborate in formulating regional strategies, which can provide considerable support to countries in implementing their national plans. For maximum effectiveness, countries should adopt the most comprehensive action plans possible.

42. **The role of government is crucial in achieving lasting change in public health.** Governments have a primary steering and stewardship role in initiating and developing the strategy, ensuring that it is implemented and monitoring its impact in the long term.

43. **Governments are encouraged to build on existing structures and processes that already address aspects of diet, nutrition and physical activity.** In many countries, existing national strategies and action plans can be used in implementing this strategy; in others they can form the basis for advancing control of noncommunicable diseases. Governments are encouraged to set up a national coordinating mechanism that addresses diet and physical activity within the context of a comprehensive plan for noncommunicable-disease prevention and health promotion. Local authorities should be closely involved. Multisectoral and multidisciplinary expert advisory boards should also be established. They should include technical experts and representatives of government agencies, and have an independent chair to ensure that scientific evidence is interpreted without any conflict of interest.

44. **Health ministries have an essential responsibility for coordinating and facilitating the contributions of other ministries and government agencies.** Bodies whose contributions should be coordinated include ministries and government institutions responsible for policies on food, agriculture, youth, recreation, sports, education, commerce and industry, finance, transportation, media and communication, social affairs and environmental and urban planning.

45. **National strategies, policies and action plans need broad support.** Support should be provided by effective legislation, appropriate infrastructure, implementation programmes, adequate funding, monitoring and evaluation, and continuing research.

(1) **National strategies on diet and physical activity.** National strategies describe the measures to promote healthy diets and physical activity that are essential to prevent disease and promote health, including those that tackle all aspects of unbalanced diets, including undernutrition and overnutrition. National strategies should include specific goals, objectives, and actions, similar to those outlined in the global strategy. Of particular importance are the elements needed to implement the plan of action, including identification of necessary resources and national focal points (key national institutes); collaboration between the health sector and other key sectors such as agriculture, education, urban planning, transportation and communication; and monitoring and follow-up.

(2) **National dietary guidelines.** Governments are encouraged to draw up national dietary guidelines, taking account of evidence from national and international sources. Such guidelines advise national nutrition policy, nutrition education, other public health interventions and intersectoral collaboration. They may be updated periodically in the light of changes in dietary and disease patterns and evolving scientific knowledge.

(3) **National physical activity guidelines.** National guidelines for health-enhancing physical activity should be prepared in accordance with the goals and objectives of the global strategy and expert recommendations.

46. **Governments should provide accurate and balanced information.** Governments need to consider actions that will result in provision of balanced information for consumers to enable them easily to make healthy choices, and to ensure the availability of appropriate health promotion and education programmes. In particular, information for consumers should be sensitive to literacy levels, communication barriers and local culture, and understood by all segments of the population. In some countries, health-promoting programmes have been designed as a function of such considerations and should be used for disseminating information about diet and physical activity. Some governments already have a legal obligation to ensure that factual information available to consumers enables them to make fully informed choices on matters that may affect their health. In other cases, actions may be specific to government policies. Governments should select the optimal mix of actions in accordance

with their national capabilities and epidemiological profile, which will vary from one country to another.

(1) **Education, communication and public awareness.** A sound basis for action is provided by public knowledge and understanding of the relationship between diet, physical activity and health, of energy intake and output, and healthy choice of food items. Consistent, coherent, simple and clear messages should be prepared and conveyed by government experts, nongovernmental and grass-roots organizations, and the appropriate industries. They should be communicated through several channels and in forms appropriate to local culture, age and gender. Behaviour can be influenced especially in schools, workplaces, and educational and religious institutions, and by nongovernmental organizations, community leaders, and mass media. Member States should form alliances for the broad dissemination of appropriate and effective messages about healthy diet and physical activity. Nutrition and physical activity education and acquisition of media literacy, starting in primary school, are important to promote healthier diets, and to counter food fads and misleading dietary advice. Support should also be provided for action that improves the level of health literacy, while taking account of local cultural and socioeconomic circumstances. Communication campaigns should be regularly evaluated.

(2) **Adult literacy and education programmes.** Health literacy should be incorporated into adult education programmes. Such programmes provide an opportunity for health professionals and service providers to enhance knowledge about diet, physical activity and prevention of noncommunicable diseases and to reach marginalized populations.

(3) **Marketing, advertising, sponsorship and promotion.** Food advertising affects food choices and influences dietary habits. Food and beverage advertisements should not exploit children's inexperience or credulity. Messages that encourage unhealthy dietary practices or physical inactivity should be discouraged, and positive, healthy messages encouraged. Governments should work with consumer groups and the private sector (including advertising) to develop appropriate multisectoral approaches to deal with the marketing of food to children, and to deal with such issues as sponsorship, promotion and advertising.

(4) **Labelling.** Consumers require accurate, standardized and comprehensible information on the content of food items in order to make healthy choices. Governments may require information to be provided on key nutritional aspects, as proposed in the Codex Guidelines on Nutrition Labelling.[1]

(5) **Health claims.** As consumers' interest in health grows, and increasing attention is paid to the health aspects of food products, producers increasingly use health-related messages. Such messages must not mislead the public about nutritional benefits or risks.

47. **National food and agricultural policies should be consistent with the protection and promotion of public health.** Where needed, governments should consider policies that facilitate the adoption of healthy diet. Food and nutrition policy should also cover food safety and sustainable food security. Governments should be encouraged to examine food and agricultural policies for potential health effects on the food supply.

[1] Codex Alimentarius Commission, document CAC/GL 2-1985, Rev. 1-1993.

(1) **Promotion of food products consistent with a healthy diet.** As a result of consumers' increasing interest in health and governments' awareness of the benefits of healthy nutrition, some governments have taken measures, including market incentives, to promote the development, production and marketing of food products that contribute to a healthy diet and are consistent with national or international dietary recommendations. Governments could consider additional measures to encourage the reduction of the salt content of processed foods, the use of hydrogenated oils, and the sugar content of beverages and snacks.

(2) **Fiscal policies.** Prices influence consumption choices. Public policies can influence prices through taxation, subsidies or direct pricing in ways that encourage healthy eating and lifelong physical activity. Several countries use fiscal measures, including taxes, to influence availability of, access to, and consumption of, various foods; and some use public funds and subsidies to promote access among poor communities to recreational and sporting facilities. Evaluation of such measures should include the risk of unintentional effects on vulnerable populations.

(3) **Food programmes.** Many countries have programmes to provide food to population groups with special needs or cash transfers to families for them to improve their food purchases. Such programmes often concern children, families with children, poor people, and people with HIV/AIDS and other diseases. Special attention should be given to the quality of the food items and to nutrition education as a main component of these programmes, so that food distributed to, or purchased by, the families not only provides energy, but also contributes to a healthy diet. Food and cash distribution programmes should emphasize empowerment and development, local production and sustainability.

(4) **Agricultural policies.** Agricultural policy and production often have a great effect on national diets. Governments can influence agricultural production through many policy measures. As emphasis on health increases and consumption patterns change, Member States need to take healthy nutrition into account in their agricultural policies.

48. **Multisectoral policies are needed to promote physical activity.** National policies to promote physical activity should be framed, targeting change in a number of sectors. Governments should review existing policies to ensure that they are consistent with best practice in population-wide approaches to increasing physical activity.

(1) **Framing and review of public policies.** National and local governments should frame policies and provide incentives to ensure that walking, cycling and other forms of physical activity are accessible and safe; transport policies include nonmotorized modes of transportation; labour and workplace policies encourage physical activity; and sport and recreation facilities embody the concept of sports for all. Public policies and legislation have an impact on opportunities for physical activity, such as those concerning transport, urban planning, education, labour, social inclusion, and health-care funding related to physical activity.

(2) **Community involvement and enabling environments.** Strategies should be geared to changing social norms and improving community understanding and acceptance of the need to integrate physical activity into everyday life. Environments should be promoted that facilitate physical activity, and supportive infrastructure should be set up to increase access to, and use of, suitable facilities.

(3) **Partnerships.** Ministries of health should take the lead in forming partnerships with key agencies, and public and private stakeholders in order to draw up jointly a common agenda and workplan aimed at promoting physical activity.

(4) **Clear public messages.** Simple, direct messages need to be communicated on the quantity and quality of physical activity sufficient to provide substantial health benefits.

49. **School policies and programmes should support the adoption of healthy diets and physical activity**. Schools influence the lives of most children in all countries. They should protect their health by providing health information, improving health literacy, and promoting healthy diets, physical activity, and other healthy behaviours. Schools are encouraged to provide students with daily physical education and should be equipped with appropriate facilities and equipment. Governments are encouraged to adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar and fats. Schools should consider, together with parents and responsible authorities, issuing contracts for school lunches to local food growers in order to ensure a local market for healthy foods.

50. **Governments are encouraged to consult with stakeholders on policy**. Broad public discussion and involvement in the framing of policy can facilitate its acceptance and effectiveness. Member States should establish mechanisms to promote participation of nongovernmental organizations, civil society, communities, the private sector and the media in activities related to diet, physical activity and health. Ministries of health should be responsible, in collaboration with other related ministries and agencies, for establishing these mechanisms, which should aim at strengthening intersectoral cooperation at the national, provincial and local levels. They should encourage community participation, and should be part of planning processes at community level.

51. **Prevention is a critical element of health services.** Routine contacts with health-service staff should include practical advice to patients and families on the benefits of healthy diets and increased levels of physical activity, combined with support to help patients initiate and maintain healthy behaviours. Governments should consider incentives to encourage such preventive services and identify opportunities for prevention within existing clinical services, including an improved financing structure to encourage and enable health professionals to dedicate more time to prevention.

(1) **Health and other services.** Health-care providers, especially for primary health care, but also other services (such as social services) can play an important part in prevention. Routine enquiries as to key dietary habits and physical activity, combined with simple information and skill-building to change behaviour, taking a life-course approach, can reach a large part of the population and be a cost-effective intervention. Attention should be given to WHO's growth standards for infants and preschool children which expand the definition of health beyond the absence of overt disease, to include the adoption of healthy practices and behaviours. The measurement of key biological risk factors, such as blood pressure, serum cholesterol and body weight, combined with education of the population and support for patients, helps to promote the necessary changes. The identification of specific high-risk groups and measures to respond to their needs, including possible pharmacological interventions, are important components. Training of health personnel, dissemination of appropriate guidelines, and availability of incentives are key underlying factors in implementing these interventions.

(2) **Involvement with health professional bodies and consumer groups.** Enlisting the strong support of professionals, consumers and communities is a cost-effective way to raise public awareness of government policies, and enhance their effectiveness.

52. **Governments should invest in surveillance, research and evaluation.** Long-term and continuous monitoring of major risk factors is essential. Over time, such data also provide the basis for analyses of changes in risk factors, which could be attributable to changes in polices and strategies. Governments may be able to build on systems already in place, at either national or regional levels. Emphasis should initially be given to standard indicators recognized by the general scientific community as valid measures of physical activity, to selected dietary components, and to body weight in order to compile comparative data at global level. Data that provide insight into within-country patterns and variations are useful in guiding community action. Where possible, other sources of data should be used, for example, from the education, transport, agriculture, and other sectors.

(1) **Monitoring and surveillance.** Monitoring and surveillance are essential tools in the implementation of national strategies for healthy diet and physical activity. Monitoring of dietary habits, patterns of physical activity and interactions between them; nutrition-related biological risk factors and contents of food products; and communication to the public of the information obtained, are important components of implementation. Of particular importance is the development of methods and procedures using standardized data-collection procedures and a common minimum set of valid, measurable and usable indicators.

(2) **Research and evaluation.** Applied research, especially in community-based demonstration projects and in evaluating different policies and interventions, should be promoted. Such research (e.g., into the reasons for physical inactivity and poor diet, and on key determinants of effective intervention programmes), combined with the increased involvement of behavioural scientists, will lead to better informed policies and ensure that a cadre of expertise is created at national and local levels. Equally important is the need to put in place effective mechanisms for evaluating the efficacy and cost-effectiveness of national disease-prevention programmes, and the health impact of policies in other sectors. More information is needed, especially on the situation in developing countries, where programmes to promote healthy diets and physical activity need to be evaluated and integrated into broader development and poverty-alleviation programmes.

53. **Institutional capacity.** Under the ministry of health, national institutions for public health, nutrition and physical activity play an important role in the implementation of national diet and physical activity programmes. They can provide the necessary expertise, monitor developments, help to coordinate activities, participate in collaboration at international level, and provide advice to decision-makers.

54. **Financing national programmes.** Various sources of funding, in addition to the national budget, should be identified to assist in implementation of the strategy. The United Nations Millennium Declaration (September 2000) recognizes that economic growth is limited unless people are healthy. The most cost-effective interventions to contain the epidemic of noncommunicable diseases are prevention and a focus on the risk factors associated with these diseases. Programmes aimed at promoting healthy diets and physical activity should therefore be viewed as a developmental need and should draw policy and financial support from national development plans.

International partners

55. The role of international partners is of paramount importance in achieving the goals and objectives of the global strategy, particularly with regard to issues of a transnational nature, or where the actions of a single country are insufficient. Coordinated work is needed among the organizations of

the United Nations system, intergovernmental bodies, nongovernmental organizations, professional associations, research institutions and private sector entities.

56. The process of preparing the strategy has led to closer interaction with other organizations of the United Nations system, such as FAO and UNICEF, and other partners, including the World Bank. WHO will build on its long-standing collaboration with FAO in implementing the strategy. The contribution of FAO in the framing of agricultural policies can play a crucial part in this regard. More research into appropriate agriculture policies, and the supply, availability, processing and consumption of food will be necessary.

57. Cooperation is also planned with bodies such as the United Nations Economic and Social Council, ILO, UNESCO, WTO, the regional development banks and the United Nations University. Consistent with the goal and objectives of the strategy, WHO will develop and strengthen partnerships, including through the establishment and coordination of global and regional networks, in order to disseminate information, exchange experiences, and provide support to regional and national initiatives. WHO proposes to set up an ad hoc committee of partners within the United Nations system in order to ensure continuing policy coherence and to draw upon each organization's unique strengths. Partners can play an important role in a global network that targets such areas as advocacy, resource mobilization, capacity building and collaborative research.

58. International partners could be involved in implementing the global strategy by:

- contributing to comprehensive intersectoral strategies to improve diet and physical activity, including, for instance, the promotion of healthy diets in poverty-alleviation programmes
- drawing up guidelines for prevention of nutritional deficiencies in order to harmonize future dietary and policy recommendations designed to prevent and control noncommunicable diseases
- facilitating the drafting of national guidelines on diet and physical activity, in collaboration with national agencies
- cooperating in the development, testing and dissemination of models for community involvement, including local food production, nutrition and physical activity education, and raising of consumer awareness
- promoting the inclusion of noncommunicable disease prevention and health promotion policies relating to diet and physical activity in development policies and programmes
- promoting incentive-based approaches to encourage prevention and control of chronic diseases.

59. **International standards**. Public health efforts may be strengthened by the use of international norms and standards, particularly those drawn up by the Codex Alimentarius Commission.[1] Areas for further development could include: labelling to allow consumers to be better informed about the benefits and content of foods; measures to minimize the impact of marketing on unhealthy dietary patterns; fuller information about healthy consumption patterns, including steps to increase the consumption of fruit and vegetables; and production and processing standards regarding the nutritional

[1] See resolution WHA56.23.

quality and safety of products. Involvement of governments and nongovernmental organizations as provided for in the Codex should be encouraged.

Civil society and nongovernmental organizations

60. Civil society and nongovernmental organizations have an important role to play in influencing individual behaviour and the organizations and institutions that are involved in healthy diet and physical activity. They can help to ensure that consumers ask governments to provide support for healthy lifestyles, and the food industry to provide healthy products. Nongovernmental organizations can support the strategy effectively if they collaborate with national and international partners. Civil society and nongovernmental organizations can particularly:

- lead grass-roots mobilization and advocate that healthy diets and physical activity should be placed on the public agenda
- support the wide dissemination of information on prevention of noncommunicable diseases through balanced, healthy diets and physical activity
- form networks and action groups to promote the availability of healthy foods and possibilities for physical activity, and advocate and support health-promoting programmes and health education campaigns
- organize campaigns and events that will stimulate action
- emphasize the role of governments in promoting public health, healthy diets and physical activity; monitor progress in achieving objectives; and monitor and work with other stakeholders such as private sector entities
- play an active role in fostering implementation of the global strategy
- contribute to putting knowledge and evidence into practice.

Private sector

61. The private sector can be a significant player in promoting healthy diets and physical activity. The food industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreation businesses, insurance and banking groups, pharmaceutical companies and the media all have important parts to play as responsible employers and as advocates for healthy lifestyles. All could become partners with governments and nongovernmental organizations in implementing measures aimed at sending positive and consistent messages to facilitate and enable integrated efforts to encourage healthy eating and physical activity. Because many companies operate globally, international collaboration is crucial. Cooperative relationships with industry have already led to many favourable outcomes related to diet and physical activity. Initiatives by the food industry to reduce the fat, sugar and salt content of processed foods and portion sizes, to increase introduction of innovative, healthy, and nutritious choices; and review of current marketing practices, could accelerate health gains worldwide. Specific recommendations to the food industry and sporting-goods manufacturers include the following:

- promote healthy diets and physical activity in accordance with national guidelines and international standards and the overall aims of the global strategy

- limit the levels of saturated fats, *trans*-fatty acids, free sugars and salt in existing products
- continue to develop and provide affordable, healthy and nutritious choices to consumers
- consider introducing new products with better nutritional value
- provide consumers with adequate and understandable product and nutrition information
- practise responsible marketing that supports the strategy, particularly with regard to the promotion and marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, especially to children
- issue simple, clear and consistent food labels and evidence-based health claims that will help consumers to make informed and healthy choices with respect to the nutritional value of foods
- provide information on food composition to national authorities
- assist in developing and implementing physical activity programmes.

62. Workplaces are important settings for health promotion and disease prevention. People need to be given the opportunity to make healthy choices in the workplace in order to reduce their exposure to risk. Further, the cost to employers of morbidity attributed to noncommunicable diseases is increasing rapidly. Workplaces should make possible healthy food choices and support and encourage physical activity.

FOLLOW-UP AND FUTURE DEVELOPMENTS

63. WHO will report on progress made in implementing the global strategy and in implementing national strategies, including the following aspects:

- patterns and trends of dietary habits and physical activity and related risk factors for major noncommunicable diseases
- evaluation of the effectiveness of policies and programmes to improve diet and increase physical activity
- constraints or barriers encountered in implementation of the strategy and the measures taken to overcome them
- legislative, executive, administrative, financial or other measures taken within the context of this strategy.

64. WHO will work at global and regional levels to set up a monitoring system and to design indicators for dietary habits and patterns of physical activity.

CONCLUSIONS

65. Actions, based on the best available scientific evidence and the cultural context, need to be designed, implemented and monitored with WHO's support and leadership. Nonetheless, a truly multisectoral approach that mobilizes the combined energy, resources and expertise of all global stakeholders is essential for sustained progress.

66. Changes in patterns of diet and physical activity will be gradual, and national strategies will need a clear plan for long-term and sustained disease-preventive measures. However, changes in risk factors and in incidence of noncommunicable diseases can occur quite quickly when effective interventions are made. National plans should therefore also have achievable short-term and intermediate goals.

67. The implementation of this strategy by all those involved will contribute to major and sustained improvements in people's health.

Eighth plenary meeting, 22 May 2004
A57/VR/8

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FIFTY-SEVENTH WORLD HEALTH ASSEMBLY WHA57.10

Agenda item 12.7 22 May 2004

Road safety and health

The Fifty-seventh World Health Assembly,

Recalling resolution WHA27.59 (1974), which noted that road traffic accidents caused extensive and serious public health problems, that coordinated international efforts were required, and that WHO should provide leadership to Member States;

Having considered the report on road safety and health;[1]

Welcoming United Nations General Assembly resolution 58/9 on the global road-safety crisis;

Noting with appreciation the adoption of resolution 58/289 by the United Nations General Assembly inviting WHO to act as a coordinator on road safety issues within the United Nations system, drawing upon expertise from the United Nations regional commissions;

Recognizing the tremendous global burden of mortality resulting from road traffic crashes, 90% of which occur in low- and middle-income countries;

Acknowledging that every road user must take the responsibility to travel safely and respect traffic laws and regulations;

Recognizing that road traffic injuries constitute a major but neglected public health problem that has significant consequences in terms of mortality and morbidity and considerable social and economic costs, and that in the absence of urgent action this problem is expected to worsen;

Further recognizing that a multisectoral approach is required successfully to address this problem, and that evidence-based interventions exist for reducing the impact of road traffic injuries;

Noting the large number of activities on the occasion of World Health Day 2004, in particular, the launch of the first world report on traffic injury prevention,[2]

1. CONSIDERS that the public health sector and other sectors – government and civil society alike – should actively participate in programmes for the prevention of road traffic injury through injury surveillance and data collection, research on risk factors of road traffic injuries, implementation and evaluation of interventions for reducing road traffic injuries, provision of prehospital and trauma

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[1] Document A57/10.

[2] *World report on road traffic injury prevention*. Geneva, World Health Organization, 2004.

care and mental-health support for traffic-injury victims, and advocacy for prevention of road traffic injuries;

2. URGES Member States, particularly those which bear a large proportion of the burden of road traffic injuries, to mobilize their public-health sectors by appointing focal points for prevention and mitigation of the adverse consequences of road crashes who would coordinate the public-health response in terms of epidemiology, prevention and advocacy, and liaise with other sectors;

3. ACCEPTS the invitation by the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions;

4. RECOMMENDS Member States:

(1) to integrate traffic injuries prevention into public health programmes;

(2) to assess the national situation concerning the burden of road traffic injury, and to assure that the resources available are commensurate with the extent of the problem;

(3) if they have not yet done so, to prepare and implement a national strategy on prevention of road traffic injury and appropriate action plans;

(4) to establish government leadership in road safety, including designating a single agency or focal point for road safety or through another effective mechanism according to the national context;

(5) to facilitate multisectoral collaboration between different ministries and sectors, including private transportation companies, communities and civil society;

(6) to strengthen emergency and rehabilitation services;

(7) to raise awareness about risk factors in particular the effects of alcohol abuse, psychoactive drugs and the use of mobile phones while driving;

(8) to take specific measures to prevent and control mortality and morbidity due to road traffic crashes, and to evaluate the impact of such measures;

(9) to enforce existing traffic laws and regulations, and to work with schools, employers and other organizations to promote road-safety education to drivers and pedestrians alike;

(10) to use the forthcoming world report on traffic injury prevention as a tool to plan and implement appropriate strategies for prevention of road traffic injury;

(11) to ensure that ministries of health are involved in the framing of policy on the prevention of road traffic injuries;

(12) especially developing countries, to legislate and strictly enforce wearing of crash helmets by motorcyclists and pillion riders, and to make mandatory both provision of seat belts by automobile manufacturers and wearing of seat belts by drivers;

(13) explore the possibilities to increase funding for road safety, including through the creation of a fund;

5. REQUESTS the Director-General:

(1) to collaborate with Member States in establishing science-based public health policies and programmes for implementation of measures to prevent road traffic injuries and mitigate their consequences;

(2) to encourage research to support evidence-based approaches for prevention of road traffic injuries and mitigation of their consequences;

(3) to facilitate the adaptation of effective measures to prevent traffic injury that can be applied in local communities;

(4) to provide technical support for strengthening systems of prehospital and trauma care for victims of road traffic crashes;

(5) to collaborate with Member States, organizations of the United Nations system, and nongovernmental organizations in order to develop capacity for injury prevention;

(6) to maintain and strengthen efforts to raise awareness of the magnitude and prevention of road traffic injuries;

(7) to organize regular meetings of experts to exchange information and build capacity;

(8) to report progress made on the promotion of road safety and traffic injury prevention in Member States to the Sixtieth World Health Assembly in May 2007.

Eighth plenary meeting, 22 May 2004
A57/VR/8

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CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES

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Geneva, May 10th 2004

To: World Health Organization (WHO) member country delegations
Re: 57th World Health Assembly

Médecins Sans Frontières (MSF) would like to share with you some of our concerns regarding the WHO prequalification project, an issue that is relevant for agenda items 12.1. (HIV/AIDS) and 12.12 (Quality and safety of medicines) of the 57th World Health Assembly.

Achieving the goal of access to essential medicines for all requires globally accepted mechanisms for ensuring that these medicines - generic and originator products - are of quality.

What is the WHO prequalification project?
It is one of WHO's key functions to improve access to quality and affordable medicines. The WHO prequalification pilot project was set up in 2001 by the United Nations (WHO, UNICEF, UNFPA and UNAIDS, supported by the World Bank) to fulfill this mandate.

The specific tasks of the prequalification project include:

a) to assess the quality of essential drugs, produced by generic and brand name companies, through the evaluation of product dossiers submitted by companies, and
b) to assess manufacturing sites to comply with Good Manufacturing Practices.

These evaluations are performed by international teams consisting of drug regulatory experts from 20 countries.

The prequalification project publishes and regularly updates a list of the drugs and manufacturing sites it has validated.

What are the achievements to date?
Three years after being set up, the WHO prequalification project has dramatically improved access to quality essential medicines, particularly AIDS drugs. More than 90 products - 50 of them generics - have been prequalified to date. The project has also contributed to improving standards of generic producers and helped enhance countries' capacity to produce quality medicines.

Why is the WHO prequalification project so important?
The final responsibility for drug evaluation and approval is in the hands of national drug regulatory authorities, but the existence of a reliable, international reference

facilitates the task of national drug authorities and procurers. The WHO evaluations inform countries' drug approval processes thus reducing the burden of product evaluations and facilitating fast track registration of essential medicines. This is particularly important for countries that lack regulatory capacity and resources for assessing drugs.

Not only governments but also other providers of medical care such as MSF and other NGOs need assurance of the quality of the drugs they use. The example of antiretroviral medicines illustrates the vital role prequalification plays in improving access to affordable medicines: today, MSF is providing ARV treatment for over 13,000 people living HIV/AIDS in more than 20 countries. Our ability to increase the number of patients on treatment has largely depended on the majority of our programmes being able to make use of WHO prequalified fixed-dose combinations of ARVs - that is, pills containing two or three AIDS drugs in one tablet.

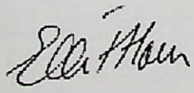
Is the WHO prequalification project equipped to face the growing challenges of AIDS, TB and malaria?

WHO's prequalification work must be adequately supported. If this is not the case, much-needed essential medicines will not be assessed in a prompt manner. This will have the undesirable effect of limiting the sources of medicines rather than expanding them - in particular when funding agencies require that drugs are WHO prequalified. It could also lead to a discrepancy between internationally recommended treatment guidelines and the availability of these particular treatments. This has already been the case with artemisinin-based malaria treatment. The prequalification project should therefore become more proactive so that treatments that are recommended and needed are assessed as soon as possible.

> **→ MSF urges the WHA to reinforce the WHO prequalification pilot project by ensuring that it is a fully-fledged permanent function of the WHO Essential Drugs and Medicines Policy Programme (EDM). In order to face current health challenges, the WHO prequalification project needs to be strengthened and expanded. We call upon the WHA to ensure that additional technical, financial and human resources are made available.**

Please do not hesitate to contact me or the relevant MSF representative in your country for more details on any of the above.

Sincerely



Ellen 't Hoen
Interim Director
Campaign for Access to Essential Medicines
Médecins Sans Frontières

COM H. 82

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 16.1

A57/24
15 April 2004

Regular budget allocations to regions

Report by the Secretariat

BACKGROUND

1. At its 101st session (1998), the Executive Board considered a report of a special group it had established to review the Constitution, including regional arrangements.[1] Among the group's recommendations was a proposal to change the way in which regional budgets were determined. The group noted that the then current practice was for the Director-General to propose to the Health Assembly an allocation of the budget between regions based primarily on historical precedents. It expressed concern that the amounts had changed little over time, and recommended instead the introduction of a model which would guide the way in which the allocation should be made.

2. The Board and subsequently the Health Assembly endorsed this recommendation.[2] Resolution WHA51.31 recommended that regional, intercountry and country allocations should for the most part be guided by a model that:

- draws upon UNDP's Human Development Index, possibly adjusted for immunization coverage
- incorporates population statistics of countries calculated according to commonly accepted methods, such as "logarithmic smoothing"
- can be implemented gradually so that the reduction for any region would not exceed 3% per year and would be spread over a period of three bienniums.

3. The Director-General was requested to present a thorough evaluation of the model to the Fifty-seventh World Health Assembly for the purpose of continuing response to health needs and equitable allocation of the resources of WHO. In preparation for the report, input was sought from the six regional committee sessions held in September 2003 (see paragraphs 16 and 17). The matter was also considered by the Board at its 113th session.[3]

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[1] See document EB101/1998/REC/1, Annex 3.

[2] Resolution EB101.R10, and resolution WHA51.31 (attached as Annex 1).

[3] See document EB113/2004/REC/2, summary records of the ninth and tenth meetings.

EVALUATION

Financial outcome

4. The programme for the model[1] was run, using the latest available data, during preparation of the budget proposals for each of the three bienniums from 2000 to 2005. The results were percentage shares of the regular budget (excluding headquarters) for each region based on the latest Human Development Index. The actual budget proposals made by the Director-General to the Health Assembly, however, modified this outcome related to the provisions and discretions set out in resolution WHA51.31.

- For the biennium 2000-2001, the Director-General adjusted the model also to take account of immunization coverage. However, in the light of fluctuations and uncertainties surrounding some immunization-coverage statistics, that variable was not used in the bienniums 2002-2003 or 2004-2005.

- The maximum reduction foreseen in paragraph 3(c) of resolution WHA51.31 of 3% per annum per region was implemented in the first biennium, 2000-2001. Thereafter, the maximum reduction for any region was limited to 2% per year in the biennium 2002-2003, and to 1.5% per year in the biennium 2004-2005. This decision was taken in part to reflect the fact that regions had to absorb cost increases in these bienniums, in addition to the decreases in regular budget allocations resulting from application of the model.

- Least developed countries were not subject to any decrease.

5. The Health Assembly subsequently adopted appropriation resolutions on the basis of the regular budget proposals for the six regions which were put forward by the Director-General in each of the three bienniums concerned.[2]

6. The result in financial terms was an increase in the share of the African Region from about 28% of regular budget allocations in 1998-1999 to around 34% in 2004-2005. The share of the European Region increased from about 9% to 10% over the same period. The allocations of the other four regions were reduced in order to pay for these increases.

7. Table 1 below shows the cumulative impact of the model in financial terms, including a transfer of US$ 12 million from the headquarters regular budget to benefit the two regions concerned over the six-year period, which was not required by the model.[3] It also compares these regular budget transfers with the total growth in regional allocations of extrabudgetary resources for which the model is not used at all. Information on these latter resources is available only for the four-year period 2000 to 2003 inclusive.

[1] The model is detailed in document EB102/4.

[2] Resolutions WHA52.20, WHA54.20 and WHA56.32.

[3] Full details are given in Annex 2.

TABLE 1. REGULAR BUDGET AND EXTRABUDGETARY EXPENDITURE: CUMULATIVE CHANGE

Office	Regular budget	Extrabudgetary expenditure
	Cumulative change pursuant to resolution WHA51.31 2000 to 2005	Cumulative change 2000 to 2003
	US$ million	US$ million
Headquarters	(12)	439
Africa	84	286
The Americas[a]	(23)	-
South-East Asia	(18)	69
Europe	9	45
Eastern Mediterranean	(20)	143[b]
Western Pacific	(20)	34

[a] In the Region of the Americas, extrabudgetary resources handled by WHO have declined slightly. Most extrabudgetary resources are accounted for under the Pan American Health Organization; figures have been relatively stable in recent years.

[b] Includes expenditure under the Iraq oil-for-food programme.

Programme impact

8. The model guided only the overall allocation to a region. It was not used to determine the individual allocation to countries within a region (although such figures are generated by the model). Those were based on judgements made by the Regional Director and Director-General, and debates in the regional committees. The Western Pacific Region however applied the model in part to assist in decisions on country allocation.

9. The model did not apply to the headquarters regular budget. Indeed, it is not designed for such an outcome since it relies on the grouping of countries into regions for apportioning the funding.

10. The two regions receiving the additional regular budget funds used them mostly to strengthen programmes in countries. The regions that had to make regular budget reductions did so both in regional offices and in country programmes. Because extrabudgetary resources are generally less flexible as to use than regular budget funds, regions whose regular budget allocations had been reduced were sometimes obliged to make cuts in areas where no source of funding other than the regular budget was available.

The model

11. With respect to the key parameters of the model, the Human Development Index is a summary measure of human development that is calculated using three basic dimensions, each one contributing an equal weight: (1) a long and healthy life, as measured by life expectancy at birth; (2) knowledge, as

measured by the adult literacy rate (with two thirds weight) and the combined primary, secondary and tertiary gross enrolment ratio (with one third weight); and (3) a decent standard of living, as measured by gross domestic product per capita (purchasing power party to US$).

12. Table 2 below shows the evolution of the Human Development Index by region (adjusted to reduce the effect of large populations) for the period 1997 to 2001 (the indices used for the actual calculations). The index has a potential range from zero to one, one being the highest level of development possible.

TABLE 2. HUMAN DEVELOPMENT INDEX: EVOLUTION BY REGION

Region	1997	2001	Percentage
Europe	0.816	0.841	3.0
The Americas	0.763	0.778	2.0
Western Pacific	0.741	0.757	2.2
Eastern Mediterranean	0.644	0.688	3.8
South-East Asia	0.580	0.609	4.9
Africa	0.460	0.462	0.5

13. The model moved the pre-1998 distribution of the regular budget towards the inverse of the above distribution, after allowing for various constraints. Europe remained the region with the smallest regular budget, Africa with the largest. However, both these regions were shown by the model to be relatively underfunded, hence the reallocations.

14. With respect to population, the adjustment to reduce the effect of large populations (the "adjusted log population squared" (ALPS)) method produces a dampening of the effect of raw population size, with the equivalent point (the intersection between the two curves) being around a population of 45 million. In other words, countries with a population greater than 45 million receive proportionally less under the ALPS method, whereas countries with less than 45 million would receive proportionally more.

15. The population adjustment has a major impact on the model. The Western Pacific and South-East Asia regions' share of the total would more than double if raw population data were used, whereas that of the African and European regions and of the Region of the Americas would halve.

VIEWS OF THE REGIONAL COMMITTEES

16. The debates in the regional committees in September 2003 indicate that the four regions whose allocations were reduced now favour discontinuing use of the model at the end of the six-year period. The committees concerned passed resolutions to this effect.

17. At the Regional Committee for Africa delegates expressed their appreciation of resolution WHA51.31; the additional funds would have an impact on meeting the health needs of the populations

in the Region. They suggested that the resolution should be fully implemented in the shortest possible time and supported an evaluation of the model. The Regional Committee for Europe discussed the question of regional allocations under the regular budget and commented on the need for a fair and equitable apportionment.

POINTS FOR CONSIDERATION

18. The pattern of distribution of WHO resources after 2005 will need to evolve in accordance with developments in global health requirements and priorities. At issue is whether the model set out in resolution WHA51.31 should, for the most part, continue to guide the allocation process between regions. It is clear from the debate in the regional committees and at the Executive Board that the four regions which have experienced regular budget reductions under resolution WHA51.31 now wish to end its use.

19. Since 2000-2001 the Organization has adopted a results-based approach to budgeting. This calls for a greater focus on priorities and expected results than the distribution of resources. An integrated approach has also been pursued for the budget (regular budget and voluntary contributions). As an example it may be noted that both the African and European regions received four times more in extrabudgetary resources in the four years to 2003 than they will under the regular budget reallocation in the six years to 2005.

20. The Director-General reported to the Executive Board at its 113th session on adjustments he intends to make to the extrabudgetary resources for 2004-2005 so as to allocate more funding to regional and country levels.[1] In the biennium 2002-2003, approximately 56% of total resources (67% of regular budget and 50% of extrabudgetary resources) were allocated to regional and country offices. The aim is to achieve an apportionment of 70% of total resources in the biennium 2004-2005 and 75% in 2006-2007. Each 5% of movement in total resources represents approximately US$ 125 million at present budget levels.

21. The Director-General would suggest therefore that the focus in the coming years be on real needs and on implementation in countries. Resource allocation would no longer be guided by the model contained in resolution WHA51.31, but would be based on clear results-based budgeting that covers both regular budget and extrabudgetary resources.

ACTION BY THE HEALTH ASSEMBLY

22. The Health Assembly is invited to consider the evaluation contained in the above report. In the light of its conclusion, a decision or resolution could be prepared for adoption.

[1] Document EB113/2004/REC/2, summary record of the first meeting, section 1.

ANNEX 1

WHA51.31 Regular budget allocations to regions

The Fifty-first World Health Assembly,

Recalling resolution EB99.R24 on regional arrangements within the context of WHO reform;

Noting that regular budget allocations to regions have not been based on objective criteria but rather on the basis of history and previous practice;

Concerned that, as a result, each region's share of such allocations has remained largely unchanged since the Organization's inception;

Recalling that two basic principles governing the work of WHO are those of equity and support to countries in greatest need, and stressing the need for the Organization to apply principles which Member States have adopted collectively;

Noting that other organizations of the United Nations system, particularly UNICEF, have already adopted models based on objective criteria to ensure a more equitable distribution of programme resources to countries,

1. THANKS the Executive Board and its special group for the review of the Constitution for the comprehensive study of allocations from the regular budget to regions;[1]

2. REAFFIRMS Article 55 of the Constitution which stipulates that it is the Director-General's prerogative to prepare and submit to the Board the budget estimates of the Organization, and requests her or him to take into account the discussion on this matter during the Fifty-first World Health Assembly when preparing future programme budgets;

3. RECOMMENDS that, globally, the regional, intercountry and country allocation in future programme budgets approved by the Health Assembly should for the most part be guided by a model that:

(a) draws upon UNDP's Human Development Index, possibly adjusted for immunization coverage;

(b) incorporates population statistics of countries calculated according to commonly accepted methods, such as "logarithmic smoothing";

(c) can be implemented gradually so that the reduction for any region would not exceed 3% per year and would be spread over a period of three bienniums;

[1] Document EB101/1998/REC/1, Annex 3.

4. REQUESTS the Director-General to present a thorough evaluation of that model to the Fifty-seventh World Health Assembly for the purpose of continuing response to health needs and equitable allocation of the resources of WHO;

5. DECIDES that the model should be applied in a flexible, rather than a mechanical, manner so as to minimize, to the extent possible, any adverse effects on countries whose budgetary allocations will be reduced;

6. REQUESTS the Director-General:

(1) to ensure that during the 2000-2001 biennium all least developed countries will be guaranteed that their regular budget allocation will not be less than that of the 1998-1999 budget by use of the 2% transfer from global and interregional activities foreseen in resolution WHA48.26 and by casual income if available; and to continue in subsequent bienniums to give high priority to protect the situation of least developed countries;

(2) while emphasizing that any additional funds resulting from the present process of reallocation should flow to country level, to enable regions to determine for themselves within the terms of the Constitution the partition between country, intercountry and regional office budgets;

(3) to monitor and evaluate closely the working and the impact of this new process in the light, in particular, of changes in international social and economic conditions, and to report annually to the Executive Board and the Health Assembly with a view to any further refinement, development or modification in order to ensure response to health needs and the equitable allocation of the resources of WHO;

(4) to report to the Executive Board at its 103rd session and to the Fifty-second World Health Assembly on the details of the model and the regional, intercountry and country allocations to be applied to the 2000-2001 biennium;

(5) further to report to the Executive Board at its 103rd session and to the Fifty-second World Health Assembly within the context of the request in paragraph 4 above, on the use of extrabudgetary allocations in regional, intercountry and country programmes in the previous three bienniums.

(Tenth plenary meeting, 16 May 1998 –
Committee B, sixth report)

ANNEX 2

REGULAR BUDGET ALLOCATIONS TO REGIONS 2000-2001 TO 2004-2005

(thousands of US dollars)

The Americas

Approved regular budget 1998-1999 = 82 686

	Unchanged budget	Theoretical budget using model	Reduction due to model	Other budget changes	Budget actually adopted
2000-2001	82 686	77 725	(4 961)	0	77 725
2002-2003	82 686	74 682	(8 004)	0	74 682
2004-2005	82 686	72 491	(10 195)	736	73 227
Total resources 2000-2005	248 058	224 898	(23 160)	736	225 634

South-East Asia

Approved regular budget 1998-1999 = 99 251

	Unchanged budget	Theoretical budget using model	Reduction due to model	Other budget changes	Budget actually adopted
2000-2001	99 251	95 595	(3 656)	0	95 595
2002-2003	99 251	93 022	(6 229)	0	93 022
2004-2005	99 251	91 169	(8 082)	2 285	93 454
Total resources 2000-2005	297 753	279 786	(17 967)	2 285	282 071

Eastern Mediterranean

Approved regular budget 1998-1999 = 90 249

	Unchanged budget	Theoretical budget using model	Reduction due to model	Other budget changes	Budget actually adopted
2000-2001	90 249	85 869	(4 380)	0	85 869
2002-2003	90 249	83 390	(6 859)	0	83 390
2004-2005	90 249	81 584	(8 665)	765	82 349
Total resources 2000-2005	270 747	250 843	(19 904)	765	251 608

Western Pacific
Approved regular budget 1998-1999 = 80 279

	Unchanged budget	Theoretical budget using model	Reduction due to model	Other budget changes	Budget actually adopted
2000-2001	80 279	75 889	(4 390)	0	75 889
2002-2003	80 279	73 262	(7 017)	0	73 262
2004-2005	80 279	71 305	(8 974)	731	72 036
Total resources 2000-2005	240 837	220 456	(20 381)	731	221 187

Africa
Approved regular budget 1998-1999 = 157 413

	Unchanged budget	Theoretical budget using model	Increase due to model	Other budget changes	Budget actually adopted
2000-2001	157 413	176 822	19 409	0	176 822
2002-2003	157 413	186 472	29 059	0	186 472
2004-2005	157 413	192 718	35 305	(983)	191 735
Total resources 2000-2005	472 239	556 012	83 773	(983)	555 029

Europe
Approved regular budget 1998-1999 = 49 823

	Unchanged budget	Theoretical budget using model	Increase due to model	Other budget changes	Budget actually adopted
2000-2001	49 823	51 699	1 876	0	51 699
2002-2003	49 823	52 771	2 948	0	52 771
2004-2005	49 823	54 332	4 509	450	54 782
Total resources 2000-2005	149 469	158 802	9 333	450	159 252

Headquarters

Approved regular budget 1998-1999 = 282 953

	Unchanged budget	Theoretical unchanged budget[a]	Reduction[b]	Other budget changes	Budget actually adopted
2000-2001	282 953	279 055	(3 898)	0	279 055
2002-2003	282 953	279 055	(3 898)	0	279 055
2004-2005	282 953	279 055	(3 898)	(527)	278 528[c]
Total resources 2000-2005	848 859	837 165	(11 694)	(527)	836 638

[a] The model does not produce any change to the headquarters budget.

[b] The reduction resulted from a recommendation to the Health Assembly by the Director-General to contribute to the transfer of resources.

[c] The total budget adopted for 2004-2005 also included US$ 34 million for miscellaneous expenditure. This amount was not apportioned by the Health Assembly between regions and headquarters.

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ComH-82

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 19

A57/30
19 April 2004

Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

Report by the Director-General

1. A number of studies on the health conditions of the Arab population in the occupied Palestinian territories have suggested the increasing presence of mental health distress among the people of the occupied Palestinian territories, higher malnutrition rates, decreased immunization coverage in specific areas, increased prevalence of low birth-weight, and higher anaemia rates among pregnant women in the past two years. Although prevalence of malnutrition among children between the ages of six months and five years has been reduced since June 2002, partly because of increased and sustained food assistance and physical access to health services, childhood malnutrition and micronutrient deficiency are major concerns for some groups. The organizations responsible for the studies include UNRWA, the nongovernmental organizations Save the Children and CARE, and the Ministry of Health of the Palestinian Authority.

2. A household survey on access to health services in the occupied Palestinian territories was carried out at the end of 2002 by WHO, in collaboration with the Palestinian Ministry of Health and Al-Quds University.[1] Findings from the districts of Nablus, Ramallah, Hebron, Rafah and Gaza indicated that more than 50% of the surveyed population changed their health-service provider between March and December 2002. In almost 90% of instances the change was related to restrictions on mobility. Of those seeking health-care services, 3% to 5% were not able to obtain them. Of pregnant women, 22% could not access some antenatal services. Of the surveyed population, 13% reportedly suffered problems related to their mental and psychological health. The study group cannot be considered as representative of the whole population of the occupied Palestinian territories, but the findings indicate the health-related problems faced by people in the districts included in the study.

3. According to information provided by UNRWA, immunization coverage has deteriorated somewhat since 2000. In some specific areas the percentage of children fully immunized has dropped from 100% to between 84% and 67%.

4. Following the 2003 review of the United Nations Humanitarian Action Plan, a United Nations Consolidated Appeal for 2004 was drawn up in October 2003 with a proposed budget of US$ 305 million, including US$ 26.6 million for health-sector activities. The analysis contained in the

[1] Access to health services in the West Bank and Gaza Strip. Facts and figures. Ministry of Health of the Palestinian Authority, World Health Organization, Al-Quds University, 2003.

Consolidated Appeal shows that the severe restrictions on movement of Palestinian people and goods is causing economic difficulties for much of the population. Military incursions, closures and curfews, the withholding of Palestinian tax revenues, land confiscation and levelling, house demolition and the construction of the "barrier" have disrupted economic life and generated unprecedented levels of unemployment. As a result, poverty, food insecurity and nutritional vulnerability are widespread.

5. The Palestinian health system is divided between Gaza and the West Bank and is severely short of funds. UNRWA, which provides health care for the refugee population, the nongovernmental organizations working in the area and even private health-service providers are, in general, underfunded or facing a critical financial situation. In this context, assistance from the international community and decentralization of health services in order to adapt to the constraints on the mobility of health workers and patients, have made possible the provision of essential health services in peripheral areas, thus avoiding a further deterioration of the health status of the Palestinian population.

6. Resolution WHA56.5 requested the institution of a fact-finding committee on the deterioration of the health situation in the occupied Palestinian territory. Under the current circumstances it has not yet proved possible to enable such a committee to undertake its role.

7. WHO, at both regional and global levels, has responded to the health needs of the Palestinian population for over 50 years, in conjunction with UNRWA. Through the WHO Regional Office for the Eastern Mediterranean the Organization assists the Palestinian Ministry of Health with a programme which focuses on several specific health interventions. Further, it is working with populations in the West Bank and Gaza Strip through the Special Technical Assistance Programme, established in 1994 to support the health of Palestinian people by promoting a health system based on equity, effectiveness and sustainability, and by addressing the broader social, economic, environmental and cultural determinants of health, particularly those which are most affected by the Israeli-Palestinian conflict. It maintains a direct link with, and provides support to, the Ministry of Health of the Palestinian Authority, and communicates and collaborates actively with the Ministry of Health of Israel.

8. During 2003, WHO continued to provide support to the Palestinian Ministry of Health for the development of a strategic response to health needs. In collaboration with the governments of Italy and of the United States of America, WHO leads the Health Inforum, a body which collects and disseminates information about the health situation.[1] Health Inforum aims to support the decision-making capacities of the Health Sector Working Group, and focuses on consolidating data on health and health sector activities, on the status of health facilities and on the availability of medical supplies.

9. With the Ministry of Health and other stakeholders, WHO has formulated a general plan for mental health and is implementing a programme financed by the European Commission to improve delivery of mental health services. The Organization is also participating in a review of the Palestinian health sector together with the European Commission, the World Bank, and the Government of Italy and of the United Kingdom of Great Britain and Northern Ireland.

10. WHO maintains its coordination role in the Health Sector Working Group, as technical adviser, where it represents the other organizations of the United Nations system. Within the same framework, thematic subgroups on nutrition, mental health, health management information and reproductive health have been established. WHO co-chairs, with the Ministry of Health of the Palestinian

[1] www.healthinforum.org.

Authority, bi-monthly emergency-support coordination meetings in the West Bank and Gaza Strip, and recently at district level. Participants at these coordination meetings have analysed the impact of the separation "barrier" on the health of the Palestinian population. One challenge is to ensure that United Nations personnel, including WHO staff, are able to enter and work in the occupied Palestinian territories in a predictable and timely manner.

11. WHO is taking steps to secure additional funding for health actions in the occupied Palestinian territories, in particular to meet with the urgent health needs of the Palestinian people. WHO is committed to supporting effective communication between Palestinian and Israeli health professionals, nongovernmental organizations and health institutions. WHO seeks to create platforms for dialogue and to take advantage of every opportunity to encourage open discussion and cooperation. A "cities partnership" project is currently being implemented involving European, Palestinian and Israeli cities that focuses on health and social action. WHO has also drawn up, together with the United Nations Office for Humanitarian Affairs, UNICEF, UNDP, UNRWA, WFP and UNFPA, an advocacy strategy for health in the occupied Palestinian territories, and is implementing specific initiatives which promote health and human rights.

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WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 20

A57/31
19 April 2004

Collaboration within the United Nations system and with other intergovernmental organizations

Report by the Secretariat

1. WHO's relations with the United Nations are a requirement based on Article 69 of the Constitution as well as a formal agreement dating back to 1948. WHO also has formal framework agreements with some specialized agencies and other intergovernmental organizations. This report does not detail all current collaboration with the United Nations system and other intergovernmental organizations. Rather, it concentrates on major events since the last report to the Health Assembly;[1] other reports on specific collaboration are provided for relevant technical agenda items.

UNITED NATIONS GENERAL ASSEMBLY, FIFTY-EIGHTH SESSION

2. An unprecedented number of health-related resolutions were adopted by the United Nations General Assembly during its fifty-eighth session in 2003. In resolution 58/236, the United Nations General Assembly welcomed the WHO/UNAIDS "3 by 5" initiative. In resolution 58/237, the General Assembly called upon the international community to support the development of manufacturing capacity of insecticide-treated nets in Africa and the transfer of technology required to make insecticide-treated nets more effective and long-lasting. It also urged the pharmaceutical industry to take note of the increasing need to provide effective combination treatment for malaria and to form alliances and partnerships so that all people at risk can benefit from prompt, affordable, quality treatment. Resolution 58/179 called on States to implement national strategies for access to comprehensive treatment, care and support for all individuals infected and affected by pandemics such as HIV/AIDS, tuberculosis and malaria. In resolution 58/173, the General Assembly requested that the international community continue to assist developing countries in promoting the full realization of the right to the enjoyment of the highest standard of physical and mental health. In addition, there were a number of resolutions with significant health components.[2]

UNITED NATIONS ECONOMIC AND SOCIAL COUNCIL

3. The substantive session of the United Nations Economic and Social Council was held in Geneva from 30 June to 25 July 2003. During the high-level segment devoted to rural development in developing countries, WHO provided input on the subject of inequities and inequalities in rural health

[1] Document A56/46.

[2] United Nations General Assembly resolutions 58/5, 58/9, 58/134, 58/156, 58/157, 58/217, 58/246.

care. WHO also hosted a Ministerial Roundtable Breakfast discussion on the Organization's extensive coordination efforts with the United Nations system and the public health community at large during the outbreak of severe acute respiratory syndrome.

UNITED NATIONS FIELD SECURITY MANAGEMENT SYSTEM

4. The fifty-eighth session of the United Nations General Assembly also discussed United Nations field security, identifying interested parties and responsibilities within the field security management system. WHO adheres strictly to the United Nations recommendations: the roles and responsibilities of WHO Representatives, who are accountable for the safety and security of employed personnel and their eligible dependants, are outlined in the Organization's security policy and are being reflected in job descriptions, terms of reference and performance appraisals.

INTERAGENCY COORDINATION THROUGH THE UNITED NATIONS SYSTEM CHIEF EXECUTIVES BOARD FOR COORDINATION AND THE UNITED NATIONS DEVELOPMENT GROUP

5. During its April 2003 session, the United Nations System **Chief Executives Board for Coordination**[1] continued the follow up of the Millennium Summit, focusing on sustainable development. The Board endorsed a note on HIV/AIDS, with particular attention to the issue of reducing the cost of antiretroviral treatment. Other matters, deliberated during the October 2003 session, included emerging global issues relating to multilateralism, financing for development and reporting on the United Nations Millennium Declaration together with more specific items, including the triple threat posed by HIV/AIDS, food insecurity and weakened capacity for governance.

6. In its capacity as a member agency of the **United Nations Development Group,** WHO participated actively in more than 15 working groups concerned with improving the operational aspects of the United Nations offices at country level in support of the Millennium Development Goals; coordinated actions at country level have been shaped according to the guiding principles of harmonization and simplification. In addition, policy development and guidance for country teams have been improved in the following areas: human rights, countries in transition, HIV/AIDS, food security and governance, joint programming, the Common Country Assessment and United Nations Development Assistance Framework Guidelines, reporting on progress towards the Millennium Development Goals at the country level and the role of United Nations agencies in support of national poverty reduction strategies.

HIGHLIGHTS OF INTERAGENCY COLLABORATION

7. **Poliomyelitis eradication.** In January 2004, United Nations Secretary-General Kofi Annan addressed a ministerial meeting in Geneva, co-hosted by WHO and UNICEF together with the ministers of health of the six countries of highest priority for stopping the transmission of poliovirus globally. WHO has also worked with the World Bank, Rotary International, the Bill & Melinda Gates Foundation and the United Nations Foundation in order to establish an innovative financing

[1] Formerly ACC.

mechanism for procuring oral poliovirus vaccine for poliomyelitis eradication campaigns in Nigeria and Pakistan. WHO is currently working with the United Nations Office for the Coordination of Humanitarian Affairs to include poliomyelitis eradication in the Common Humanitarian Action Plan. WHO also worked closely with the Organization of the Islamic Conference (OIC) in support of the adoption by the Conference's 57 Member States of a landmark resolution on poliomyelitis eradication at the Tenth Islamic Summit Conference, held in Putrajaya, Malaysia, in October 2003.

8. **International outbreak response.** The Global Outbreak Alert and Response Network (GOARN) was set up by WHO to improve the coordination of international outbreak response. Since its inception, GOARN has responded to 34 events in 26 countries and has grown to a partnership of 120 institutions and networks, including United Nations and intergovernmental organizations. GOARN played a critical role in the rapid containment of the outbreak of severe acute respiratory syndrome by immediately dispatching multinational teams to the field and developing virtual networks of clinicians and epidemiologists to improve treatment and control of the virus. GOARN was also mobilized rapidly in response to the avian influenza outbreak, providing Viet Nam and Thailand with expertise in epidemiology, clinical diagnosis and management, virology and logistics.

9. **Communicable diseases.** In its capacity as a lead agency of Partners for Parasite Control, WHO has managed to involve new partners – the World Bank, UNICEF, WFP and the Schistosomiasis Control Initiative, funded by the Bill & Melinda Gates Foundation – in order to reach the target of regular deworming by 2010 of at least 75% of school-age children at risk of morbidity. Partners for Parasite Control assisted more than one million children in 2003. WHO is also working with the "anchor unit" of the World Bank's Human Development Network to promote deworming activities in the FRESH Start initiative (Focusing Resources on Effective School Health). WHO also collaborates with the Office International des Epizooties and FAO, providing support on surveillance, prevention and control in connection with zoonotic diseases, including severe acute respiratory syndrome, avian influenza, rabies and brucellosis.

10. **Health in emergencies.** During the launch of the 2004 interagency Consolidated Appeals Process, WHO called on Member States to invest as a matter of urgency in health systems for 45 million children, women and men caught up in the world's deadliest crises. WHO is committed both to greater harmonization of policy procedures and collective competencies through interagency coordination and to bringing health action to the forefront of humanitarian interventions.

11. WHO is making progress on a systematic analysis of the health needs of children in emergency settings. In connection with this work, WHO and UNICEF called a meeting on child health in complex emergencies in 2003. WHO co-chairs the Inter-Agency Standing Committee Task Force on Gender and Humanitarian Assistance. The Organization also helps to ensure a global culture of – and a capacity for – crisis preparedness, especially in the health sector. To this end, WHO participates in the Inter-Agency Standing Committee mechanisms dealing with contingency planning, preparedness and natural disasters.

12. **United Nations Ad Hoc Interagency Task Force on Tobacco Control.** Comprising 17 United Nations bodies, the United Nations Ad Hoc Interagency Task Force on Tobacco Control was established in 1999 by the Secretary-General of the United Nations in order to galvanize a joint United Nations response. Tobacco control can only be effective with the involvement of the different sectors of society. This was emphasized in the WHO Framework Convention on Tobacco Control and is an important aspect of the mission of the Tobacco Free Initiative. At the last meeting of the Task Force – held at the World Bank's headquarters in Washington, DC on 21 and 22 October 2003 – members pledged to involve the United Nations Development Group system in order to improve intersectoral

cooperation between Task Force members at country level. They also stressed the importance of linking tobacco with poverty, development and the Millennium Development Goals.

13. **Partnership for Safe Motherhood.** WHO was invited to host the secretariat for the newly established Partnership for Safe Motherhood and Newborn Health whose steering committee currently comprises 21 members and includes the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, WHO, the World Bank, UNICEF and UNFPA as permanent members. Total membership of the Partnership exceeds 35 and is made up of international and regional organizations, multilateral and bilateral agencies and nongovernmental organizations.

14. **Collaboration with UNAIDS for the HIV Vaccine Initiative.** United Nations HIV vaccine activities are managed within the joint WHO/UNAIDS HIV Vaccine Initiative, hosted in WHO, with core budget and staff provided by UNAIDS. The Initiative's mission, performed with a focus on developing countries, consists of promoting the development and evaluation of HIV-preventive vaccines, and addressing issues of future access.

15. **Health technology and pharmaceuticals.** The AIDS Medicines and Diagnostics Service is the operational arm of the "3 by 5" initiative. Established in November 2003, it ensures that developing countries have access to quality antiretroviral medicines and diagnostic tools at the best prices. The service aims to help countries to buy products for the treatment and monitoring of HIV/AIDS, and to forecast and manage their supply and delivery. In addressing the AIDS treatment gap in developing countries, the AIDS Medicines and Diagnostics Service builds on years of work by WHO, the World Bank, UNICEF, UNAIDS and the global health community, as well as some more recent initiatives, such as that by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

16. **Prequalification project.** Since the beginning of 2001, WHO – together with partners including UNICEF, UNFPA, UNAIDS, Roll Back Malaria and the Global Drug Facility, and with support from the World Bank – has been managing the United Nations Pilot Procurement, Quality and Sourcing Project, which aims to provide access to HIV/AIDS, tuberculosis and malaria products of acceptable quality. To date, more than 444 products have either been received and assessed or are in the process of assessment for HIV/AIDS, tuberculosis and malaria; very few products have passed assessment.

17. **Millennium Development Goals (MDGs).** During the period 2003-2004, two meetings took place with the MDG Task Force 5 (working group on access to medicines). A detailed set of recommendations and a series of commissioned papers were agreed at an MDG Task Force meeting in December 2003. WHO has actively worked as a member of the United Nations Development Group to ensure consistency of messages and to provide input into policy discussions on the health-related MDGs, in addition to being the focal point for initiatives such as the United Nations Millennium Project and the Global Governance Initiative of the World Economic Forum. WHO, together with the World Bank, is also acting as secretariat for the High Level Forum on Health, Nutrition and Population-Related MDGs. The High Level Forum provides an opportunity for informal discussions between donors, technical agencies and developing countries on progress towards achieving the MDGs. At its first meeting in Geneva on 8 and 9 January 2004, the Forum concentrated on the need to increase the flow of aid to developing countries over the next 10 to 15 years. The Forum will hold a maximum of four meetings, the next being later in 2004, probably in Africa.

EXAMPLES OF INTERAGENCY COLLABORATION AT REGIONAL AND COUNTRY LEVELS

18. **Africa.** The Health Strategy of the New Partnership for Africa's Development (NEPAD) calls for a more coordinated effort by international partners, in collaboration with African governments, to eradicate preventable diseases and promote good health on the continent. WHO is promoting the NEPAD Health Strategy with a view to establishing health as an integral component of Africa's development programme. WHO is also involved in discussions on tackling critical issues relating to staff shortages and migration. WHO's proposal of establishing health and social affairs desks within the regional economic communities has been adopted. WHO is also collaborating with the International Organization for Migration to establish a database on health professionals.

19. **Europe.** Over the last year, WHO has been increasingly involved in collaborative activities with the World Bank thematic group on health, nutrition, population and poverty. This collaboration is particularly strong at country level: in Eastern Europe, for example, in 2003 WHO and the World Bank worked very closely on a health transformation programme in several countries, including Turkey. In the Russian Federation, collaboration involved both initiatives to combat tuberculosis and HIV/AIDS and work in the area of pharmaceuticals. During the last year, the European Observatory on Health Systems, in partnership with the World Bank and the European Investment Bank, has collaborated on issues like health and European enlargement and social and voluntary health insurance. In relation to the **European Union**, a series of high-level meetings have reaffirmed the priority areas for cooperation, especially within the WHO/European Union strategic partnership. The partnership focuses on the health-related Millennium Development Goals and diseases of poverty (HIV/AIDS, tuberculosis and malaria) by means of the European and Developing Countries Clinical Trials Partnership. The Council of European Union Health Ministers has continuously been updated on the epidemics of severe acute respiratory syndrome and avian influenza. WHO will provide technical input into the European centre for disease control and prevention, which will be formally established in 2005. New perspectives for cooperation are being opened up in the areas of eHealth and pharmaceuticals with the Directorates-General of InfoSociety and Enterprise. The Financial and Administrative Framework Agreement between the European Commission and WHO has been signed and will greatly facilitate future collaboration.

20. **South-East Asia.** A cooperative Memorandum of Agreement was signed in July 2003 between the WHO Regional Office for South-East Asia and the United Nations Office on Drugs and Crime for an effective regional response to HIV vulnerability. WHO also signed a Memorandum of Understanding with the International Federation of Red Cross and Red Crescent Societies in order to encourage collaboration to ensure that Members States' needs receive an effective health system response in the following areas: prevention and control of communicable diseases (including HIV/AIDS), promotion of voluntary non-remunerated blood donations, and collaboration on preparedness and response in relation to health emergencies and disasters.

21. **Western Pacific.** WHO has further strengthened its collaboration and partnership with members of the United Nations family and other intergovernmental organizations in the Western Pacific Region. Significant events over the last year include collaboration with the Asian Development Bank on control of severe acute respiratory syndrome and with FAO on control of highly pathogenic avian influenza, and the joint WHO/UNICEF/UNFPA workshop on the progress of maternal mortality reduction together with a consultation for the development of the adolescent sexual and reproductive health regional strategy.

22. **The Americas.** A high-level meeting with representatives of ILO, UNESCO, WHO, the World Bank, UNICEF, UNDP, UNFPA, UNAIDS and the United Nations Office on Drugs and Crime was held in Washington, DC in June 2003. The purpose of the meeting was to strengthen the policy dialogue on HIV/AIDS with government leaders in order to counter discrimination against people living with HIV/AIDS and strengthen HIV prevention among adolescents and vulnerable populations. One outcome of this meeting was the establishment of a Regional Interagency Coordinating Committee on HIV/AIDS for Latin America and the Caribbean. The Committee has coordinated formulation and execution of projects backed by the Global Fund to Fight AIDS, Tuberculosis and Malaria together with three rounds of subregional negotiations for the reduction of prices for antiretroviral agents, laboratory supplies and diagnostic kits. In addition, a Regional Interagency Coordinating Committee Task Force, focusing on maternal mortality and morbidity reduction in Latin America and the Caribbean, was launched in February 2004. The Task Force, which involves WHO, the World Bank, UNICEF, UNFPA, Family Care International, the Population Council, the Inter-American Development Bank and USAID, signed a Joint Statement of Support for Maternal Mortality and Morbidity Reduction. The Task Force has developed a consensus strategy for the next 10 years and identified five priority areas for action.

23. **Eastern Mediterranean.** Since the last World Health Assembly, the WHO Regional Office for the Eastern Mediterranean has signed several Memoranda of Understanding with partners such as the International Federation of Red Cross and Red Crescent Societies, the Economic Commission for Africa, the Common Market for Eastern and Southern Africa, and the Arab Red Crescent societies. WHO cooperated with the World Bank in accomplishing a joint United Nations/World Bank needs assessment mission in Iraq following the recent war in that country. The assessment report was prepared as a strategic document for the health sector, enabling it to identify the relevant needs, priorities and financial requirements. WHO has, in close coordination and cooperation with all other United Nations bodies and other interested parties, established an effective coordination and resource mobilization mechanism in the health sector to cope with the aftermath of the recent war. WHO chaired the Health Sector Working Group and, jointly with other sister organizations, the Health Sector Contingency Plan was developed; available resources of other agencies involved under the health sector were pooled and additional resources thus mobilized. The effective coordination mechanism established by WHO with the assistance of other partners was a key factor in achieving control of cholera and measles outbreaks during the crisis.

ACTION BY THE HEALTH ASSEMBLY

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

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WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 19

A57/30
19 April 2004

Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

Report by the Director-General

1. A number of studies on the health conditions of the Arab population in the occupied Palestinian territories have suggested the increasing presence of mental health distress among the people of the occupied Palestinian territories, higher malnutrition rates, decreased immunization coverage in specific areas, increased prevalence of low birth-weight, and higher anaemia rates among pregnant women in the past two years. Although prevalence of malnutrition among children between the ages of six months and five years has been reduced since June 2002, partly because of increased and sustained food assistance and physical access to health services, childhood malnutrition and micronutrient deficiency are major concerns for some groups. The organizations responsible for the studies include UNRWA, the nongovernmental organizations Save the Children and CARE, and the Ministry of Health of the Palestinian Authority.

2. A household survey on access to health services in the occupied Palestinian territories was carried out at the end of 2002 by WHO, in collaboration with the Palestinian Ministry of Health and Al-Quds University.[1] Findings from the districts of Nablus, Ramallah, Hebron, Rafah and Gaza indicated that more than 50% of the surveyed population changed their health-service provider between March and December 2002. In almost 90% of instances the change was related to restrictions on mobility. Of those seeking health-care services, 3% to 5% were not able to obtain them. Of pregnant women, 22% could not access some antenatal services. Of the surveyed population, 13% reportedly suffered problems related to their mental and psychological health. The study group cannot be considered as representative of the whole population of the occupied Palestinian territories, but the findings indicate the health-related problems faced by people in the districts included in the study.

3. According to information provided by UNRWA, immunization coverage has deteriorated somewhat since 2000. In some specific areas the percentage of children fully immunized has dropped from 100% to between 84% and 67%.

4. Following the 2003 review of the United Nations Humanitarian Action Plan, a United Nations Consolidated Appeal for 2004 was drawn up in October 2003 with a proposed budget of US$ 305 million, including US$ 26.6 million for health-sector activities. The analysis contained in the

[1] Access to health services in the West Bank and Gaza Strip. Facts and figures. Ministry of Health of the Palestinian Authority, World Health Organization, Al-Quds University, 2003.

Consolidated Appeal shows that the severe restrictions on movement of Palestinian people and goods is causing economic difficulties for much of the population. Military incursions, closures and curfews, the withholding of Palestinian tax revenues, land confiscation and levelling, house demolition and the construction of the "barrier" have disrupted economic life and generated unprecedented levels of unemployment. As a result, poverty, food insecurity and nutritional vulnerability are widespread.

5. The Palestinian health system is divided between Gaza and the West Bank and is severely short of funds. UNRWA, which provides health care for the refugee population, the nongovernmental organizations working in the area and even private health-service providers are, in general, underfunded or facing a critical financial situation. In this context, assistance from the international community and decentralization of health services in order to adapt to the constraints on the mobility of health workers and patients, have made possible the provision of essential health services in peripheral areas, thus avoiding a further deterioration of the health status of the Palestinian population.

6. Resolution WHA56.5 requested the institution of a fact-finding committee on the deterioration of the health situation in the occupied Palestinian territory. Under the current circumstances it has not yet proved possible to enable such a committee to undertake its role.

7. WHO, at both regional and global levels, has responded to the health needs of the Palestinian population for over 50 years, in conjunction with UNRWA. Through the WHO Regional Office for the Eastern Mediterranean the Organization assists the Palestinian Ministry of Health with a programme which focuses on several specific health interventions. Further, it is working with populations in the West Bank and Gaza Strip through the Special Technical Assistance Programme, established in 1994 to support the health of Palestinian people by promoting a health system based on equity, effectiveness and sustainability, and by addressing the broader social, economic, environmental and cultural determinants of health, particularly those which are most affected by the Israeli-Palestinian conflict. It maintains a direct link with, and provides support to, the Ministry of Health of the Palestinian Authority, and communicates and collaborates actively with the Ministry of Health of Israel.

8. During 2003, WHO continued to provide support to the Palestinian Ministry of Health for the development of a strategic response to health needs. In collaboration with the governments of Italy and of the United States of America, WHO leads the Health Inforum, a body which collects and disseminates information about the health situation.[1] Health Inforum aims to support the decision-making capacities of the Health Sector Working Group, and focuses on consolidating data on health and health sector activities, on the status of health facilities and on the availability of medical supplies.

9. With the Ministry of Health and other stakeholders, WHO has formulated a general plan for mental health and is implementing a programme financed by the European Commission to improve delivery of mental health services. The Organization is also participating in a review of the Palestinian health sector together with the European Commission, the World Bank, and the Government of Italy and of the United Kingdom of Great Britain and Northern Ireland.

10. WHO maintains its coordination role in the Health Sector Working Group, as technical adviser, where it represents the other organizations of the United Nations system. Within the same framework, thematic subgroups on nutrition, mental health, health management information and reproductive health have been established. WHO co-chairs, with the Ministry of Health of the Palestinian

[1] www.healthinforum.org.

Authority, bi-monthly emergency-support coordination meetings in the West Bank and Gaza Strip, and recently at district level. Participants at these coordination meetings have analysed the impact of the separation "barrier" on the health of the Palestinian population. One challenge is to ensure that United Nations personnel, including WHO staff, are able to enter and work in the occupied Palestinian territories in a predictable and timely manner.

11. WHO is taking steps to secure additional funding for health actions in the occupied Palestinian territories, in particular to meet with the urgent health needs of the Palestinian people. WHO is committed to supporting effective communication between Palestinian and Israeli health professionals, nongovernmental organizations and health institutions. WHO seeks to create platforms for dialogue and to take advantage of every opportunity to encourage open discussion and cooperation. A "cities partnership" project is currently being implemented involving European, Palestinian and Israeli cities that focuses on health and social action. WHO has also drawn up, together with the United Nations Office for Humanitarian Affairs, UNICEF, UNDP, UNRWA, WFP and UNFPA, an advocacy strategy for health in the occupied Palestinian territories, and is implementing specific initiatives which promote health and human rights.

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WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 18.2

A57/29
25 March 2004

Rules of Procedure of the World Health Assembly: amendment to Rule 72

Report by the Secretariat

1. At its 112th session the Executive Board adopted resolution EB112.R1 amending several of its rules of procedure and recommending a resolution to the Health Assembly which proposes inter alia to amend Rule 72 of the Health Assembly's Rules of Procedure, so as to change the majority required to appoint the Director-General. The recommended resolution also deals with gender inequality in the texts contained in the *Basic Documents*, following the approach taken in other international organizations of the United Nations system.

2. The resolution adopted by the Board was in response to resolution WHA54.22 in which the Health Assembly requested the Board to review its working methods in order to ensure that they are effective, efficient and transparent, and to ensure improved participation of Member States in its proceedings. As requested by the Health Assembly, the Board established an open-ended working group to consider the question in depth.

3. The proposed change to Rule 72 arose from a review by the Ad hoc open-ended working group to review the working methods of the Executive Board of the process for nomination of the Director-General. Article 31 of the WHO Constitution provides that the Director-General shall be appointed by the Health Assembly on the nomination of the Board. Rule 52 of the Board's Rules of Procedure sets forth the nomination process in the Board[1] and Rules 108 and 110 of the Health Assembly's Rules of Procedure set forth the appointment process for the Director-General in the Health Assembly upon receiving the Board's nomination. The majority required for nomination of a candidate as Director-General by the Board, and for the decision by the Health Assembly on whether to accept the Board's nomination, is currently dealt with in general terms in Rule 43 and Rule 73 of the Rules of Procedure of the Board and of the Health Assembly, respectively. In each case the decision is to be taken by a majority of those present and voting.

4. However, the open-ended group considered that, although the nomination of a candidate as Director-General could remain as a decision taken by a majority of the members present and voting in the Board, the decision by the Health Assembly whether to accept the nomination should be subject to more than just a majority of the Member States present and voting. The Board accepted the group's proposal to recommend to the Health Assembly that it amend Rule 72 of the Health Assembly's Rules of Procedure so as to include "the appointment of the Director-General" as one of the questions listed in that rule requiring a two-thirds majority of the Members present and voting.

[1] See also Rule 109 of the Rules of Procedure of the World Health Assembly.

ACTION BY THE HEALTH ASSEMBLY

5. The Health Assembly is invited to consider the draft resolution contained in resolution EB112.R1.

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WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 18.1

A57/28
8 April 2004

Agreement with the Office International des Epizooties

Report by the Secretariat

1. The Office International des Epizooties (OIE) is an intergovernmental organization established in 1924. OIE, which currently has 165 Member Countries, maintains relations with more than 20 international organizations, including WHO.

2. A previous agreement establishing relations between OIE and WHO was approved by resolution WHA14.50 (1961). The agreement was revised in 2003 to take into account a number of recent developments of shared concern. Food safety became a formal area of OIE activity in 2001. The emergence of such zoonotic diseases as bovine spongiform encephalopathy and the related variant Creutzfeldt-Jakob disease, severe acute respiratory syndrome, and avian influenza, has drawn renewed attention to the animal health component of consequential new diseases in humans. These developments have underscored the need for closer collaboration between the two organizations in the surveillance, prevention, and control of zoonotic diseases.

3. A revised agreement reflecting these developments was endorsed by the OIE International Committee at its 71st session in May 2003. By virtue of Article 6, its entry into force is subject to the approval of the Health Assembly.

ACTION BY THE HEALTH ASSEMBLY

4. The Health Assembly is invited to approve the revised agreement with OIE, attached as Annex.

ANNEX

AGREEMENT BETWEEN THE OFFICE INTERNATIONAL DES EPIZOOTIES (OIE) AND THE WORLD HEALTH ORGANIZATION (WHO)

The World Health Organization (hereinafter referred to as WHO) and the Office International des Epizooties (hereinafter referred to as the OIE) wishing to co-ordinate their efforts for the promotion and improvement of veterinary public health (VPH) and food security and safety, and to collaborate closely for this purpose

Have agreed to the following:

Article 1

1.1 WHO and the OIE agree to cooperate closely in matters of common interest pertaining to their respective fields of competence as defined by their respective constitutional instruments and by the decisions of their Governing Bodies.

Article 2

2.1 WHO shall transmit relevant resolutions of the World Health Assembly and the recommendations of relevant WHO consultations, workshops and other official WHO meetings to OIE for the purpose of circulating them to OIE Member Countries.

2.2 The OIE shall transmit the recommendations and resolutions of its International Committee as well as the recommendations of relevant OIE consultations, workshops and other official OIE meetings to WHO for the purpose of circulating them to WHO Member States.

2.3 These resolutions and recommendations sent for the consideration of the respective bodies of the two Organizations (hereinafter referred to as the Parties) shall form the basis for coordinated international action between the two Parties.

Article 3

3.1 Representatives of WHO shall be invited to attend the meetings of the International Committee and Regional Conferences of OIE and to participate without vote in the deliberations of these bodies with respect to items on their agenda in which WHO has an interest.

3.2 Representatives of OIE shall be invited to attend the meetings of the Executive Board and of the World Health Assembly and Regional Committees of WHO and to participate without vote in the deliberations of these bodies with respect to items on their agenda in which OIE has an interest.

3.3 Appropriate arrangements shall be made by agreement between the Director-General of WHO and the Director-General of OIE for participation of WHO and OIE in other meetings of a non-private character convened under their respective auspices which consider matters in which the other party has an interest; this especially involves those meetings leading to the definition of norms and standards.

3.4 The two Parties agree to avoid holding meetings and conferences dealing with matters of mutual interest without prior consultation with the other party.

Article 4

WHO and OIE shall collaborate in areas of common interest particularly by the following means:

4.1. Reciprocal exchange of reports, publications and other information, particularly the timely exchange of information on zoonotic and foodborne disease outbreaks. Special arrangements will be concluded between the two Parties to coordinate the response to outbreaks of zoonotic or/and foodborne diseases of recognized or potential international public health importance.

4.2 Organizing on both a regional and a world-wide basis meetings and conferences on zoonoses, food-borne diseases and related issues such as animal feeding practices and anti-microbial resistance related to the prudent use of anti-microbials in animal husbandry and their containment/control policies and programmes .

4.3 Joint elaboration, advocacy and technical support to national, regional or global programmes for the control or elimination of major zoonotic and food-borne diseases or emerging/ re-emerging issues of common interest.

4.4 Promoting and strengthening, especially in developing countries, VPH education, operationalization of VPH and effective co-operation between the public health and animal health/veterinary sectors.

4.5 International promotion and coordination of research activities on zoonoses, VPH and food safety.

4.6 Promoting and strengthening collaboration between the network of OIE Reference Centres and Laboratories and that of WHO Collaborating Centres and Reference Laboratories to consolidate their support to WHO Member States and OIE Member Countries on issues of common interest.

Article 5

5.1 WHO and OIE will, in the course of the preparation of their respective programmes of work, exchange their draft programmes for comment.

5.2 Each party will take into account the recommendations of the other in preparing its final programme for submission to its governing body.

5.3 WHO and OIE will conduct one annual coordinating meeting of high level officials from headquarters and/or regional representation.

5.4 The two Parties should devise administrative arrangements necessary to implement these policies, such as the sharing of experts, common organization of joint scientific and technical meetings, joint training of health and veterinary personnel.

Article 6

6.1 The present Agreement shall enter into force on the date on which it is signed by the Director-General of WHO and the Director-General of the OIE, subject to the approval of the International Committee of the OIE and the World Health Assembly.

6.2 This Agreement may be modified by mutual consent expressed in writing. It may also be terminated by either party by giving 6 months' notice in writing to the other party.

Article 7

7.1 This Agreement supersedes the Agreement between the WHO and OIE adopted by WHO on 4 August 1960 and by the OIE on 8 August 1960.

Adopted by WHO on 18 December 2002 and the OIE on 26 May 2003

Dr D.L. Heymann,
Executive Director
Communicable Diseases

Dr B. Vallat
Director-General

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Com H. 82.

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 16.2

A57/25
15 April 2004

Programme budget 2002-2003

Performance assessment report: summary of initial findings

Note by the Secretariat

1. The assessment of 2002-2003 programme budget performance is part of a biennial monitoring and evaluation cycle and focuses on the delivery of the programme budget. It assesses the contribution of each WHO office to expected results, and overall achievement of the expected results by the whole Organization. A full report will be submitted to the Executive Board at its 115th session.[1] The present document summarizes some of the findings.

2. WHO first introduced results-based management in the Programme budget for the financial period 2000-2001. Since then, application of results-based management has been furthered throughout WHO with each subsequent programme-budget cycle. These efforts have met with considerable success and are seen as a positive step in building a focus on results, improving the targeting of resources and achieving greater accountability. At the same time, various challenges remain to be addressed if results-based management practices are to be applied consistently across organizational levels and areas of work.

GREATER DIALOGUE AND COLLABORATION BETWEEN ORGANIZATIONAL LEVELS

3. Changes in preparation of the proposed programme budget, requiring a more collaborative approach, have facilitated dialogue among the levels of the Organization. With greater input from the country offices, regional offices have worked with headquarters in drafting the proposed programme budget. Country input was based on national health strategies and priorities and the priorities for WHO action as identified in WHO Country Cooperation Strategies or equivalent strategic planning processes. The regional offices consolidated individual country inputs, identifying commonalities to be included in the proposed programme budget. This iterative process has allowed for better communication and coordination between the various levels, while respecting the differences among regions and countries within agreed Organization-wide objectives and strategies.

[1] An initial draft, in English, is available on request.

FOCUS ON ACCOUNTABILITY AND IMPROVED MANAGEMENT

4. WHO's governing bodies, including the regional committees, and WHO partners and donors have commended the Organization's move to establish results-based budgeting within a broader framework of results-based management. For the first time, through performance monitoring, evaluation and reporting on expected results, the governing bodies are able to "visualize" results to which the Organization is committed. As a result of adopting results-based management, WHO is seen as being a more transparent and accountable organization. Furthermore, senior staff are increasingly gearing management to results, drawing on, and applying, lessons learnt during implementation.

ENSURING THAT ORGANIZATION-WIDE EXPECTED RESULTS INFORM THE DEVELOPMENT OF OFFICE-SPECIFIC EXPECTED RESULTS AND WORKPLANS

5. Implicit in the collaborative planning process is a shared responsibility for achieving the Organization-wide expected results and the assumption that the different levels and offices will undertake the activities necessary to ensure their achievement. This assumption has not held across all areas of work. Although the expected results are adopted by the governing bodies for the Organization as a whole, regional and country offices may give priority to locally defined needs, while at global level Organization-wide commitments may be considered synonymous with achievements at headquarters. This perspective may have an impact on joint planning among organizational levels in support of Organization-wide expected results, and on resource allocation, programme implementation, and reporting.

DEVELOPING MEANINGFUL ORGANIZATION-WIDE EXPECTED RESULTS

6. WHO's results-based management is reflected in the programme budget, which sets out what the Organization collectively intends to accomplish over the biennium. The nature of the Organization and geographical scope of its programmes require Organization-wide expected results that are sufficiently broad to accommodate the unique needs of Member States while providing a level of specificity that clearly expresses desired results and facilitates accountability. This balance is not easy to achieve. Expected results may be formulated in an abstract way that makes measurement of their achievement difficult and does not provide sufficient guidance for drawing up workplans.

ENSURING CONSISTENCY BETWEEN STRATEGIC AND OPERATIONAL PLANNING

7. The programme budget provides a strategic framework, and sets out common objectives, for WHO's work. However, the timeframe for preparation of the proposed programme budget at headquarters may mean that regional and country offices draw up their operational plans before, or at the same time as, the proposed programme budget is finalized. This conjuncture may affect the consistency and linkage between strategic and operational planning and necessitate adjustments in the planning cycles.

8. The challenge of ensuring consistency between strategic and operational planning is further illustrated during resource allocation. The Organization-wide expected results and the integrated

budget for areas of work are vertical in nature, cutting across the three levels of the Organization, whereas budget allocations are horizontal: that is, they are allotted by organizational level. It is therefore important to ensure that actual allocations are commensurate with the resources required to achieve the contribution of regional and country offices to the collectively agreed upon Organization-wide expected results.

TACKLING CONSTRAINTS DERIVING FROM ORGANIZATIONAL CULTURE

9. Results-based management as implemented in WHO implies a greater degree of interdependence across organizational levels and among offices; an element of uniformity of processes; greater responsibility; and a greater acceptance and compliance with Organization-wide business rules than previously had been the case. Similarly, there is a demand for greater accountability, and a need to demonstrate results and to strengthen the focus within and across programmes. Further, programmes are expected to adopt a "planning, performance monitoring, evaluation, and reporting culture" that does not favour ad hoc programming and ad hoc mobilization of resources. The challenge of overcoming resistance to change is real and remains a significant factor in the introduction and effective application of results-based management.

LESSONS LEARNT IN IMPLEMENTING THE PROGRAMME BUDGET 2002-2003

10. An examination of the performance analysis by area of work highlights certain commonalities across the 35 areas and are applicable to the Organization as a whole.

Cause-and-effect logic underpinning the programme budget

11. WHO objectives, Organization-wide expected results and indicators are sometimes drafted with insufficient attention to their logical connection, by persons other than those charged with their implementation. As a result, workplans do not necessarily support the achievement of the Organization-wide expected results and WHO objectives. Greater attention should be given to these linkages when preparing the proposed programme budget.

Improved use of indicators

12. Similarly, indicators are sometimes poorly chosen and drafted or require data that are incomplete or unavailable, which affects reporting on the achievement of Organization-wide expected results. In general, measurable targets and baseline data for the indicators were absent. Indicators, targets and baseline data have therefore been refined in order to measure more accurately the achievement of the Organization-wide expected results in the Programme budget 2004-2005.

13. In order to avoid similar problems when preparing the proposed programme budget 2006-2007, a practical, detailed guide for drafting expected results, indicators, targets, and baseline data has been prepared and disseminated throughout the Organization, and training courses and seminars have been held for regional and headquarters staff. Indicators are being reviewed as part of the process to prepare the proposed programme budget so as to ensure their technical quality and practicality.

Closer coordination between organizational levels

14. WHO's results-based management, with its single programme budget, requires close coordination among the three levels of the Organization. This coordination has been identified as a crucial factor for success in many of the areas of work. Coordination is being strengthened through a greater emphasis on joint planning, performance monitoring, and evaluation. Preparation of the proposed programme budget 2006-2007 will maximize input from countries through greater reliance on the Country Cooperation Strategy. The joint planning process will identify what is required from countries, regions, and headquarters in order to achieve the Organization's expected results, and will ensure that collectively agreed upon contributions of each office are reflected in their workplans.

Programme budget as a basis for mobilization, prioritization and allocation of funds

15. In order to function as a single instrument for the whole Organization the programme budget should integrate different sources of funding. The breakdown for the regular budget and for extrabudgetary resources needs to be the basis for mobilization, prioritization and allocation of funds across areas of work and by organizational level.

16. In conformity with WHO's Financial Rules and appropriation resolution WHA56.32, the allocation of the regular budget and of extrabudgetary resources across areas of work will be adjusted and resources shifted as necessary throughout the biennium 2004-2005 in order to ensure that the total amount planned by area of work is made available.

Monitoring and reporting for more effective programme management

17. Results-based management also requires clearly defined roles and a robust monitoring and reporting system. Specific responsibilities for the development and implementation of results-based management instruments will be defined for each level of the Organization. The framework for performance monitoring quality assurance, evaluation and reporting will be revised in order to provide programme managers with the tools necessary for more effective management.

Capacity building to support results-based management

18. In order to implement effectively results-based management, staff skills need to be improved. Beyond the need for general orientation to results-based management for staff at all levels, including senior management, extensive training is needed in the logical framework approach, with particular reference to the formulation of results, indicators and targets. To supplement the training that is being offered at country, regional and global levels, tools are being developed for quality control of operational and strategic planning.

ACTION BY THE HEALTH ASSEMBLY

19. The Health Assembly is invited to note the above report.

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