a52191

World Health Organization
Organisation mondiale de la Santé

FIFTIETH WORLD HEALTH ASSEMBLY

See Corr.1

Provisional agenda item 19

A50/6
25 February 1997

Implementation of resolutions and decisions

Report by the Director-General

This document presents progress reports on the implementation of resolutions and decisions of the Health Assembly. The Health Assembly is invited to note the reports and to consider the resolutions recommended by the Board.

CONTENTS

I. PREVENTION OF VIOLENCE[1]

1. In May 1996 the Forty-ninth World Health Assembly adopted resolution WHA49.25, requesting the Director-General "... to initiate public health activities to address the problem of violence ..." and *inter alia*, "... to present a report to the ninety-ninth session of the Executive Board describing progress made so far and to present a plan of action for progress towards a science-based public health approach to violence prevention".

2. The Executive Board welcomed the report by the Director-General and supported the proposal for a review of progress in the prevention of violence.

3. The plan of action (document A50/INF.DOC./4) has set a time frame and priority objectives whereby, within three years, sufficient data and experience should have been accumulated so as to allow for the formulation of precise goals and quantifiable targets for the programme; the first such objective is to describe the full public health scope of the problem in its different forms and circumstances. With the establishment of adequate information systems for monitoring and surveillance it will be possible to describe the determinants and consequences of violence and evaluate the effectiveness of interventions and specific policies. This will require methodology development and adaptation, and the strengthening of local and national capacities for data collection, analysis and use of information.

4. As requested in resolution WHA49.25, a short summary of progress made in prevention of violence was presented to the ninety-ninth session of the Executive Board. In addition to the collaboration within the United Nations system on the study of the effects of armed conflict on children, and the preparation of a manual on the mental health of refugees with UNHCR, WHO has established working relations with the United Nations Crime Prevention and Criminal Justice Division in Vienna.

5. Since the report to the Executive Board, work has continued on the International Classification for External Causes of Injury (ICECI) as part of the International Classification of Diseases (ICD), to provide a framework for the classification of violent circumstances and the characteristics of persons involved in violence or mortality and morbidity related to intentional self-harm. A meeting of experts will be convened in the autumn to refine the definitions and typology of violence so as to facilitate monitoring and surveillance of the health consequences of and factors contributing to violence. The task force will ensure consistency in classification between programmes. In 1998 the final draft of ICECI will be presented at a WHO-sponsored international conference on injury prevention and, after wide evaluation, it will be finalized as an essential tool for monitoring and surveillance. An intersectoral meeting will be convened to initiate dialogue between public health authorities, criminal justice systems and human rights organizations on violence. The Governments of the United States of America and South Africa, having established a binational commission for collaboration *inter alia* in the field of health, have specifically named violence as a priority area for their collaboration. The collaborating institutions in the United States and South Africa, within the framework of the WHO plan of action, are proposing to establish a regional centre for violence surveillance. Additional institutional arrangements for collaboration are being developed with Brazil, Canada (Quebec), Colombia, Netherlands, Switzerland, Togo and several other countries. Finally, support to initiate activities will be forthcoming through extrabudgetary funding.

[1] This report should be read in conjunction with document A50/INF.DOC./4 on prevention of violence.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

6. In view of the strong interest expressed by the Executive Board in this matter, the Health Assembly may wish to consider the following resolution:

The Fiftieth World Health Assembly,

Welcoming the report of the Director-General on prevention of violence;

Expressing satisfaction with the rapid progress in the development of the plan of action for progress towards a public health approach to violence prevention based on scientific data;

Recognizing the opportunities to give effect to the plan of action through the collaborative mechanisms of the WHO programmes concerned, collaborating centres and institutions, professional and other nongovernmental organizations, and in collaboration with other appropriate organizations and agencies of the United Nations system, with particular attention to those dealing with human rights;

Reiterating WHO's role of leadership and guidance to Member States in assessing the problem of violence and in order to prevent self-inflicted violence and violence against others,

1. ENDORSES the Organization's integrated plan of action on violence prevention and health;

2. URGES Member States to collaborate with WHO in attaining the objectives and implementing the tasks of the plan of action.

II. REORIENTATION OF MEDICAL EDUCATION AND MEDICAL PRACTICE[1]

DIVERSITY OF HEALTH PERSONNEL

1. This report is submitted in response to paragraph 2(6) of resolution WHA48.8 "Reorientation of medical education and medical practice for health for all", which requests the Director-General to report on the reorientation of the education and practice of "health care providers for health for all" other than doctors, nurses and midwives. The types of health personnel covered by this resolution are very broad. In the United States of America, there are about 250 different disciplines under the heading of "allied health personnel" alone. Such health care providers may be distinguished in several ways: by the scope of their practice, by their level in the health system, by their degree of autonomy, by entry requirements to the training programmes and by the length of education.

2. For the purpose of this report, the types of personnel covered are grouped into two broad categories: those working at first contact level and assuming responsibilities of a broad spectrum of functions related to preventive, promotive and curative care (i.e., community health workers, health officers, medical assistants, etc.) and those assuming responsibility for more specific and specialized tasks at different levels of the health care system (i.e., radiographers, laboratory technicians, physiotherapists, occupational therapists, nutritionists, traditional medical practitioners, etc.). Their training ranges from several months (for community health workers) to several years for a bachelor's, master's or even PhD degree. Leaving aside the more firmly established professions such as dentist, pharmacist or others that are internationally recognized, this report will be limited to situations and trends and draw conclusions for the reorientation of education and practice of the health personnel concerned.

3. The health sector will always be labour-intensive, and since human resources for health take up some 70% of recurrent health budgets, there will always be a search for cost-effective means of providing care. Although nurses and midwives have become the most important providers of primary health care, there are still numerous examples where it is assumed by other categories of health personnel.

4. Responding to demographic, epidemiological and technological changes as well as new expectations from the community, health care systems evolve rapidly and health personnel must adapt accordingly. As a rule the other categories of personnel can respond more easily than the more firmly established professions. With the ageing of the population, an increase in the range of providers to support the needs of the elderly in a wide range of social settings may be foreseen. To respond to the heavy burden of diseases due to "lifestyle", health promotion and education services with the participation of other professions such as nutritionists will have to be strengthened to enable individuals to make the right decisions and abide by them. The falling cost of new informatics and technologies will allow even developing countries to reduce the isolation of frontline health workers and facilitate consultation, supervision and continuing education. With these changes, the profiles of health personnel will evolve, as will the composition of the primary health care team.

5. Although care by non-physicians is far from new, it was not until the Declaration of Alma-Ata with its concern for equity that their contribution to primary health care was seriously considered. Over the years, many lessons have been learned about factors critical for successful performance and sustainability. The introduction of new categories of providers must be carefully planned, and their scope of practice within the health workforce as a whole must be clearly defined, with referral and supervisory functions and relations with other providers. Employment conditions and career prospects are important for the retention of such workers in the health system. It is now widely accepted that when properly trained and properly used these types of health personnel can improve cost-effectiveness and equity in health care delivery and replace more highly trained and costly

[1] A detailed report on Reorientation of the education and practice of health care providers other than doctors, nurses and midwives is available on request.

providers in a wide range of functions. With the trend to privatization in health care, the public sector may find that they are increasingly attracted to private sector employment.

EDUCATION

6. Greater efforts must be made to ensure that curricula contents are relevant to the health needs and priorities of the communities in which the health personnel will serve, and that learning processes are appropriate. Providers with limited basic education, such as community health workers, should be trained for specific skills and acquainted with such tools as diagnostic flowcharts and algorithms, whereas health personnel with a larger degree of autonomy should be trained in critical and problem-solving skills. The education system must ensure that graduates will fit into their working environment, through initiatives such as: joint leadership of educational institutions and district health systems; centralization of training and merging of several categories of health personnel in health teams; promoting consciousness of cost and absolute commitment to performance standards, as well as concern for equity and right to health.

7. The education programme should also strengthen curricula applying well-tried principles and methods of competency-based education, early exposure of students to the social environment, and problem-based learning, with special attention to the acquisition of skills in personal communication, multiprofessional teamwork, and management. Continuing education is considered an indispensable means to maintain these skills and acquire new ones when the need arises. Learning materials and resources that are locally appropriate must be developed and made widely available. Sustainable changes in education must be ensured through the strong commitment of educational institutions and the proper preparation and recognition of leaders and teachers in these institutions.

EMPLOYMENT, DEPLOYMENT AND WORKING CONDITIONS

8. Improvement of conditions and circumstances that bear on work performance and productivity should be achieved with the use of performance indicators and methods to improve quality and efficiency. Special attention must be paid to health personnel with prime responsibility for first-contact-level care who are very often assigned to workplaces in remote or disadvantaged areas. They usually work under difficult conditions, with inadequate equipment and supplies, rare or poor supervision, unreliable communications with more central parts of the health care system, and social isolation. Even when they come from the local area, as is often the case, these factors cannot be ignored. An incentive system - financial and otherwise - must be established to attract and retain health personnel where they are most needed.

9. Provision of personnel must be related to the actual circumstances of employment. Unlike the more firmly established professions, most of the types of providers described here do not easily find employment outside the domain for which they have been trained. Planners should take care that, being less well organized, the attribution of responsibilities to these providers, and their workloads, include measures to ensure stability, so that sufficient time is given for their contribution to be recognized.

10. Career prospects are especially difficult to determine for the primary health care group when they have been introduced to fill a specific gap in the service. An innovative "ladder" curriculum has been used in Tacloban, Philippines, by which a student may qualify as a community health worker after one year, as a community health nurse after two, as a community health scientist after three and as a doctor after six. After each stage the student may return to service or take leave before proceeding to the next. Fiji has also introduced a "ladder" curriculum.

CONCLUSIONS

11. There are a wide range of health care providers besides doctors, nurses and midwives. The difficulty in defining them has been exacerbated by the vast array of titles which have been used to identify them. Sometimes the same titles are used to describe very different categories, making international comparison impossible. Yet they may greatly contribute to the health of the communities they serve, and important lessons may be learned from such experience.

12. With the wide access to basic school education throughout the world, it is likely that in time the very basic categories such as traditional birth attendant and community health worker will be phased out in favour of a more multiskilled worker capable of more independent work. The wide availability of modern communications technology and its application in the health sector will further enhance the productivity and effectiveness of these health care providers.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

III. GUIDELINES ON THE WHO CERTIFICATION SCHEME ON THE QUALITY OF PHARMACEUTICAL PRODUCTS MOVING IN INTERNATIONAL COMMERCE

1. A first version of the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce was adopted by the Twenty-second World Health Assembly in 1969 (resolution WHA22.50) in response to complaints from developing countries about being supplied with substandard pharmaceutical products. The Scheme has subsequently been revised periodically, and the current revised guidelines[1] are the result of field trials in a number of WHO Member States and discussions during the sixth and seventh biennial International Conferences of Drug Regulatory Authorities; they have been endorsed by the Expert Committee on Specifications for Pharmaceutical Preparations in its thirty-fourth report.[2]

2. In its current revised form the Scheme provides an important administrative instrument in support of drug registration in the importing country by providing access to clear information on the quality and regulatory status of the pharmaceutical products in the exporting country and true origin of products to be imported.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

3. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB99.R21.[3]

[1] WHO Technical Report Series, No. 863 (1996), Annex 10 (see A50/INF.DOC./3).

[2] WHO Technical Report Series, No. 863 (1996), section 6.2, p. 7.

[3] Document EB99/1997/REC/1.

IV. QUALITY OF BIOLOGICAL PRODUCTS MOVING IN INTERNATIONAL COMMERCE

1. Noting the increasing movement across international boundaries of vaccines and other biologicals used in the prevention, treatment or diagnosis of diseases, together with the rapid development and introduction into public health programmes of medicines produced by modern biotechnology both in developed and developing countries, the Forty-ninth World Health Assembly recognized and endorsed the aim and intentions of a draft resolution sponsored by 26 countries on the quality of biological products moving in international commerce. It recommended to the Director-General that he convene an ad hoc working group to study the technical and legal implications of the draft resolution and report to the Executive Board at its ninety-ninth session in January 1997.

2. An ad hoc working group was therefore convened in Geneva on 4 and 5 October 1996, where the responsibilities of WHO, assumed through its Biologicals unit, its four International Laboratories for Biological Standards, and with the advice of the Expert Committee on Biological Standardization, were considered. These include: the development, evaluation, establishment and distribution of a range of international biological reference materials which ensure the comparability of the activities of biologicals worldwide; and the publication of guidelines and requirements for the production and quality control of specific biological products. Such documents provide guidance to national health authorities and serve as a basis for deciding on the acceptability of biologicals, facilitating their use in different countries.

3. During the wide-ranging discussions, while there was broad agreement that many Member States needed independent advice from WHO and other bodies to assist in selecting biological products for local use, differing views were expressed on the mechanism to be used. Although the incorporation of requirements published by WHO into national health regulations had proved useful for many countries, concern was expressed that recent changes in international trade laws could result in the requirements having the status of international standards, perhaps requiring some countries to license products which would not meet the standards set by their own national control authority.

4. The ad hoc working group encouraged the Director-General to seek a solution which would meet the intent of the draft resolution without the danger of inadvertently creating trade disputes, and to review issues of potential conflict of interest and confidentiality as they relate to the application of the requirements and guidelines published by WHO, including advice on the acceptability of vaccines intended for purchase by other organizations of the United Nations system.

5. Many countries find the information contained in the guidelines and requirements published by WHO invaluable for the guidance of national control authorities and manufacturers. The ad hoc working group recommended that WHO should continue to provide such guidance but that the main body of the reports should focus on principles and essential elements that ensure product safety and efficacy, and that the finer details of specifications, assays and processes be presented as appendices or references. It is important for recipients to recognize that such information is intended for guidance and is not prescriptive.

6. Attention was drawn to the difficulties encountered by WHO in continuing to fulfil its mandate in biological standardization at a time when products are being developed at an unprecedented rate. Many new techniques are being introduced and the resources available to the Organization and its collaborators in this field are decreasing. Given that WHO's role concerning biologicals was established almost 50 years ago, the ad hoc working group suggested that the role of the responsible unit, the scope of its activities, its mechanisms for establishing priorities and its links with other bodies having related functions should be reviewed. A review along the lines of the recent scientific review of biological standardization and control conducted on behalf of

the National Biological Standards Board of the United Kingdom of Great Britain and Northern Ireland was suggested.

7. The recommendations of the ad hoc working group were presented in the report of the Director-General to the Executive Board at its ninety-ninth session (document EB99/29).[1] These recommendations are considered important not only from the scientific and technical point of view but also from the institutional viewpoint in order to strengthen national control authorities, particularly in developing countries, and to strengthen WHO activities aimed at assuring the safety and efficacy of biological products used in medicine - not only those in current use but also new products manufactured with modern biotechnology.

8. Having considered the report of the ad hoc working group on the quality of biological products moving in international commerce, the Executive Board adopted resolution EB99.R22, which reflects both the intent of the original draft resolution discussed at the Forty-ninth World Health Assembly, and the recommendations of the working group in document EB99/29.[1]

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

9. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB99.R22.

[1] See document EB99/1997/REC/1, Annex 3.

V. REPRODUCTIVE HEALTH

1. The challenge of meeting people's needs in this domain throughout their lives has led to an expansion of maternal and child health and family planning, one of the elements of primary health care, to the broader concept of reproductive health. Reproductive health includes: promotion of safe and responsible sexual behaviour, particularly during adolescence; family planning; prevention of maternal and newborn deaths and disabilities; prevention and management of unsafe abortion and reproductive tract infections, including those which are sexually transmitted, of harmful practices such as female genital mutilation, and of violence related to sexuality and reproduction.

2. Good reproductive health eludes many people because of their poor knowledge of human sexuality; inappropriate, poor-quality, or inaccessible reproductive health information and services; the prevalence of high-risk sexual behaviour; and the limited choices many women and girls have in their lives. Many problems arise first during adolescence, a time when basic behavioural patterns are formed that have major consequences for reproductive health.

3. WHO aims to ensure that people have the knowledge, skills, environment and access to health care services that give them the capacity for healthy, equitable and responsible relationships and their fulfilment; the capacity safely to have the children they desire; the ability to avoid unwanted pregnancy, illness, disease, injury and disability related to sexuality and reproduction; and the opportunity to receive appropriate counselling, care and rehabilitation when needed.

4. The basis for WHO's work in reproductive health is the need to strengthen action in countries through research, standard-setting and technical cooperation. At headquarters the method of work links the technical support and normative work with research in an iterative process. The underlying principle is that a rigorous scientific review and analysis of available evidence precedes WHO's work in advocacy, the setting of norms and standards, technical cooperation and research, information from which contributes to the pool of evidence, thus completing the cycle.

5. Technical cooperation supports the planning, implementation, monitoring and evaluation of reproductive health policies and programmes, for example through WHO participation in the UNFPA-funded Technical Support Services network. It includes the application of norms and standards to specific settings and involves the development of generic guidelines, manuals and training modules and their adaptation for use at country level in collaboration with governments and other partners. Research covers the extent and nature of reproductive health problems, the influence of behaviour, and the best practices for the delivery and quality of services. Information is gathered on people's needs and perspectives so as to develop and improve reproductive health technology. WHO disseminates the scientific information and promotes its use in policy-making and planning for reproductive health.

6. Reproductive health is a crucial part of general health, firmly linked to sustainable human development, and related activities should involve the revitalization and reorganization of existing health systems and structures rather than the establishment of new ones. This approach enables WHO to expand perennial support to maternal and child health and family planning and the promotion of adolescent reproductive health, while initiating activities to meet the needs of underserved groups and to tackle neglected or emerging problems such as cervical cancer, violence and female genital mutilation. The approach acknowledges the central importance of equality between the sexes and of men's participation and responsibility, and it expands upon the views and recommendations that characterized the United Nations International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995.

7. WHO establishes priorities for its work by taking account of the public health magnitude and effects of the problem; the availability of cost-effective, sustainable measures to meet people's needs, or the feasibility

of their development; the anticipated impact of such measures; WHO's essential competencies; the role of WHO's "partners" at the global and country levels; and the need to use WHO's resources to maximum effect. Recent achievements of the reproductive health programme include guidelines for assessing and expanding the "mix" of contraceptive methods in family planning programmes and for improving the quality of care; advice to governments on the quality, safety and efficacy of fertility regulating methods; guidelines on assessing needs in reproductive health and the ability of services to address them, particularly with respect to maternal mortality; training materials for upgrading midwifery skills; the widespread introduction of a minimum set of measures to ensure safe pregnancy and childbirth (the Mother-Baby Package); guidance on integrating prevention and care of sexually transmitted diseases (STDs) within other reproductive health services; research on the improvement and introduction of methods that protect against unwanted pregnancy as well as STDs; information on adolescent sexual behaviour and the role of men in reproductive health; definition and classification of female genital mutilation; and a review (with UNICEF) of the health status of young people in developing countries.

8. To increase the information available for advocacy and action in reproductive health, WHO has developed and maintains databases on a number of reproductive health indicators, including maternal mortality, morbidity, unsafe abortion, anaemia during pregnancy, infertility, neonatal and perinatal mortality, and low birth weight. WHO and UNICEF have jointly developed new estimates of maternal mortality, and guidelines have been developed on the use of "process indicators" for monitoring maternal mortality. Collaborative efforts with other agencies are under way to develop additional reproductive health indicators and the methodology needed for generating and analysing reproductive health information.

9. WHO's regional offices are giving support to Member States developing strategies and country-level programmes that promote comprehensive reproductive health care through priority measures that are feasible within the context of primary health care and which build on existing systems and services. In the African Region reproductive health has been advocated as an important component of health sector reform and WHO is launching a regional action plan for reproductive health within the United Nations System-wide Special Initiative for Africa. Governments and institutions are being sensitized to the concept of reproductive health, and training curricula are being updated. The Mother-Baby Package has been introduced to all countries of the Region, several having conducted "safe motherhood needs assessments" and developed operational plans based on the findings. In the Americas priority has been given to supporting Member States in the promotion of adolescent reproductive health, reducing maternal mortality and incorporating "gender perspectives" in health. In South-East Asia a framework has been developed to guide countries in making operational the essential package of high-priority reproductive health care measures. The strategy has both long-term and short-term features, and a list of priority activities at country level has been made. Support in Europe emphasizes eastern European and central Asian countries and focuses on those in greatest need, including those with high rates of abortion and maternal morbidity and mortality. In the Eastern Mediterranean the Mother-Baby Package has been promoted as the central element of comprehensive reproductive health care, notably through a regional workshop held in late 1995. The reproductive health of adolescent girls is receiving increasing attention, and guidelines on adolescent reproductive health education have been developed that reflect cultural and social norms in the Region. In the Western Pacific the strategy has been developed in the context of an innovative approach to health policy and planning contained in the document "New horizons in health", and four subregional groups of countries have been encouraged to determine priority problems, and suggest strategies, targets and corresponding activities.

10. Member States are requesting assistance as they move to a more integrated reproductive health approach. In responding, the reproductive health programme is focusing on: determining research priorities; estimating the magnitude and costs of reproductive ill-health; determining reproductive health indicators appropriate at different levels; developing mechanisms for reaching consensus on priorities; defining and costing the minimal set of measures and quality services for adaptation to different settings; promoting the integration of measures and services where this is likely to be cost-effective and to have clear advantages; and developing materials to improve human resources in reproductive health. WHO's reproductive health programme will make a concerted

effort to support the actions needed to shift from traditionally problem-specific and separately-organized health programmes in order to ensure reproductive health for all.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

VI. TOBACCO OR HEALTH

1. The Forty-third World Health Assembly, in resolution WHA43.16, requested the Director-General to report biennially to the Health Assembly on the progress and effectiveness of Member States' comprehensive tobacco control programmes. The present report concentrates on developments in the past two years, and discusses the progress made towards the development of an international framework convention for tobacco control, called for in resolution WHA49.17.

2. WHO's "tobacco or health" activities are based on the aim of reducing mortality and morbidity caused by the use of tobacco. The Organization will continue to play a leading role in the prevention and reduction of tobacco use and in the promotion of tobacco-free societies. The work of the "tobacco or health" programme is centred in three areas:

- strengthening of national and international tobacco control programmes
- promotion, public information and advocacy
- a WHO "tobacco or health" information centre.

3. In 1990, resolution WHA43.16 urged all Member States to implement comprehensive multisectoral tobacco control strategies. To this end, the "tobacco or health" programme has engaged in numerous activities to assist Member States in bringing about comprehensive tobacco control policies and programmes.

4. The programme has also been working towards the implementation of resolution WHA46.8 with follow-up of resolution WHA43.16 to ensure protection from involuntary exposure to environmental tobacco smoke. Over the last two years, a number of countries have advanced legislation to ensure such protection. Further collaboration with the International Civil Aviation Organization (ICAO) has led to an increasing number of airlines offering smoke-free services, and work is progressing towards the fulfilment of ICAO's resolution calling for a smoke-free travel environment on all aircraft. WHO has also been working towards the implementation of smoke-free environments in all buildings of the United Nations and its specialized agencies in accordance with resolution WHA46.8.

5. WHO has continued its strong partnerships with a number of nongovernmental organizations (NGOs), and in particular has worked closely with the newly established International Non-governmental Coalition against Tobacco (INGCAT).

6. Due to the alarming trends in tobacco-related mortality and morbidity in countries of central and eastern Europe (CEE), particular emphasis has been placed on working with these countries to develop comprehensive tobacco control policies and programmes. In October 1995, a "training of trainers" seminar was held in Warsaw with the participation of 14 CEE countries. The proceedings of the seminar were subsequently issued in 1996 as a technical document WHO/PSA/96.9. A large-scale tobacco-control conference is being planned for May 1997 in Moscow.

7. In September 1996, as part of a tobacco control seminar in southern Africa, WHO "tobacco or health" staff facilitated a three-day training course to help develop an action plan for strengthening tobacco control in South Africa.

8. Over the last two years, the "tobacco or health" programme has also completed drafts of several publications which will be of great use in moving countries towards comprehensive tobacco control programmes. *Guidelines for controlling and monitoring the tobacco epidemic* concern practical measures for structured and orderly implementation and management of long-term, multisectoral, comprehensive tobacco

control policies and programmes, with revised WHO recommendations for the measurement of smoking prevalence aiming at global standardization. WHO will offer training workshops to promote optimum use of the guidelines.

9. Another important text prepared for publication in 1996, entitled *Tobacco or health: first global status report*, is the first such comprehensive report, with the first global and regional comparisons for a number of indicators concerning the extent of the global tobacco epidemic.

10. Two other reports were completed by the "tobacco or health" programme in 1996: *Evaluating tobacco control activities: experiences and guiding principles* (now available as a WHO publication); and *Le rôle des médias à l'appui de la lutte contre le tabagisme* ("The role of the media in support of control of tobacco use", in preparation).

11. The quarterly newsletter *Tobacco Alert*, with worldwide distribution to those concerned with "tobacco or health" issues, continues to be an effective tool for health promotion, providing up-to-date information on the tobacco situation. Since July 1996, due to budgetary constraints, the newsletter now only appears in electronic form on the Internet.

12. World No-Tobacco Day continues to be observed annually in WHO Member States, often serving as one of the most significant means of health promotion and education on "tobacco or health" issues. Specific material issued for each World No-Tobacco Day provides essential information and contains recommended tobacco control strategies based on the particular theme chosen for that year. The theme chosen for World No-Tobacco Day 1997 is "United for a tobacco-free world". Owing to budgetary constraints, the advisory material for 1997 appears only in electronic form on the Internet.

13. In 1996 resolution WHA49.17 was adopted by the Health Assembly, again calling on all Member States and, where applicable, organizations of the United Nations system and other international organizations progressively to implement comprehensive tobacco control strategies as called for in previous resolutions.

14. Resolution WHA49.17 also requested the Director-General to initiate the development of a framework convention which would encourage Member States to move progressively towards the adoption of comprehensive tobacco control policies and also to deal with aspects of tobacco control that transcend national boundaries. A background paper entitled "An international strategy for tobacco control" has been issued as technical document WHO/PSA/96.6. In order to develop a convention that is both appropriate and feasible, staff have consulted other United Nations agencies having established international conventions. The preparatory process foresees close consultation with Member States and with experts on public health, international law and convention administration. It is planned to submit the draft convention to the World Health Assembly in the year 2000. The preparation of the convention is subject to extrabudgetary funding for the related work of WHO, which has been initiated with funds so far made available by some Member States.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

VII. WORLD TUBERCULOSIS DAY

1. In 1982, on the one-hundredth anniversary of Dr Robert Koch's announcement that he had discovered the tuberculosis bacillus, the International Union against Tuberculosis and Lung Disease, a nongovernmental organization in official relations with WHO, proposed that 24 March be proclaimed World Tuberculosis Day. Except for the activities of a few organizations, very little was done to highlight the occasion until 1996.

2. In 1995, WHO, the International Union and a variety of other organizations concerned embraced a plan to commemorate World Tuberculosis Day, hoping to make a real difference to the millions of people now suffering from and dying of tuberculosis.

3. The first World Tuberculosis Day campaign was launched by WHO on 24 March 1996, when nearly 100 governments, nongovernmental organizations and other associations undertook "media events" and activities in over 50 countries to draw attention to the tuberculosis epidemic. Over 1000 different groups have signalled their intent to become involved in World Tuberculosis Day in 1997.

4. At its ninety-ninth session (January 1997), the Executive Board recommended in resolution EB99.R27 that the Health Assembly endorse World Tuberculosis Day and request the Director-General to coordinate its annual observance.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

5. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB99.R27.

VIII. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

1. This report is submitted in response to resolution WHA49.27 and describes the development and implementation to date of an overall strategy for WHO's activities relating to HIV/AIDS and sexually transmitted diseases.

2. The seriousness of the health problem is reflected in the estimate that by the end of 1996 a cumulative total of 29.4 million children and adults had been infected with HIV and that 8.4 million AIDS cases had occurred. The 1995 estimated annual incidence of curable sexually transmitted diseases was 333 million cases worldwide. Although there are hopeful signs that the HIV/AIDS epidemic has stabilized in certain countries and population groups, women are becoming increasingly vulnerable to HIV as a result of greater heterosexual transmission. Clinical and behavioural research has produced more effective therapies and interventions to influence behaviour; however, these need to be more accessible to have a significant impact on the global course of the epidemic.

3. In order to respond to the still evolving and dynamic epidemic, WHO will be guided by its global AIDS strategy based on three fundamental goals: reduction of transmission of HIV; provision of care and support to those infected and affected by the epidemic to reduce its impact; and advocacy for mobilization of a worldwide response. With the disestablishment of the Global Programme on AIDS as of 31 December 1995 and the transfer of specific HIV/AIDS activities to UNAIDS, WHO has assured the continuity of its response with the establishment of the Office of HIV/AIDS and Sexually Transmitted Diseases at headquarters and of similar structures in the six regional offices. At country level WHO Representatives are actively involved in United Nations theme groups on AIDS within the framework of UNAIDS, chairing the theme group in over 90% of countries.

4. Within the context of its role as a cosponsor of UNAIDS' expanded response to the epidemic, WHO's objectives are: to coordinate efforts within headquarters and with regional offices in order to strengthen WHO's response to the epidemic; to integrate HIV/AIDS activities into relevant WHO programmes; to liaise with other partners; and to mobilize resources.

5. WHO policy and strategic orientations on HIV/AIDS and sexually transmitted diseases have been drawn up on the basis of the following considerations:

- HIV/AIDS is a major health problem
- WHO will mobilize all relevant technical resources to support national public health responses to the epidemic
- WHO will promote prevention, detection and treatment of sexually transmitted diseases as a major strategy for decreasing the risk of sexual transmission of HIV
- WHO will encourage safer sexual behaviour and promote sexual health
- WHO will promote cost-effective strategies that minimize unnecessary transfusions of blood and blood products
- WHO will promote prevention of nosocomial transmission through sound control of infection based on the principle of universal precautions

- WHO will encourage programmes covering the misuse of substances, including injecting drugs, and related sexual transmission

- WHO will contribute to promotion of prevention methods that can be controlled by women and of risk-reduction strategies for newborns including options for infant feeding

- WHO will advocate humane care, and will cooperate with countries to strengthen health care systems and to improve care and support for persons with HIV/AIDS and related conditions, including tuberculosis

- WHO will support clinical and operational research, as appropriate

- WHO will advocate a comprehensive, nondiscriminatory, nonjudgemental response at country level from all partners.

6. The strategic plan, drawn up on the basis of WHO's policy and strategic orientations at two planning meetings (May and October 1996), brought together programmes at all levels of the Organization, and in UNAIDS, and has five fundamental objectives: reduction of transmission from unsafe sexual behaviour, reduction of transmission through blood and blood products, reduction of perinatal transmission, strengthening of health systems, and improvement of the societal response. It has been built on the principles of: developing WHO's vision and approach in response to the HIV/AIDS epidemic and sexually transmitted diseases in the context of the United Nations cosponsored effort; integrating key HIV/AIDS activities and those relating to sexually transmitted diseases into the work of WHO in response to national governments; creating a spirit of teamwork, co-ownership and coresponsibility for WHO's work on HIV/AIDS and sexually transmitted diseases at all levels; and establishing a mechanism for feedback, monitoring and evaluation of WHO activities.

7. Technical support to Member States has taken the form of visits of staff from headquarters to countries and regional offices for collaboration in preparing strategic and operational plans and in defining the roles of UNAIDS country programme advisers, theme groups and WHO Representatives. Guidelines on syndromic management of sexually transmitted diseases have been translated from English and printed in Arabic, French, Portuguese, Russian and Spanish. Regional offices have been active in providing technical support to countries in areas such as surveillance, strengthening national blood transfusion services, nursing care, clinical management and counselling, and management of sexually transmitted diseases.

8. Integrating activities on HIV/AIDS and sexually transmitted diseases into the overall framework of the Organization has taken several forms. A matrix of activities related to HIV/AIDS and sexually transmitted diseases in some 20 programmes at headquarters and in the regional offices has been produced in the course of the strategic planning exercise. Working groups have been established to strengthen and to integrate HIV/AIDS-related activities involving UNAIDS, notably those concerning sexually transmitted diseases; HIV/AIDS epidemiological surveillance; access to drugs for HIV/AIDS and sexually transmitted diseases; infant feeding; and infectious disease control. This coherent and collaborative approach played a key part in preparing the strategic plan, and an even greater one in bringing it into operation. The Office of HIV/AIDS and Sexually Transmitted Diseases has participated in the preparation of the UNAIDS workplan and the sharing of activities between UNAIDS, WHO and the other cosponsors.

9. Efforts have been coordinated with other cosponsors. WHO, UNICEF and UNESCO are collaborating on various school health initiatives. WHO, UNICEF and UNDP collaborated in production of a policy guide on HIV and infant feeding. WHO is cooperating with the World Bank on technical reviews of major credits to developing countries in the areas of sexually transmitted diseases, HIV/AIDS and tuberculosis.

10. A quarterly newsletter has been produced since June 1996 and information is accessible electronically on WHO's Internet site.

11. Research activities on HIV/AIDS and sexually transmitted diseases are being continued and strengthened. For example, acceptability studies on new, non-latex male condoms, feasibility studies of preventive therapy for tuberculosis in persons also infected with HIV, and multicentre studies in four countries to assess increased access to tuberculosis treatment by involving community-based and home-based AIDS programmes are under way, as is the development of tools to improve access to drugs.

12. Financial support for the biennium 1996-1997 has been made available largely through reallocation of regular budget funds that had been budgeted for the Global Programme on AIDS and for sexually transmitted diseases, specified projects carried over from the Global Programme on AIDS, and from UNAIDS. Initially, the regular budget provision covers four staff in headquarters, 20 posts in regional offices and three country posts. UNAIDS is supporting four regional office posts and providing funds for regional and intercountry activities.

13. WHO has provided support to UNAIDS financially, in the form of US$ 720 000 for the biennium, and technically, in the form of participation in working groups for technical areas and for preparation of strategic and operational plans.

14. To mobilize resources, WHO actively participated in the preparation of the "UNAIDS Cosponsors' Coordinated Appeal for Supplemental Funded Activities" for the biennium 1996-1997 which was issued in June 1996. Of 18 proposals from all cosponsors totalling US$ 18 million, 11 were from WHO programmes for a total of US$ 3.7 million. UNAIDS has contributed US$ 1 million and Japan a similar amount. Proposals for the Coordinated Appeal for 1998-1999 have been prepared and submitted to UNAIDS for transmittal to the donor community.

15. An outcome of the strategic planning meetings has been the preparation of materials to reinforce the role of the WHO Representatives, including information on resource mobilization at country level.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

= = =

World Health Organization
Organisation mondiale de la Santé

FIFTIETH WORLD HEALTH ASSEMBLY

Provisional agenda item 19

A50/6 Corr.1
30 April 1997

Implementation of resolutions and decisions

Report by the Director-General

CORRIGENDUM

Page 16, paragraph 5

delete "WHO will promote cost-effective strategies that minimize unnecessary transfusions of blood and blood products"

insert "WHO will promote cost-effective strategies that prevent HIV transmission through blood and blood products by promoting safer blood donation, testing all blood and minimizing unnecessary transfusions."

= = =