



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD
105th Session
Provisional agenda item 8.2

EB105/36
10 November 1999

Implementation of resolutions and decisions

Report by the Secretariat

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I. GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION

1. Resolution WHA44.4 requests the Director-General *inter alia* to keep the Executive Board informed of progress relating to the Children's Vaccine Initiative. The Children's Vaccine Initiative was established by a group of cosponsors including WHO, UNICEF, the World Bank, UNDP and the Rockefeller Foundation after the World Summit for Children (New York, 1990). The Initiative was an international, collective effort, designed to harness new scientific developments in order to increase protection from infectious diseases and to simplify vaccine delivery.

2. Today, about two million children are still dying each year from diseases that can be prevented by currently available vaccines, and several million more lives could be saved if there were effective vaccines against diseases such as AIDS, tuberculosis and malaria.

3. There is now a new commitment of philanthropic foundations, and a renewed commitment of vaccine-producing industries and a variety of public sector institutions to bring these vaccines to current and future generations of children. The Global Alliance for Vaccines and Immunization (GAVI) has been established after a series of meetings (World Bank, Washington, March 1998; Bellagio, Italy, March 1999; Seattle, United States of America, July 1999) and a one-year, in-depth review of immunization-related activities undertaken by major interested partners.

4. The Alliance has been set up to fulfil the right of every child to be protected against vaccine-preventable diseases of public health concern. Its mission is to save children's lives and to protect peoples' health through the widespread use of safe vaccines, with a particular focus on the needs of developing countries.

5. The underlying principle of the Alliance is that partners agree on a set of shared objectives to which they will all contribute through joint action. The Alliance is not a new organization; it is a grouping which broadens the partnership for vaccines and immunization and enhances the synergy between the partners' contributions.

6. The strategic objectives of the Alliance are: (i) to improve access to sustainable immunization services; (ii) to expand the use of all existing cost-effective vaccines; (iii) to accelerate the development and introduction of new vaccines; (iv) to accelerate research and development efforts for vaccines and related products specifically needed by developing countries; and (v) to make immunization coverage an integral part of the design and assessment of health systems and international development efforts. Interim targets have been adopted to assure within a specific time-frame a reduction in the inequalities of access to vaccines and to reduce the preventable disease burden, especially among the poor.

7. The Alliance will operate through the following mechanisms:

- a Global Fund for Children's Vaccines to facilitate (i) the financing of underutilized and new vaccines; (ii) the strengthening of immunization delivery infrastructure; and (iii) the research and development of priority vaccines for poor populations and countries;
- a governing board of initially 12 members, expressing the highest political commitment of partners and providing a forum for decision-making on common objectives and strategies. The Executive Heads of partner organizations, *ex officio*, act in turn as Chairmen of the Board for a term of two years. The Director-General of WHO has accepted to serve as Chair for the first two years, and the Executive Director of UNICEF, for the second term. Members on the

Board include representatives from WHO, UNICEF, the World Bank, industrialized and developing countries, technical agencies, research and development agencies, the Rockefeller Foundation and the Bill and Melinda Gates Foundation;

- a coordinating secretariat, facilitating the work of the Board and helping to ensure the involvement and representation of all bodies involved in immunization activities; the secretariat will be housed by UNICEF at its Geneva premises;
- a working group consisting of dedicated staff within each of the major partners, to ensure that the decisions of the Board are translated into operational actions appropriate to each lead agency;
- task forces of limited duration to address specific issues: three task forces with agreed terms of reference are currently operating – on country coordination under WHO leadership, on advocacy led by UNICEF, and on financing led by the World Bank. In addition, the Board has requested that an analysis of gaps in research and development should be completed within a year;
- an international meeting to be held approximately every two years in order to bring together the broader immunization community.

8. It is expected that the Alliance will be publicly launched at the same time as the Global Fund for Children's Vaccines at the end of January 2000, possibly during the World Economic Forum.

9. As a result of the establishment of the Alliance, the partners involved in setting up the Children's Vaccine Initiative have agreed to close it down as of 31 December 1999.

II. REVISED DRUG STRATEGY

1. In May 1999 Member States adopted resolution WHA52.19 on the revised drug strategy. The resolution addresses challenges in the areas of international trade agreements, access to essential drugs, drug quality, and rational use of medicines. The resolution builds on the original revised drug strategy adopted by the Health Assembly in resolution WHA39.27 (1986). This strategy identified principles and goals for WHO's work in the pharmaceutical sector.

2. WHO areas of responsibility outlined in resolution WHA52.19 will be reflected in a broader document on WHO strategy for essential drugs and medicines' policies, 2000-2003, which is being prepared at all levels of WHO and with a wide range of development partners. Current work on key areas highlighted by the resolution are summarized in the following paragraphs.

3. **National drug policies.** By the end of 1999 nearly 100 Member States had framed national drug policies and 145 had drawn up national lists of essential drugs. Support continues to be provided for policy development, implementation and monitoring, with a particular focus on moving from policy to implementation and on evaluating policy impact. The publication, *Indicators for monitoring national drug policies*, is being revised, and a new edition of *Guidelines for developing national drug policies* will be issued shortly. Tools and strategies to ensure the introduction of a gender perspective into national drug policies are also being developed. Support for implementation of national drug policy also extends to collaboration on drug financing, and drug management and supply. At global level, a database on the world drug situation has been compiled.

4. **Pharmaceuticals and trade.** Countries are being advised on the new international economic environment, within the framework of national drug policies. Guidance is being prepared in response to queries from Member States about the relationship between international agreements and such subjects as drug prices, innovation and local production, the use of exceptions, transfer of technology, licensing arrangements, and the transition period for least developed countries. An updated bibliography on globalization, patents and drugs – of use to countries in researching such issues themselves – is being finalized. Simultaneously, methods for monitoring the pharmaceutical and public health implications of new agreements are being developed together with WHO collaborating centres (in Brazil and Thailand). Cooperative work is also proceeding with UNAIDS on trade agreements and access to HIV-related drugs. A contact group with interested parties from WHO, WTO, WIPO and UNCTAD has been set up.

5. **Drug quality.** Mechanisms are being devised to extend the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce to cover control of starting materials and to provide guidance on quality issues related to trade. At the same time, monographs are being drafted for inclusion in *The international pharmacopoeia* for drugs listed in the Model List of Essential Drugs, including antimalarial and antituberculosis drugs. Basic tests are also being developed for these drugs. More recent work has involved assembling screening tests for antimalarial and antituberculosis drugs. These activities accord with a step-by-step approach to quality control.

6. A major training and technical cooperation project to strengthen WHO good manufacturing practices (GMP) is well under way. Additionally, a model inspection certificate for the national inspection of pharmaceutical manufacturing sites of starting materials and finished pharmaceutical products is being drafted. The aim is to ensure compliance with WHO GMP. Implementation is being planned in collaboration with Member States.

7. **Drug information and drug promotion.** WHO continues to publish model prescribing information for HIV-related drugs, antimicrobials, and other drugs of public health importance. Publication of the eleventh Model List of Essential Drugs and of the latest WHO Model Formulary is expected in 2000. WHO and interested parties are working on ways to operationalize WHO's *Ethical criteria for medicinal drug promotion* and to monitor their implementation. A project to examine critically evidence of inappropriate drug promotion worldwide is also moving ahead.

8. **Drug donations.** The basis of the WHO strategy to improve drug donations continues to be active promotion for implementation of good donation practices, based on the revised Guidelines for drug donations issued in August 1999 and cosponsored by 15 organizations with experience in emergency humanitarian relief.¹ A scheme has been launched for organizations and pharmaceutical companies to endorse the guidelines publicly. In parallel, WHO is creating a mechanism for recipients to report unhelpful donations. Plans are being made to publicize repeated infringements of good donation practices.

9. **Expanding partnerships.** WHO is increasingly working in collaboration with organizations such as UNICEF, the World Bank, other organizations of the United Nations system, *Médecins sans Frontières*, nongovernmental organizations and the private sector on issues related to access to essential drugs. This work should maximize the impact of WHO pharmaceutical policies and broaden support for the revised drug strategy.

¹ Document WHO/EDM/PAR/99.4.

III. HEALTH PROMOTION

1. Resolution WHA51.12 called on WHO to undertake a number of specific actions related to health promotion, to which the Organization is responding.
2. WHO is continuing to stimulate the use of a “settings” approach to ensure that health is on the development agenda of local and national planners and policy-makers. Much effort has been made globally and nationally to mobilize support for healthy cities, islands, communities, markets, schools, workplaces and health services.
3. In order to strengthen the evidence base for health promotion policy and practice, WHO is preparing frameworks to guide the collection of baseline information at the outset of any work where a comprehensive settings approach is used to tackle a health development issue. Methods and tools are being developed to guide subsequent evaluation of processes and outcomes, including a participatory assessment. These practical guides will improve the capability of local and national governments to monitor and evaluate complex processes of social change taking place within specific settings. WHO will incorporate in these instruments specific recommendations for collecting information that advances knowledge about the link between poverty and ill-health, including the influence of gender, ethnicity, age and disability on health. The outcome will provide an essential input for healthy public policy.
4. WHO is refocusing its activities so that it can more effectively advance and share the knowledge base on ways to undertake health promotion that addresses the needs of the poor. For example, it will demonstrate that incorporation of health promotion strategies into health policies, programmes and projects contributes to attaining good health and better quality of life among vulnerable populations living in resource-poor environments. WHO is compiling and disseminating a comprehensive database of published evaluation studies of health promotion activities in developing countries. Over 450 such studies out of more than 1000 have been screened over the past six months, on the basis of their potential for providing methodologies of proven effectiveness.
5. In order to draw attention to the contribution of health promotion strategies to redressing growing inequity in health, WHO is cosponsoring, together with PAHO and the Ministry of Health of Mexico, the Fifth Global Conference on Health Promotion (Mexico City, June 2000). The Conference will focus on health promotion as a way of bridging the equity gap. Case studies are being selected that demonstrate that policies, programmes or projects that incorporate health promotion strategies across the life span have had a positive influence on health.
6. The cornerstone of health promotion is a commitment to achieving equity through the use of approaches that empower communities and individuals of all ages to make healthy choices. However, that is not sufficient. Health promotion is also about ensuring that public policies facilitate healthy choices. It is concerned with acting on the variety of complex and synergistic determinants of health that lie outside the health sector and operate at the individual, household, community, national and global levels. The nature of this work necessitates the formation of intersectoral partnerships. Efforts will therefore focus on three areas: promoting health action, promoting healthy policies, and advancing knowledge and ability to act upon the social determinants of health.
7. Further, WHO is taking the first steps to establish an alliance for global health promotion. Such an alliance explicitly recognizes that effective action for health goes beyond the health sector and involves mobilizing and joining forces with the many social institutions and organizations whose work influences the social determinants of health. WHO is therefore stimulating multisectoral action at

national level so that countries can effectively implement the strategies outlined in the Jakarta Declaration. It is at national level that the health sector can best identify and work with a wide range of groups, often with competing interests, to plan, programme and evaluate their efforts from a health and development viewpoint. Work at national level is the cornerstone upon which regional and global alliances and networks for health promotion can be built and sustained.

8. There is consistent evidence that health promotion and protection strategies are socially and economically viable, and that sustainable approaches improve health outcomes and elicit responsible action from the various social actors. However, the role of health promotion is still not well understood in ministries of health, partly because health promotion has gone beyond the boundaries of traditional medical practice and has called for a broader understanding of what makes populations healthy or sick. The philosophy and practice of health promotion is anchored in the belief that health gains can be best achieved by helping individuals and communities to gain a sense of control over the way they choose to lead their lives.

9. Many medical and other health practitioners acknowledge that being healthy is a complex equation of multiple factors, a number still unknown to current medical and social science. Drawing upon advanced medical knowledge, WHO will act as a bridge between biomedical advances that improve health and social factors that contribute in a substantial way to health and wellbeing. Through its appreciation of the wider context in which people live, it will contribute to the understanding of effective and responsible ways to reduce unnecessary suffering, illness and death.

10. In view of the increasing need to draw upon a wide array of local and national bodies to ensure health action and healthy public policies, the situation of health promotion within ministries of health may need to be reviewed. Health promotion may need to be redirected in order to strengthen the contribution it can make to generating and consolidating alliances for health.

11. The evidence base for health promotion exists and is growing. There are many examples of intersectoral health action that has benefited disadvantaged or vulnerable populations. The forthcoming conference on health promotion will provide a platform for ministers of health from around the world to share information on successes in, and challenges to, promoting and protecting their populations' health.

IV. ELIMINATION OF TRANSMISSION OF CHAGAS DISEASE

1. Progress towards interruption of the transmission of Chagas disease presented here is measured by epidemiological and entomological rates. Reduction of the incidence of infection in young population groups over the period 1985 to 1999 is summarized in the table below.

REDUCTION OF INCIDENCE OF INFECTION IN YOUNG POPULATION GROUPS, 1985-1999 (rates x100)¹

| Subregion | Country | Age group (years) | 1985 | 1995 | 1999 | Reduction 1985-1999 | Comments |
|------------------|---------------|-------------------|------|------|-------|---------------------|---|
| Southern Cone | Brazil | 7-15 | 18.5 | 0.23 | 0.04 | 99.8 | Evaluation by independent commission in 2000 |
| | Chile | 0-10 | 5.9 | 5.4 | 0.38 | 94.0 | Certified free of transmission in 1999 |
| | Uruguay | 6-12 | 5.6 | 0.7 | 0.06* | 99.0 | Certified free of transmission in 1997 |
| Andean countries | Venezuela | 0-4 | 1.7 | 0.1 | 0.1 | 95.0 | Evaluation by independent commission in 2000 |
| Central America | All countries | -- | -- | -- | -- | N/A | Prevalence studies being carried out in response to resolution WHA51.14 |

¹ Data provided by countries.

* Figure for 1997.

-- No data available.

N/A Not applicable.

SOUTHERN CONE COUNTRIES

Brazil

2. The prevalence of human *Trypanosoma cruzi* infection in the 7 to 14 year group in 1999 was 0.04%, which represents a 99.8% reduction of the incidence of infection in this age group. Results of serological tests in a limited number of samples in the population of the 0 to 4 year group in 1999 indicated that the seroprevalence in this age group is 0.0% which can be interpreted as a proof of the interruption of vectorial transmission of Chagas disease in Brazil.

3. The number of domiciliated *Triatoma infestans* insects captured by the control programme in the whole country in 1998 was only 485. This represents an average of one insect per 10 000 houses surveyed, i.e. an infestation rate far below the minimum required for effective transmission of the parasite into new patients.

4. These data confirm the interruption of vectorial transmission of Chagas disease in Brazil. The international commission in charge of evaluating the interruption of vectorial transmission will visit Brazil in 2000 to confirm these achievements. On the basis of the above epidemiological and entomological data, the country is expected to be certified as free of transmission in the year 2000.

Chile

5. In 1999 just 113 houses were reinfected and 55 *T. infestans* insects captured in the whole country.

6. The infection rate in the age group 0 to 10 years in 1998 was 0.38%. This is significantly lower than 5%-9% found in this age group in 1985 and than 5.4% found in the same age group in 1995. It represents a 94% reduction during the period.

7. An independent commission visited the endemic regions to certify the interruption of vectorial transmission. Certification was issued in Santiago on 10 November 1999.

ANDEAN COUNTRIES

Venezuela

8. Advances towards interruption of transmission are noteworthy and include a 37% reduction in the house infestation rates between 1993 and 1998. With the exception of the states of Barinas and Portuguesa where there are infestation rates of more than 2.9%, the other 10 states of the country have rates of less than 1.1%. This represents a significant accomplishment, as the stated goal of the control programme is to attain a rate of less than 2.0% for the country. The prevalence of infected blood banks has been reduced from 1.16% in 1993 to 0.78% in 1998.

9. The incidence of infection in the age group 0 to 4 years has been reduced by 90% between 1992 and 1998, from 1.0% to 0.1%.

V. TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

1. Resolution WHA42.37 requests the Director-General, *inter alia*, to promote programmes for technical cooperation among developing countries (TCDC) and to identify areas of cooperation. The concept and practices of TCDC are being reviewed in the context of rapid global changes. WHO is defining new criteria for itself and working with countries to define a more strategic approach to TCDC in crucial areas such as poverty alleviation and public sector reform. The links between TCDC and economic cooperation among developing countries are close and shaped by the expansion of South-South trade and the strengthening of the private sector in many developing countries. The role of nongovernmental organizations, civil society and the private sector is now widely recognized as vital for the development of TCDC, in the perspective of the emerging global economic system.

2. Globalization and trade liberalization have reinforced the significance of, and given renewed impetus to, cooperation among developing countries, especially at regional and subregional levels. Two decades after the launching of TCDC, it is clear that this type of South-South cooperation has grown considerably. Regional trade groupings, for example, are not confined to issues of trade alone: the development of the social sector is an integral part of their agenda. It is evident that more and more countries, especially the middle-income developing countries, are using TCDC as a political means of expressing solidarity and expanding collaboration and trade. The role of the United Nations system in the promotion of TCDC has also expanded.

3. The Twenty-third Meeting of Ministers of Health of the Non-Aligned Movement (Havana, June 1998) and the subsequent summit of Heads of State or Government of the Non-Aligned Countries (Durban, South Africa, September 1998) identified four areas of joint activities with WHO:

- social values as a basis for policy formulation
- globalization and health for all
- health sector reform
- the revised drug strategy.

In this perspective, and in order to ensure that health is brought into the mainstream of action for sustainable development and the eradication of poverty, a task force on health and poverty reduction has recently been established. In addition, WHO has increased its support in order to give the necessary impetus to TCDC as the main modality of technical cooperation. In view of the growing importance of regional and subregional cooperation, WHO is responding in ways that will strengthen regional dynamics.

4. WHO is approaching TCDC in a more strategic fashion, promoting collaboration in the areas of health services and disease control, and addressing the challenges of globalization. It is recognized that TCDC should be used to position health at the core of the development and political agendas. Similarly, horizontal cooperation should be promoted in the broader determinants of health, such as poverty reduction and improved nutrition, and in sustainable development as a whole.

VI. INFANT AND YOUNG CHILD NUTRITION

1. Worldwide, more than one-third of under-five children are malnourished – whether stunted, wasted, or deficient in iodine, vitamin A or iron. These often irreversible and life-threatening forms of malnutrition are so thoroughly rooted in poverty and underdevelopment that sustainable development is compromised in populations where hunger and malnutrition prevail. This report focuses on improving the nutritional status of infants and young children, particularly through appropriate feeding.¹

2. **Protein-energy malnutrition.** The prevalence of protein-energy malnutrition, as determined by rates of stunting and underweight, continues to decrease slowly. However, more than a quarter of the world's children are still malnourished – 26.7% (150 million) underweight and 32.5% (182 million) stunted – of which 70% are Asia, 26% in Africa and 4% in Latin America. The situation in some parts of Africa is particularly disturbing because numbers are increasing as a result of ecological disasters, war, civil disturbances, or mass population displacements.

3. Poverty underlies most of the world's malnutrition, with attendant inadequate and insecure food supply, inappropriate feeding practices and care, nutritional emergencies, and widespread infection and infestation compounded by lack of health services. Maternal malnutrition remains a major factor for the 30 million infants born each year with intrauterine growth retardation leading to retarded physical, mental and intellectual growth, and heightened risk of infectious diseases and death. Malnutrition contributes to nearly half (49%) of the 10.7 million deaths each year among preschool children in developing countries.

4. WHO provides support to countries in assessing, monitoring, preventing and managing protein-energy malnutrition. The global database on child growth and malnutrition covers 95% of the world's under-five population.² A recently published manual covering assessment, management and rehabilitation of severely malnourished children provides a basis for developing simplified guidelines and training materials for different settings, for example, in the context of the integrated management of childhood illness.³ Meanwhile, the multicentre study to determine a new international growth reference is well under way in Brazil, Norway and the United States of America and is about to begin in Ghana, India and Oman.⁴

5. **National nutrition policies and programmes.** Both of this decade's major global nutrition conferences acknowledged the importance of multisectoral nutrition policies and plans for achieving sustainable food and nutrition security and reducing most forms of malnutrition.⁵ Close collaboration with FAO and UNICEF and vigorous WHO regional nutrition programmes have contributed to preparing or strengthening comprehensive national nutrition plans and policies consistent with the

¹ This report is submitted in accordance with resolutions WHA33.32 and WHA49.15, and Article 11.7 of the International Code of Marketing of Breast-milk Substitutes. For a comprehensive summary of global malnutrition and WHO's response, see: Nutrition for health and development: progress and prospects on the eve of the 21st century (document WHO/NHD/99.9 (English only)).

² Now accessible on the World Wide Web: <http://www.who.int/nutgrowthdb>

³ *Management of severe malnutrition: a manual for physicians and other senior health workers*. Geneva, WHO, 1999.

⁴ For further information on the current status of the multicentre growth reference study, see document EB105/INF.DOC./1.

⁵ The International Conference on Nutrition (Rome, 1992) and the World Food Summit (Rome, 1996).

goals of the World Declaration and Plan of Action for Nutrition. To date, 151 Member States (79%) have completed their nutrition plans and policies and another 21 (11%) are preparing them. In 1999, in collaboration with FAO and UNICEF, national nutrition programmes were reviewed and regional strategies developed for South-East Asia, Europe and the Western Pacific. WHO is also conducting a multicountry study to identify critical food and nutrition security issues in the context of strengthening national nutrition policies and programmes.¹

6. **Other major forms of childhood malnutrition.** Some 740 million people – both children and adults – in 130 countries are affected by **iodine deficiency disorders**, still the greatest single cause of preventable brain damage to the fetus, infant and young child. Progress has nevertheless been remarkable, as discussed at the Health Assembly in 1999.² **Vitamin A deficiency** affects 100-140 million children in 118 countries, mainly in Africa and South-East Asia, causing blindness and increased risk of infection and death. Successful prevention and control strategies include supplementation, food fortification and dietary improvement. In 1998 vitamin A supplements provided through national immunization programmes produced rapid, if temporary, improvement in the vitamin A status of 24 million children. Still other major forms of childhood malnutrition, including **iron deficiency, anaemia**, and the startling problem of **childhood obesity**, are discussed in the report on global malnutrition.³

7. **Nutrition in emergencies.** To help prevent, diagnose and manage malnutrition and outbreaks of specific nutrient deficiencies that regularly occur among refugees and other severely deprived or famine-affected populations, technical reviews have been prepared on **scurvy, thiamine deficiency**⁴ and **pellagra**. WHO and UNHCR jointly organized a consultation (Rome, February 1998) to draw up guiding principles on caring for the nutritionally vulnerable during emergencies. During the crisis in the south Balkans (April to July 1999), the **Inter-Agency Medical/Health Task Force**, chaired by WHO, met weekly to review queries from the field on basic public health matters, including optimal feeding of infants and young children.⁵ WHO, UNICEF, the International Baby Food Action Network and Linkages (Washington, DC) are preparing a training module on infant feeding in emergencies.

8. **HIV and infant feeding.** In 1998 a joint WHO/UNICEF/UNAIDS technical consultation on HIV and infant feeding introduced policy and practice guidelines.⁶ A recent article⁷ suggested that HIV is less likely to be transmitted through exclusive breastfeeding than mixed feeding. Although concluding that no change is warranted in current guidelines, WHO is nevertheless taking the lead in conducting further research. Meanwhile, WHO, UNICEF and UNAIDS are jointly developing a counselling course on HIV and infant feeding to be used in conjunction with breastfeeding training.

¹ The study on improving household food and nutrition security for the vulnerable is under way in China, Egypt, Ghana, Indonesia, Myanmar and South Africa. Cambodia has also indicated interest in participating.

² See document WHA52/1999/REC/3, summary records of Committee A, eighth and ninth meetings, and resolution WHA52.24. See also: Progress towards the elimination of iodine deficiency disorders (document WHO/NHD/99.4).

³ Nutrition for health and development, op. cit.

⁴ Scurvy and its prevention and control in major emergencies (document WHO/NHD/99.11); Thiamine deficiency and its prevention and control in major emergencies (document WHO/NHD/99.13) (in press).

⁵ Information Sheet No. 6, "Feeding of infants and young children during emergencies" in: Report of the Inter-Agency Medical/Health Task Force in the South-Balkans (in preparation).

⁶ HIV and infant feeding (documents WHO/FRH/NUT/CHD/98.1-3).

⁷ Coutsooudis A. et al. Influence of infant-feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study. *The Lancet*, 1999, 354: 471-476.

9. **Breastfeeding and complementary feeding.** Proper feeding is crucial for growth, health and nutritional well-being during the first two years of life. Inappropriate feeding is responsible for a major proportion of childhood malnutrition and related mortality. WHO's Global Data Bank on Breastfeeding now covers 94 countries and 65% of the world's infant population, showing that only an estimated 35% of infants are exclusively breastfed between 0 to 4 months of age.¹

10. The Baby-friendly Hospital Initiative, launched in 1992, is being implemented in 171 countries; the number of hospitals designated "baby-friendly" has risen from 4300 in 1995 to more than 16 000 at the end of 1999. There is nevertheless growing concern that standards have not been maintained in all cases. Accordingly, WHO is seeking to strengthen national capabilities through, among other means, training health workers,² sensitizing administrators and policy-makers,^{3,4} and disseminating a monitoring and reassessment package⁵ developed in collaboration with Wellstart International to help ensure the Initiative's sustainability.

11. Faulty complementary feeding practices compounded by nutritionally inadequate, and frequently contaminated, foods often introduced too early (in developing and developed countries) or too late (in developing countries) remain a major cause of malnutrition. A review of the scientific evidence for making sound infant-feeding recommendations has been widely disseminated.⁶ Practical guidelines for training community health workers on complementary feeding, for example in the context of the integrated management of childhood illness, are being drawn up on this basis in collaboration with the London School of Hygiene and Tropical Medicine.

12. **Progress in implementing the International Code of Marketing of Breast-milk Substitutes.** Since the Thirty-fourth World Health Assembly adopted the International Code in 1981, 160 Member States (84%) have reported to WHO on action taken to give effect to its principles and aim (83% of Member States in Africa, 97% in the Americas, 80% in South-East Asia, 63% in Europe, 95% in the Eastern Mediterranean, and 96% in Western Pacific). National action includes adopting or strengthening legislation, guidelines for health workers or distributors, agreements with manufacturers, and monitoring and reporting mechanisms. Since the last report by the Director-General (1998) Cambodia, Croatia, France, Georgia, Guinea, Malaysia and Panama have provided information on a range of new action.

13. WHO responded to requests for technical support from a number of countries, including Australia, New Zealand and Pakistan, and organized training workshops in Thailand and in the African Region (for 12 French-speaking countries). In November 1998 the Director-General convened two round tables, one with consumer and community-based nongovernmental organizations and another with the International Association of Infant Food Manufacturers. The meetings discussed improving implementation of the Code in countries and improving dialogue between interested parties.

¹ The WHO Global Data Bank on Breastfeeding will soon be accessible on the Internet.

² Breastfeeding counselling: a training course (documents WHO/CDR/93.3-6).

³ Promoting breastfeeding in health facilities – a short course for administrators and policy-makers (document WHO/NUT/96.3).

⁴ Evidence for the ten steps to successful breastfeeding (document WHO/CHD/98.9).

⁵ WHO, UNICEF and Wellstart International. The Baby-friendly Hospital Initiative. Monitoring and reassessment: tools to sustain progress (document WHO/NHD/99.2).

⁶ WHO, UNICEF, University of California (Davis), ORSTOM. Complementary feeding of young children in developing countries: a review of current scientific knowledge (document WHO/NUT/98.1).

14. **Global technical consultation on infant and young child feeding.** WHO and UNICEF are jointly organizing an expert consultation (Geneva, 13 to 17 March 2000) to assess infant and young child feeding policies, review key interventions, and develop a comprehensive strategy for the next decade. Information on the outcome will be submitted to the Fifty-third World Health Assembly.

VII. CLONING IN HUMAN HEALTH

1. In response to resolution WHA51.10, a small working group of independent and government experts (Geneva, 12 to 14 October 1998) considered a first draft of guiding principles and recommendations in the field of cloning in human health. A consultation on the draft, which included governments, international organizations and scientific and professional bodies, was subsequently carried out through electronic mail.¹
2. Following up discussions at the Fifty-second World Health Assembly, and in response to expressions of interest on the part of Member States, international experts and other parties, to the effect that WHO should take a leading role in responding to the health and ethical dimensions of issues posed by advances in genetics, a further consultation is to be held in Geneva in December 1999.
3. The consultation will consider in the light of comments received during the Health Assembly a report on the implications for public health of medical genetics and biotechnology. Further, taking advantage of both this valuable work and the presence of various parties at the consultation, it will define possible future directions for WHO's work in this and related areas.
4. A report of this consultation will be submitted to the Fifty-third World Health Assembly so that a broader discussion can take place, responding to the health and ethical dimensions of questions posed by cloning and related subjects.

¹ See document A52/12.

VIII. POLIOMYELITIS ERADICATION

1. Resolution WHA52.22 (1999) called for acceleration of the initiative to eradicate poliomyelitis by the end of the year 2000. Certification should be completed by 2005.
2. Substantial success has been achieved; three of the six WHO regions are now reporting zero cases of poliomyelitis. The last reported cases in the Americas, and in the European and Western Pacific regions occurred in August 1991, November 1998 and March 1997, respectively. In the remaining poliomyelitis-endemic regions, the number of cases reported in 1999 was less than half that reported in the previous year. The eradication initiative has progressed with great energy and impact. It is now in its final stretch. Yet, the ultimate success of the global effort will require acceleration of eradication and surveillance efforts in the countries where poliomyelitis remains or was recently endemic.
3. Central to the success of acceleration is the need for Member States in which poliomyelitis is endemic to conduct extra rounds of national immunization days in 2000 and 2001, particularly in the 10 countries of global priority: Afghanistan, Angola, Bangladesh, Democratic Republic of the Congo, Ethiopia, India, Nigeria, Pakistan, Somalia and Sudan.
4. In the South-East Asia and Eastern Mediterranean regions, the four global priority countries have either begun extra rounds of immunization days, or made commitments to do so. In India alone, over 1000 million doses of oral poliomyelitis vaccine are being distributed during four national and two subnational immunization days between October 1999 and March 2000. Depending on the availability of resources, Afghanistan, Bangladesh and Pakistan will increase the rounds from two to four each year in 2000 and 2001.
5. Among the six global priority countries in Africa, the eradication initiative passed a historic milestone between August and October 1999 when three, first ever rounds were conducted in the Democratic Republic of the Congo. Angola expanded its activities to three rounds during June to August 1999. In addition to immunization days, Nigeria and Sudan conducted two extra subnational rounds in high-risk areas in 1999. In Ethiopia only two rounds were conducted. In Somalia immunization days were compromised by security concerns.
6. Recognizing the substantial financial resources required for acceleration and completion of the campaign up to 2005 (the shortfall was US\$ 500 million as of May 1999), the Health Assembly called on the Director-General to mobilize additional financing. A commitment of US\$ 75 million has since been received from the United Nations Foundation and the Bill and Melinda Gates Foundation. Pasteur-Mérieux-Connaught donated poliomyelitis vaccine worth US\$ 5 million for areas of Africa affected by conflict. The World Bank provided support to the Government of India for a massive acceleration of eradication activities. Canada, the United Kingdom of Great Britain and Northern Ireland and the United States of America have increased their overall support to the eradication initiative. Rotary International and several development agencies continue to extend their active support for global eradication.
7. The importance of meeting the target date for eradication of poliomyelitis is still underestimated in some countries and by some organizations. However, the longer intense poliovirus transmission continues in sub-Saharan Africa and south Asia, the higher the risk of reinfesting areas that are now free of the disease. Major outbreaks in Angola and Iraq in 1999 demonstrate the fragility of the progress that has been made. A delay in achieving the target on time would increase the total cost of eradication by as much as US\$ 100 million each year. In addition, it will be very difficult to sustain

current levels of funding for more than 24 to 36 months, especially for poliomyelitis-free countries that would need to maintain immunization days in order to protect against importation of the disease.

8. Organizations of the United Nations system and partners in poliomyelitis eradication must increase their capacity to meet the demands of accelerating this initiative. In 1999 insufficient planning and coordination resulted in delays or cancellation of immunization days in Africa and south Asia. Improved vaccine forecasting, planning and coordination among organizations of the United Nations system, vaccine manufacturers and donor governments must be reinforced to prevent or forestall further shortfalls in poliomyelitis vaccine at a time when Member States are responding to the call for acceleration of eradication.

9. Successful efforts to establish peace for the conduct of national immunization days, or at least a safe working environment and access to unreached communities, must be expanded to all areas affected by protracted conflict. In Somalia, two United Nations staff members, recruited locally for poliomyelitis eradication activities, were murdered in 1999. Two members of a vaccination team were also murdered in Angola, where few children could be immunized in UNITA-controlled areas during immunization days. The success of the Secretary-General of the United Nations in establishing “Days of tranquillity” for immunization days in the Democratic Republic of the Congo demonstrated the feasibility of working successfully in these areas, despite seemingly overwhelming logistical and security problems.

10. The standards set by the Global Commission for the Certification of the Eradication of Poliomyelitis are not being respected everywhere. Some countries have even stopped supplementary immunization activities, despite surveillance sensitivity that remains well below certification standards. Experience in the Americas, and in the European, Eastern Mediterranean and Western Pacific regions has conclusively demonstrated that such actions may jeopardize historical gains, because low-level transmission of poliomyelitis can continue undetected for more than three years in areas where surveillance is suboptimal.

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