WHA56/2003/REC/1

WORLD HEALTH ORGANIZATION

FIFTY-SIXTH WORLD HEALTH ASSEMBLY

GENEVA, 19-28 MAY 2003

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
2003

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ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research
ASEAN	– Association of South-East Asian Nations
CEB	– United Nations System Chief Executives Board for Coordination (formerly ACC)
CIOMS	– Council for International Organizations of Medical Sciences
FAO	– Food and Agriculture Organization of the United Nations
IAEA	– International Atomic Energy Agency
IARC	– International Agency for Research on Cancer
ICAO	– International Civil Aviation Organization
IFAD	– International Fund for Agricultural Development
ILO	– International Labour Organization (Office)
IMF	– International Monetary Fund
IMO	– International Maritime Organization
ITU	– International Telecommunication Union
OECD	– Organisation for Economic Co-operation and Development
PAHO	– Pan American Health Organization
UNAIDS	– Joint United Nations Programme on HIV/AIDS
UNCTAD	– United Nations Conference on Trade and Development
UNDCP	– United Nations International Drug Control Programme
UNDP	– United Nations Development Programme
UNEP	– United Nations Environment Programme
UNESCO	– United Nations Educational, Scientific and Cultural Organization
UNFPA	– United Nations Population Fund
UNHCR	– Office of the United Nations High Commissioner for Refugees
UNICEF	– United Nations Children's Fund
UNIDO	– United Nations Industrial Development Organization
UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
WFP	– World Food Programme
WIPO	– World Intellectual Property Organization
WMO	– World Meteorological Organization
WTO	– World Trade Organization

PREFACE

The Fifty-sixth World Health Assembly was held at the Palais des Nations, Geneva, from 19 to 28 May 2003, in accordance with the decision of the Executive Board at its 110th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA56/2003/REC/1

Verbatim records of plenary meetings, list of participants – document WHA56/2003/REC/2

Summary records of committees and ministerial round tables, reports of committees – document WHA56/2003/REC/3

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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President
Dr Khandaker Mosharraf HOSSAIN (Bangladesh)

Vice-Presidents
Mr U. OLANGUENA AWONO (Cameroon)
Dr J. TORRES-GOITIA C. (Bolivia)
Dr W. AL-MAANI (Jordan)
Mr H. VOIGTLÄNDER (Germany)
Dr C. OTTO (Palau)

Secretary
Dr Gro Harlem BRUNDTLAND, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Azerbaijan, Brazil, Congo, Equatorial Guinea, Haiti, Nepal, Norway, Oman, Portugal, Samoa, Sri Lanka and Zambia.

Chairman: Dr B. CHITUWO (Zambia)
Vice-Chairman: Dr O.T. CHRISTIANSEN (Norway)
Rapporteur: Dr E. ENOSA (Samoa)
Secretary: Mr T.S.R. TOPPING, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Albania, Bhutan, Cape Verde, Egypt, France, Gabon, Guinea-Bissau, Hungary, Lao People's Democratic Republic, Madagascar, Marshall Islands, Mauritius, Mexico, Myanmar, Namibia, Peru, Qatar, Russian Federation, Singapore, Spain, Thailand, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Dr J.F. López Beltrán, El Salvador (President, Fifty-fifth World Health Assembly, *ex officio*).

Chairman: Dr J.F. LÓPEZ BELTRÁN (El Salvador)
Secretary: Dr Gro Harlem BRUNDTLAND, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Algeria, Bahrain, Burundi, China, Cuba, France, Ghana, Greece, India, Iran (Islamic Republic of), Jamaica, Lesotho, Poland, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, and United States of America.

Chairman: Dr Khandaker Mosharraf HOSSAIN (Bangladesh)
Secretary: Dr Gro Harlem BRUNDTLAND, Director-General

MAIN COMMITTEES

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr J. LARIVIÈRE (Canada)
Vice-Chairmen: Dr Y.C. SEIGNON (Benin) and Dr J. MAHJOUR (Morocco)
Rapporteur: Mrs B. JANKÁSKOVÁ (Czech Republic)
Secretary: Dr S. HOLCK, Director, Health Information Management and Dissemination

Committee B

Chairman: Mr L. ROKOVADA (Fiji)
Vice-Chairmen: Dr R. CONSTANTINIU (Romania) and Mr SO Se Pyong (Democratic People's Republic of Korea)
Rapporteur: Mrs C. VELÁSQUEZ DE VISBAL (Venezuela)
Secretary: Dr M.K. BEHBEHANI, Director, Eastern Mediterranean Liaison

RESOLUTIONS

WHA56.1 WHO Framework Convention on Tobacco Control

The Fifty-sixth World Health Assembly,

Recalling resolutions WHA49.17 and WHA52.18 calling for the development of a WHO framework convention on tobacco control in accordance with Article 19 of the Constitution of WHO;

Determined to protect present and future generations from tobacco consumption and exposure to tobacco smoke;

Noting with profound concern the escalation in smoking and other forms of tobacco use worldwide;

Acknowledging with appreciation the report of the Chair of the Intergovernmental Negotiating Body on the outcome of the work of the Intergovernmental Negotiating Body;[1]

Convinced that this convention is a groundbreaking step in advancing national, regional and international action and global cooperation to protect human health against the devastating impact of tobacco consumption and exposure to tobacco smoke, and mindful that special consideration should be given to the particular situation of developing countries and countries with economies in transition;

Emphasizing the need for expeditious entry into force and effective implementation of the convention,

1. ADOPTS the Convention attached to this resolution;

2. NOTES, in accordance with Article 34 of the Convention, that the Convention shall be open for signature at WHO headquarters in Geneva, from 16 June 2003 to 22 June 2003, and thereafter at United Nations headquarters in New York, from 30 June 2003 to 29 June 2004;

3. CALLS UPON all States and regional economic integration organizations entitled to do so, to consider signing, ratifying, accepting, approving, formally confirming or acceding to the Convention at the earliest opportunity, with a view to bringing the Convention into force as soon as possible;

4. URGES all States and regional economic integration organizations, pending entry into force of the Convention, to take all appropriate measures to curb tobacco consumption and exposure to tobacco smoke;

5. URGES all Member States, regional economic integration organizations, observers and other interested parties to support the preparatory activities referred to in this resolution and effectively to encourage prompt entry into force and implementation of the Convention;

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[1] Document A56/INF.DOC./7 Rev.1.

6. CALLS UPON the United Nations and invites other relevant international organizations to continue to provide support for strengthening national and international tobacco control programmes;

7. DECIDES to establish, in accordance with Rule 42 of the Rules of Procedure of the World Health Assembly, an open-ended intergovernmental working group that shall be open to all States and regional economic integration organizations referred to in Article 34 of the Convention in order to consider and prepare proposals on those issues identified in the Convention for consideration and adoption, as appropriate, by the first session of the Conference of the Parties; such issues should include:

(1) rules of procedure for the Conference of the Parties (Article 23.3), including criteria for participation of observers at sessions of the Conference of the Parties (Article 23.6);

(2) options for the designation of a permanent secretariat and arrangements for its functioning (Article 24.1);

(3) financial rules for the Conference of the Parties and its subsidiary bodies, and financial provisions governing the functioning of the secretariat (Article 23.4);

(4) a draft budget for the first financial period (Article 23.4);

(5) a review of existing and potential sources and mechanisms of assistance to Parties in meeting their obligations under the Convention (Article 26.5);

8. FURTHER DECIDES that the Open-ended Intergovernmental Working Group shall also oversee preparations for the first session of the Conference of the Parties and report directly to it;

9. RESOLVES that decisions that had been taken by the Intergovernmental Negotiating Body on the WHO framework convention on tobacco control concerning the participation of nongovernmental organizations shall apply to the activities of the Open-ended Intergovernmental Working Group;

10. REQUESTS the Director-General:

(1) to provide secretariat functions under the Convention until such time as a permanent secretariat is designated and established;

(2) to take appropriate steps to provide support to Member States, in particular developing countries and countries with economies in transition, in preparation for entry into force of the Convention;

(3) to convene, as frequently as necessary, between 16 June 2003 and the first session of the Conference of the Parties, meetings of the Open-ended Intergovernmental Working Group;

(4) to continue to ensure that WHO plays a key role in providing technical advice, direction and support for global tobacco control;

(5) to keep the Health Assembly informed of progress made toward entry into force of the Convention and of preparations under way for the first session of the Conference of the Parties.

ANNEX

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Preamble

The Parties to this Convention,

Determined to give priority to their right to protect public health,

Recognizing that the spread of the tobacco epidemic is a global problem with serious consequences for public health that calls for the widest possible international cooperation and the participation of all countries in an effective, appropriate and comprehensive international response,

Reflecting the concern of the international community about the devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke,

Seriously concerned about the increase in the worldwide consumption and production of cigarettes and other tobacco products, particularly in developing countries, as well as about the burden this places on families, on the poor, and on national health systems,

Recognizing that scientific evidence has unequivocally established that tobacco consumption and exposure to tobacco smoke cause death, disease and disability, and that there is a time lag between the exposure to smoking and the other uses of tobacco products and the onset of tobacco-related diseases,

Recognizing also that cigarettes and some other products containing tobacco are highly engineered so as to create and maintain dependence, and that many of the compounds they contain and the smoke they produce are pharmacologically active, toxic, mutagenic and carcinogenic, and that tobacco dependence is separately classified as a disorder in major international classifications of diseases,

Acknowledging that there is clear scientific evidence that prenatal exposure to tobacco smoke causes adverse health and developmental conditions for children,

Deeply concerned about the escalation in smoking and other forms of tobacco consumption by children and adolescents worldwide, particularly smoking at increasingly early ages,

Alarmed by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies,

Deeply concerned about the high levels of smoking and other forms of tobacco consumption by indigenous peoples,

Seriously concerned about the impact of all forms of advertising, promotion and sponsorship aimed at encouraging the use of tobacco products,

Recognizing that cooperative action is necessary to eliminate all forms of illicit trade in cigarettes and other tobacco products, including smuggling, illicit manufacturing and counterfeiting,

Acknowledging that tobacco control at all levels and particularly in developing countries and in countries with economies in transition requires sufficient financial and technical resources commensurate with the current and projected need for tobacco control activities,

Recognizing the need to develop appropriate mechanisms to address the long-term social and economic implications of successful tobacco demand reduction strategies,

Mindful of the social and economic difficulties that tobacco control programmes may engender in the medium and long term in some developing countries and countries with economies in transition, and recognizing their need for technical and financial assistance in the context of nationally developed strategies for sustainable development,

Conscious of the valuable work being conducted by many States on tobacco control and commending the leadership of the World Health Organization as well as the efforts of other organizations and bodies of the United Nations system and other international and regional intergovernmental organizations in developing measures on tobacco control,

Emphasizing the special contribution of nongovernmental organizations and other members of civil society not affiliated with the tobacco industry, including health professional bodies, women's, youth, environmental and consumer groups, and academic and health care institutions, to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts,

Recognizing the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts,

Recalling Article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly on 16 December 1966, which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,

Recalling also the preamble to the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,

Determined to promote measures of tobacco control based on current and relevant scientific, technical and economic considerations,

Recalling that the Convention on the Elimination of All Forms of Discrimination against Women, adopted by the United Nations General Assembly on 18 December 1979, provides that States Parties to that Convention shall take appropriate measures to eliminate discrimination against women in the field of health care,

Recalling further that the Convention on the Rights of the Child, adopted by the United Nations General Assembly on 20 November 1989, provides that States Parties to that Convention recognize the right of the child to the enjoyment of the highest attainable standard of health,

Have agreed, as follows:

PART I: INTRODUCTION

Article 1
Use of terms

For the purposes of this Convention:

(a) "illicit trade" means any practice or conduct prohibited by law and which relates to production, shipment, receipt, possession, distribution, sale or purchase including any practice or conduct intended to facilitate such activity;

(b) "regional economic integration organization" means an organization that is composed of several sovereign states, and to which its Member States have transferred competence over a range of matters, including the authority to make decisions binding on its Member States in respect of those matters;[1]

(c) "tobacco advertising and promotion" means any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

(d) "tobacco control" means a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke;

(e) "tobacco industry" means tobacco manufacturers, wholesale distributors and importers of tobacco products;

(f) "tobacco products" means products entirely or partly made of the leaf tobacco as raw material which are manufactured to be used for smoking, sucking, chewing or snuffing;

(g) "tobacco sponsorship" means any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

Article 2
Relationship between this Convention and other agreements and legal instruments

1. In order to better protect human health, Parties are encouraged to implement measures beyond those required by this Convention and its protocols, and nothing in these instruments shall prevent a Party from imposing stricter requirements that are consistent with their provisions and are in accordance with international law.

2. The provisions of the Convention and its protocols shall in no way affect the right of Parties to enter into bilateral or multilateral agreements, including regional or subregional agreements, on issues relevant or additional to the Convention and its protocols, provided that such agreements are compatible with their obligations under the Convention and its protocols. The Parties concerned shall communicate such agreements to the Conference of the Parties through the Secretariat.

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[1] Where appropriate, national will refer equally to regional economic integration organizations.

PART II: OBJECTIVE, GUIDING PRINCIPLES AND GENERAL OBLIGATIONS

Article 3
Objective

The objective of this Convention and its protocols is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke.

Article 4
Guiding principles

To achieve the objective of this Convention and its protocols and to implement its provisions, the Parties shall be guided, *inter alia*, by the principles set out below:

1. Every person should be informed of the health consequences, addictive nature and mortal threat posed by tobacco consumption and exposure to tobacco smoke and effective legislative, executive, administrative or other measures should be contemplated at the appropriate governmental level to protect all persons from exposure to tobacco smoke.

2. Strong political commitment is necessary to develop and support, at the national, regional and international levels, comprehensive multisectoral measures and coordinated responses, taking into consideration:

(a) the need to take measures to protect all persons from exposure to tobacco smoke;

(b) the need to take measures to prevent the initiation, to promote and support cessation, and to decrease the consumption of tobacco products in any form;

(c) the need to take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally appropriate to their needs and perspectives; and

(d) the need to take measures to address gender-specific risks when developing tobacco control strategies.

3. International cooperation, particularly transfer of technology, knowledge and financial assistance and provision of related expertise, to establish and implement effective tobacco control programmes, taking into consideration local culture, as well as social, economic, political and legal factors, is an important part of the Convention.

4. Comprehensive multisectoral measures and responses to reduce consumption of all tobacco products at the national, regional and international levels are essential so as to prevent, in accordance with public health principles, the incidence of diseases, premature disability and mortality due to tobacco consumption and exposure to tobacco smoke.

5. Issues relating to liability, as determined by each Party within its jurisdiction, are an important part of comprehensive tobacco control.

6. The importance of technical and financial assistance to aid the economic transition of tobacco growers and workers whose livelihoods are seriously affected as a consequence of tobacco control programmes in developing country Parties, as well as Parties with economies in transition, should be recognized and addressed in the context of nationally developed strategies for sustainable development.

7. The participation of civil society is essential in achieving the objective of the Convention and its protocols.

Article 5
General obligations

1. Each Party shall develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with this Convention and the protocols to which it is a Party.

2. Towards this end, each Party shall, in accordance with its capabilities:

(a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control; and

(b) adopt and implement effective legislative, executive, administrative and/or other measures and cooperate, as appropriate, with other Parties in developing appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.

3. In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.

4. The Parties shall cooperate in the formulation of proposed measures, procedures and guidelines for the implementation of the Convention and the protocols to which they are Parties.

5. The Parties shall cooperate, as appropriate, with competent international and regional intergovernmental organizations and other bodies to achieve the objectives of the Convention and the protocols to which they are Parties.

6. The Parties shall, within means and resources at their disposal, cooperate to raise financial resources for effective implementation of the Convention through bilateral and multilateral funding mechanisms.

PART III: MEASURES RELATING TO THE REDUCTION OF DEMAND FOR TOBACCO

Article 6
Price and tax measures to reduce the demand for tobacco

1. The Parties recognize that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons.

2. Without prejudice to the sovereign right of the Parties to determine and establish their taxation policies, each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include:

(a) implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption; and

(b) prohibiting or restricting, as appropriate, sales to and/or importations by international travellers of tax- and duty-free tobacco products.

3. The Parties shall provide rates of taxation for tobacco products and trends in tobacco consumption in their periodic reports to the Conference of the Parties, in accordance with Article 21.

Article 7
Non-price measures to reduce the demand for tobacco

The Parties recognize that comprehensive non-price measures are an effective and important means of reducing tobacco consumption. Each Party shall adopt and implement effective legislative, executive, administrative or other measures necessary to implement its obligations pursuant to Articles 8 to 13 and shall cooperate, as appropriate, with each other directly or through competent international bodies with a view to their implementation. The Conference of the Parties shall propose appropriate guidelines for the implementation of the provisions of these Articles.

Article 8
Protection from exposure to tobacco smoke

1. Parties recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability.

2. Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

Article 9
Regulation of the contents of tobacco products

The Conference of the Parties, in consultation with competent international bodies, shall propose guidelines for testing and measuring the contents and emissions of tobacco products, and for the regulation of these contents and emissions. Each Party shall, where approved by competent national authorities, adopt and implement effective legislative, executive and administrative or other measures for such testing and measuring, and for such regulation.

Article 10
Regulation of tobacco product disclosures

Each Party shall, in accordance with its national law, adopt and implement effective legislative, executive, administrative or other measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products. Each Party shall further adopt and implement effective measures for public disclosure of

information about the toxic constituents of the tobacco products and the emissions that they may produce.

Article 11
Packaging and labelling of tobacco products

1. Each Party shall, within a period of three years after entry into force of this Convention for that Party, adopt and implement, in accordance with its national law, effective measures to ensure that:

(a) tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly creates the false impression that a particular tobacco product is less harmful than other tobacco products. These may include terms such as "low tar", "light", "ultra-light", or "mild"; and

(b) each unit packet and package of tobacco products and any outside packaging and labelling of such products also carry health warnings describing the harmful effects of tobacco use, and may include other appropriate messages. These warnings and messages:

(i) shall be approved by the competent national authority,

(ii) shall be rotating,

(iii) shall be large, clear, visible and legible,

(iv) should be 50% or more of the principal display areas but shall be no less than 30% of the principal display areas,

(v) may be in the form of or include pictures or pictograms.

2. Each unit packet and package of tobacco products and any outside packaging and labelling of such products shall, in addition to the warnings specified in paragraph 1(b) of this Article, contain information on relevant constituents and emissions of tobacco products as defined by national authorities.

3. Each Party shall require that the warnings and other textual information specified in paragraphs 1(b) and paragraph 2 of this Article will appear on each unit packet and package of tobacco products and any outside packaging and labelling of such products in its principal language or languages.

4. For the purposes of this Article, the term "outside packaging and labelling" in relation to tobacco products applies to any packaging and labelling used in the retail sale of the product.

Article 12
Education, communication, training and public awareness

Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Towards this end, each Party shall adopt and implement effective legislative, executive, administrative or other measures to promote:

(a) broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke;

(b) public awareness about the health risks of tobacco consumption and exposure to tobacco smoke, and about the benefits of the cessation of tobacco use and tobacco-free lifestyles as specified in Article 14.2;

(c) public access, in accordance with national law, to a wide range of information on the tobacco industry as relevant to the objective of this Convention;

(d) effective and appropriate training or sensitization and awareness programmes on tobacco control addressed to persons such as health workers, community workers, social workers, media professionals, educators, decision-makers, administrators and other concerned persons;

(e) awareness and participation of public and private agencies and nongovernmental organizations not affiliated with the tobacco industry in developing and implementing intersectoral programmes and strategies for tobacco control; and

(f) public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption.

Article 13
Tobacco advertising, promotion and sponsorship

1. Parties recognize that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products.

2. Each Party shall, in accordance with its constitution or constitutional principles, undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship. This shall include, subject to the legal environment and technical means available to that Party, a comprehensive ban on cross-border advertising, promotion and sponsorship originating from its territory. In this respect, within the period of five years after entry into force of this Convention for that Party, each Party shall undertake appropriate legislative, executive, administrative and/or other measures and report accordingly in conformity with Article 21.

3. A Party that is not in a position to undertake a comprehensive ban due to its constitution or constitutional principles shall apply restrictions on all tobacco advertising, promotion and sponsorship. This shall include, subject to the legal environment and technical means available to that Party, restrictions or a comprehensive ban on advertising, promotion and sponsorship originating from its territory with cross-border effects. In this respect, each Party shall undertake appropriate legislative, executive, administrative and/or other measures and report accordingly in conformity with Article 21.

4. As a minimum, and in accordance with its constitution or constitutional principles, each Party shall:

(a) prohibit all forms of tobacco advertising, promotion and sponsorship that promote a tobacco product by any means that are false, misleading or deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions;

(b) require that health or other appropriate warnings or messages accompany all tobacco advertising and, as appropriate, promotion and sponsorship;

(c) restrict the use of direct or indirect incentives that encourage the purchase of tobacco products by the public;

(d) require, if it does not have a comprehensive ban, the disclosure to relevant governmental authorities of expenditures by the tobacco industry on advertising, promotion and sponsorship not yet prohibited. Those authorities may decide to make those figures available, subject to national law, to the public and to the Conference of the Parties, pursuant to Article 21;

(e) undertake a comprehensive ban or, in the case of a Party that is not in a position to undertake a comprehensive ban due to its constitution or constitutional principles, restrict tobacco advertising, promotion and sponsorship on radio, television, print media and, as appropriate, other media, such as the internet, within a period of five years; and

(f) prohibit, or in the case of a Party that is not in a position to prohibit due to its constitution or constitutional principles restrict, tobacco sponsorship of international events, activities and/or participants therein.

5. Parties are encouraged to implement measures beyond the obligations set out in paragraph 4.

6. Parties shall cooperate in the development of technologies and other means necessary to facilitate the elimination of cross-border advertising.

7. Parties which have a ban on certain forms of tobacco advertising, promotion and sponsorship have the sovereign right to ban those forms of cross-border tobacco advertising, promotion and sponsorship entering their territory and to impose equal penalties as those applicable to domestic advertising, promotion and sponsorship originating from their territory in accordance with their national law. This paragraph does not endorse or approve of any particular penalty.

8. Parties shall consider the elaboration of a protocol setting out appropriate measures that require international collaboration for a comprehensive ban on cross-border advertising, promotion and sponsorship.

Article 14

Demand reduction measures concerning tobacco dependence and cessation

1. Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.

2. Towards this end, each Party shall endeavour to:

(a) design and implement effective programmes aimed at promoting the cessation of tobacco use, in such locations as educational institutions, health care facilities, workplaces and sporting environments;

(b) include diagnosis and treatment of tobacco dependence and counselling services on cessation of tobacco use in national health and education programmes, plans and strategies, with the participation of health workers, community workers and social workers as appropriate;

(c) establish in health care facilities and rehabilitation centres programmes for diagnosing, counselling, preventing and treating tobacco dependence; and

(d) collaborate with other Parties to facilitate accessibility and affordability for treatment of tobacco dependence including pharmaceutical products pursuant to Article 22. Such products and their constituents may include medicines, products used to administer medicines and diagnostics when appropriate.

PART IV: MEASURES RELATING TO THE REDUCTION OF THE SUPPLY OF TOBACCO

Article 15
Illicit trade in tobacco products

1. The Parties recognize that the elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting, and the development and implementation of related national law, in addition to subregional, regional and global agreements, are essential components of tobacco control.

2. Each Party shall adopt and implement effective legislative, executive, administrative or other measures to ensure that all unit packets and packages of tobacco products and any outside packaging of such products are marked to assist Parties in determining the origin of tobacco products, and in accordance with national law and relevant bilateral or multilateral agreements, assist Parties in determining the point of diversion and monitor, document and control the movement of tobacco products and their legal status. In addition, each Party shall:

(a) require that unit packets and packages of tobacco products for retail and wholesale use that are sold on its domestic market carry the statement: *"Sales only allowed in (insert name of the country, subnational, regional or federal unit)"* or carry any other effective marking indicating the final destination or which would assist authorities in determining whether the product is legally for sale on the domestic market; and

(b) consider, as appropriate, developing a practical tracking and tracing regime that would further secure the distribution system and assist in the investigation of illicit trade.

3. Each Party shall require that the packaging information or marking specified in paragraph 2 of this Article shall be presented in legible form and/or appear in its principal language or languages.

4. With a view to eliminating illicit trade in tobacco products, each Party shall:

(a) monitor and collect data on cross-border trade in tobacco products, including illicit trade, and exchange information among customs, tax and other authorities, as appropriate, and in accordance with national law and relevant applicable bilateral or multilateral agreements;

(b) enact or strengthen legislation, with appropriate penalties and remedies, against illicit trade in tobacco products, including counterfeit and contraband cigarettes;

(c) take appropriate steps to ensure that all confiscated manufacturing equipment, counterfeit and contraband cigarettes and other tobacco products are destroyed, using environmentally-friendly methods where feasible, or disposed of in accordance with national law;

(d) adopt and implement measures to monitor, document and control the storage and distribution of tobacco products held or moving under suspension of taxes or duties within its jurisdiction; and

(e) adopt measures as appropriate to enable the confiscation of proceeds derived from the illicit trade in tobacco products.

5. Information collected pursuant to subparagraphs 4(a) and 4(d) of this Article shall, as appropriate, be provided in aggregate form by the Parties in their periodic reports to the Conference of the Parties, in accordance with Article 21.

6. The Parties shall, as appropriate and in accordance with national law, promote cooperation between national agencies, as well as relevant regional and international intergovernmental organizations as it relates to investigations, prosecutions and proceedings, with a view to eliminating illicit trade in tobacco products. Special emphasis shall be placed on cooperation at regional and subregional levels to combat illicit trade of tobacco products.

7. Each Party shall endeavour to adopt and implement further measures including licensing, where appropriate, to control or regulate the production and distribution of tobacco products in order to prevent illicit trade.

Article 16
Sales to and by minors

1. Each Party shall adopt and implement effective legislative, executive, administrative or other measures at the appropriate government level to prohibit the sales of tobacco products to persons under the age set by domestic law, national law or eighteen. These measures may include:

(a) requiring that all sellers of tobacco products place a clear and prominent indicator inside their point of sale about the prohibition of tobacco sales to minors and, in case of doubt, request that each tobacco purchaser provide appropriate evidence of having reached full legal age;

(b) banning the sale of tobacco products in any manner by which they are directly accessible, such as store shelves;

(c) prohibiting the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products which appeal to minors; and

(d) ensuring that tobacco vending machines under its jurisdiction are not accessible to minors and do not promote the sale of tobacco products to minors.

2. Each Party shall prohibit or promote the prohibition of the distribution of free tobacco products to the public and especially minors.

3. Each Party shall endeavour to prohibit the sale of cigarettes individually or in small packets which increase the affordability of such products to minors.

4. The Parties recognize that in order to increase their effectiveness, measures to prevent tobacco product sales to minors should, where appropriate, be implemented in conjunction with other provisions contained in this Convention.

5. When signing, ratifying, accepting, approving or acceding to the Convention or at any time thereafter, a Party may, by means of a binding written declaration, indicate its commitment to prohibit the introduction of tobacco vending machines within its jurisdiction or, as appropriate, to a total ban on tobacco vending machines. The declaration made pursuant to this Article shall be circulated by the Depositary to all Parties to the Convention.

6. Each Party shall adopt and implement effective legislative, executive, administrative or other measures, including penalties against sellers and distributors, in order to ensure compliance with the obligations contained in paragraphs 1-5 of this Article.

7. Each Party should, as appropriate, adopt and implement effective legislative, executive, administrative or other measures to prohibit the sales of tobacco products by persons under the age set by domestic law, national law or eighteen.

Article 17
Provision of support for economically viable alternative activities

Parties shall, in cooperation with each other and with competent international and regional intergovernmental organizations, promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers.

PART V: PROTECTION OF THE ENVIRONMENT

Article 18
Protection of the environment and the health of persons

In carrying out their obligations under this Convention, the Parties agree to have due regard to the protection of the environment and the health of persons in relation to the environment in respect of tobacco cultivation and manufacture within their respective territories.

PART VI: QUESTIONS RELATED TO LIABILITY

Article 19
Liability

1. For the purpose of tobacco control, the Parties shall consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate.

2. Parties shall cooperate with each other in exchanging information through the Conference of the Parties in accordance with Article 21 including:

(a) information on the health effects of the consumption of tobacco products and exposure to tobacco smoke in accordance with Article 20.3(a); and

(b) information on legislation and regulations in force as well as pertinent jurisprudence.

3. The Parties shall, as appropriate and mutually agreed, within the limits of national legislation, policies, legal practices and applicable existing treaty arrangements, afford one another assistance in legal proceedings relating to civil and criminal liability consistent with this Convention.

4. The Convention shall in no way affect or limit any rights of access of the Parties to each other's courts where such rights exist.

5. The Conference of the Parties may consider, if possible, at an early stage, taking account of the work being done in relevant international fora, issues related to liability including appropriate international approaches to these issues and appropriate means to support, upon request, the Parties in their legislative and other activities in accordance with this Article.

PART VII: SCIENTIFIC AND TECHNICAL COOPERATION AND COMMUNICATION OF INFORMATION

Article 20
Research, surveillance and exchange of information

1. The Parties undertake to develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control. Towards this end, each Party shall:

(a) initiate and cooperate in, directly or through competent international and regional intergovernmental organizations and other bodies, the conduct of research and scientific assessments, and in so doing promote and encourage research that addresses the determinants and consequences of tobacco consumption and exposure to tobacco smoke as well as research for identification of alternative crops; and

(b) promote and strengthen, with the support of competent international and regional intergovernmental organizations and other bodies, training and support for all those engaged in tobacco control activities, including research, implementation and evaluation.

2. The Parties shall establish, as appropriate, programmes for national, regional and global surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke. Towards this end, the Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analysed at the regional and international levels, as appropriate.

3. Parties recognize the importance of financial and technical assistance from international and regional intergovernmental organizations and other bodies. Each Party shall endeavour to:

(a) establish progressively a national system for the epidemiological surveillance of tobacco consumption and related social, economic and health indicators;

(b) cooperate with competent international and regional intergovernmental organizations and other bodies, including governmental and nongovernmental agencies, in regional and global tobacco surveillance and exchange of information on the indicators specified in paragraph 3(a) of this Article; and

(c) cooperate with the World Health Organization in the development of general guidelines or procedures for defining the collection, analysis and dissemination of tobacco-related surveillance data.

4. The Parties shall, subject to national law, promote and facilitate the exchange of publicly available scientific, technical, socioeconomic, commercial and legal information, as well as information regarding practices of the tobacco industry and the cultivation of tobacco, which is relevant to this Convention, and in so doing shall take into account and address the special needs of developing country Parties and Parties with economies in transition. Each Party shall endeavour to:

(a) progressively establish and maintain an updated database of laws and regulations on tobacco control and, as appropriate, information about their enforcement, as well as pertinent jurisprudence, and cooperate in the development of programmes for regional and global tobacco control;

(b) progressively establish and maintain updated data from national surveillance programmes in accordance with paragraph 3(a) of this Article; and

(c) cooperate with competent international organizations to progressively establish and maintain a global system to regularly collect and disseminate information on tobacco production, manufacture and the activities of the tobacco industry which have an impact on the Convention or national tobacco control activities.

5. Parties should cooperate in regional and international intergovernmental organizations and financial and development institutions of which they are members, to promote and encourage provision of technical and financial resources to the Secretariat to assist developing country Parties and Parties with economies in transition to meet their commitments on research, surveillance and exchange of information.

Article 21
Reporting and exchange of information

1. Each Party shall submit to the Conference of the Parties, through the Secretariat, periodic reports on its implementation of this Convention, which should include the following:

(a) information on legislative, executive, administrative or other measures taken to implement the Convention;

(b) information, as appropriate, on any constraints or barriers encountered in its implementation of the Convention, and on the measures taken to overcome these barriers;

(c) information, as appropriate, on financial and technical assistance provided or received for tobacco control activities;

(d) information on surveillance and research as specified in Article 20; and

(e) information specified in Articles 6.3, 13.2, 13.3, 13.4(d), 15.5 and 19.2.

2. The frequency and format of such reports by all Parties shall be determined by the Conference of the Parties. Each Party shall make its initial report within two years of the entry into force of the Convention for that Party.

3. The Conference of the Parties, pursuant to Articles 22 and 26, shall consider arrangements to assist developing country Parties and Parties with economies in transition, at their request, in meeting their obligations under this Article.

4. The reporting and exchange of information under the Convention shall be subject to national law regarding confidentiality and privacy. The Parties shall protect, as mutually agreed, any confidential information that is exchanged.

Article 22
Cooperation in the scientific, technical, and legal fields and provision of related expertise

1. The Parties shall cooperate directly or through competent international bodies to strengthen their capacity to fulfill the obligations arising from this Convention, taking into account the needs of developing country Parties and Parties with economies in transition. Such cooperation shall promote the transfer of technical, scientific and legal expertise and technology, as mutually agreed, to establish and strengthen national tobacco control strategies, plans and programmes aiming at, *inter alia*:

(a) facilitation of the development, transfer and acquisition of technology, knowledge, skills, capacity and expertise related to tobacco control;

(b) provision of technical, scientific, legal and other expertise to establish and strengthen national tobacco control strategies, plans and programmes, aiming at implementation of the Convention through, *inter alia*:

(i) assisting, upon request, in the development of a strong legislative foundation as well as technical programmes, including those on prevention of initiation, promotion of cessation and protection from exposure to tobacco smoke;

(ii) assisting, as appropriate, tobacco workers in the development of appropriate economically and legally viable alternative livelihoods in an economically viable manner; and

(iii) assisting, as appropriate, tobacco growers in shifting agricultural production to alternative crops in an economically viable manner;

(c) support for appropriate training or sensitization programmes for appropriate personnel in accordance with Article 12;

(d) provision, as appropriate, of the necessary material, equipment and supplies, as well as logistical support, for tobacco control strategies, plans and programmes;

(e) identification of methods for tobacco control, including comprehensive treatment of nicotine addiction; and

(f) promotion, as appropriate, of research to increase the affordability of comprehensive treatment of nicotine addiction.

2. The Conference of the Parties shall promote and facilitate transfer of technical, scientific and legal expertise and technology with the financial support secured in accordance with Article 26.

PART VIII: INSTITUTIONAL ARRANGEMENTS AND FINANCIAL RESOURCES

Article 23
Conference of the Parties

1. A Conference of the Parties is hereby established. The first session of the Conference shall be convened by the World Health Organization not later than one year after the entry into force of this Convention. The Conference will determine the venue and timing of subsequent regular sessions at its first session.

2. Extraordinary sessions of the Conference of the Parties shall be held at such other times as may be deemed necessary by the Conference, or at the written request of any Party, provided that, within six months of the request being communicated to them by the Secretariat of the Convention, it is supported by at least one-third of the Parties.

3. The Conference of the Parties shall adopt by consensus its Rules of Procedure at its first session.

4. The Conference of the Parties shall by consensus adopt financial rules for itself as well as governing the funding of any subsidiary bodies it may establish as well as financial provisions governing the functioning of the Secretariat. At each ordinary session, it shall adopt a budget for the financial period until the next ordinary session.

5. The Conference of the Parties shall keep under regular review the implementation of the Convention and take the decisions necessary to promote its effective implementation and may adopt protocols, annexes and amendments to the Convention, in accordance with Articles 28, 29 and 33. Towards this end, it shall:

(a) promote and facilitate the exchange of information pursuant to Articles 20 and 21;

(b) promote and guide the development and periodic refinement of comparable methodologies for research and the collection of data, in addition to those provided for in Article 20, relevant to the implementation of the Convention;

(c) promote, as appropriate, the development, implementation and evaluation of strategies, plans, and programmes, as well as policies, legislation and other measures;

(d) consider reports submitted by the Parties in accordance with Article 21 and adopt regular reports on the implementation of the Convention;

(e) promote and facilitate the mobilization of financial resources for the implementation of the Convention in accordance with Article 26;

(f) establish such subsidiary bodies as are necessary to achieve the objective of the Convention;

(g) request, where appropriate, the services and cooperation of, and information provided by, competent and relevant organizations and bodies of the United Nations system and other international and regional intergovernmental organizations and nongovernmental organizations and bodies as a means of strengthening the implementation of the Convention; and

(h) consider other action, as appropriate, for the achievement of the objective of the Convention in the light of experience gained in its implementation.

6. The Conference of the Parties shall establish the criteria for the participation of observers at its proceedings.

Article 24
Secretariat

1. The Conference of the Parties shall designate a permanent secretariat and make arrangements for its functioning. The Conference of the Parties shall endeavour to do so at its first session.

2. Until such time as a permanent secretariat is designated and established, secretariat functions under this Convention shall be provided by the World Health Organization.

3. Secretariat functions shall be:

(a) to make arrangements for sessions of the Conference of the Parties and any subsidiary bodies and to provide them with services as required;

(b) to transmit reports received by it pursuant to the Convention;

(c) to provide support to the Parties, particularly developing country Parties and Parties with economies in transition, on request, in the compilation and communication of information required in accordance with the provisions of the Convention;

(d) to prepare reports on its activities under the Convention under the guidance of the Conference of the Parties and submit them to the Conference of the Parties;

(e) to ensure, under the guidance of the Conference of the Parties, the necessary coordination with the competent international and regional intergovernmental organizations and other bodies;

(f) to enter, under the guidance of the Conference of the Parties, into such administrative or contractual arrangements as may be required for the effective discharge of its functions; and

(g) to perform other secretariat functions specified by the Convention and by any of its protocols and such other functions as may be determined by the Conference of the Parties.

Article 25
Relations between the Conference of the Parties and intergovernmental organizations

In order to provide technical and financial cooperation for achieving the objective of this Convention, the Conference of the Parties may request the cooperation of competent international and regional intergovernmental organizations including financial and development institutions.

Article 26
Financial resources

1. The Parties recognize the important role that financial resources play in achieving the objective of this Convention.

2. Each Party shall provide financial support in respect of its national activities intended to achieve the objective of the Convention, in accordance with its national plans, priorities and programmes.

3. Parties shall promote, as appropriate, the utilization of bilateral, regional, subregional and other multilateral channels to provide funding for the development and strengthening of multisectoral comprehensive tobacco control programmes of developing country Parties and Parties with economies in transition. Accordingly, economically viable alternatives to tobacco production, including crop diversification should be addressed and supported in the context of nationally developed strategies of sustainable development.

4. Parties represented in relevant regional and international intergovernmental organizations, and financial and development institutions shall encourage these entities to provide financial assistance for developing country Parties and for Parties with economies in transition to assist them in meeting their obligations under the Convention, without limiting the rights of participation within these organizations.

5. The Parties agree that:

(a) to assist Parties in meeting their obligations under the Convention, all relevant potential and existing resources, financial, technical, or otherwise, both public and private that are available for tobacco control activities, should be mobilized and utilized for the benefit of all Parties, especially developing countries and countries with economies in transition;

(b) the Secretariat shall advise developing country Parties and Parties with economies in transition, upon request, on available sources of funding to facilitate the implementation of their obligations under the Convention;

(c) the Conference of the Parties in its first session shall review existing and potential sources and mechanisms of assistance based on a study conducted by the Secretariat and other relevant information, and consider their adequacy; and

(d) the results of this review shall be taken into account by the Conference of the Parties in determining the necessity to enhance existing mechanisms or to establish a voluntary global fund or other appropriate financial mechanisms to channel additional financial resources, as needed, to developing country Parties and Parties with economies in transition to assist them in meeting the objectives of the Convention.

PART IX: SETTLEMENT OF DISPUTES

Article 27
Settlement of disputes

1. In the event of a dispute between two or more Parties concerning the interpretation or application of this Convention, the Parties concerned shall seek through diplomatic channels a settlement of the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation, or conciliation. Failure to reach agreement by good offices, mediation or conciliation shall not absolve parties to the dispute from the responsibility of continuing to seek to resolve it.

2. When ratifying, accepting, approving, formally confirming or acceding to the Convention, or at any time thereafter, a State or regional economic integration organization may declare in writing to the Depositary that, for a dispute not resolved in accordance with paragraph 1 of this Article, it accepts, as compulsory, ad hoc arbitration in accordance with procedures to be adopted by consensus by the Conference of the Parties.

3. The provisions of this Article shall apply with respect to any protocol as between the parties to the protocol, unless otherwise provided therein.

PART X: DEVELOPMENT OF THE CONVENTION

Article 28
Amendments to this Convention

1. Any Party may propose amendments to this Convention. Such amendments will be considered by the Conference of the Parties.

2. Amendments to the Convention shall be adopted by the Conference of the Parties. The text of any proposed amendment to the Convention shall be communicated to the Parties by the Secretariat at least six months before the session at which it is proposed for adoption. The Secretariat shall also communicate proposed amendments to the signatories of the Convention and, for information, to the Depositary.

3. The Parties shall make every effort to reach agreement by consensus on any proposed amendment to the Convention. If all efforts at consensus have been exhausted, and no agreement reached, the amendment shall as a last resort be adopted by a three-quarters majority vote of the Parties present and voting at the session. For purposes of this Article, Parties present and voting means

Parties present and casting an affirmative or negative vote. Any adopted amendment shall be communicated by the Secretariat to the Depositary, who shall circulate it to all Parties for acceptance.

4. Instruments of acceptance in respect of an amendment shall be deposited with the Depositary. An amendment adopted in accordance with paragraph 3 of this Article shall enter into force for those Parties having accepted it on the ninetieth day after the date of receipt by the Depositary of an instrument of acceptance by at least two-thirds of the Parties to the Convention.

5. The amendment shall enter into force for any other Party on the ninetieth day after the date on which that Party deposits with the Depositary its instrument of acceptance of the said amendment.

Article 29
Adoption and amendment of annexes to this Convention

1. Annexes to this Convention and amendments thereto shall be proposed, adopted and shall enter into force in accordance with the procedure set forth in Article 28.

2. Annexes to the Convention shall form an integral part thereof and, unless otherwise expressly provided, a reference to the Convention constitutes at the same time a reference to any annexes thereto.

3. Annexes shall be restricted to lists, forms and any other descriptive material relating to procedural, scientific, technical or administrative matters.

PART XI: FINAL PROVISIONS

Article 30
Reservations

No reservations may be made to this Convention.

Article 31
Withdrawal

1. At any time after two years from the date on which this Convention has entered into force for a Party, that Party may withdraw from the Convention by giving written notification to the Depositary.

2. Any such withdrawal shall take effect upon expiry of one year from the date of receipt by the Depositary of the notification of withdrawal, or on such later date as may be specified in the notification of withdrawal.

3. Any Party that withdraws from the Convention shall be considered as also having withdrawn from any protocol to which it is a Party.

Article 32
Right to vote

1. Each Party to this Convention shall have one vote, except as provided for in paragraph 2 of this Article.

2. Regional economic integration organizations, in matters within their competence, shall exercise their right to vote with a number of votes equal to the number of their Member States that are Parties to the Convention. Such an organization shall not exercise its right to vote if any of its Member States exercises its right, and vice versa.

Article 33
Protocols

1. Any Party may propose protocols. Such proposals will be considered by the Conference of the Parties.

2. The Conference of the Parties may adopt protocols to this Convention. In adopting these protocols every effort shall be made to reach consensus. If all efforts at consensus have been exhausted, and no agreement reached, the protocol shall as a last resort be adopted by a three-quarters majority vote of the Parties present and voting at the session. For the purposes of this Article, Parties present and voting means Parties present and casting an affirmative or negative vote.

3. The text of any proposed protocol shall be communicated to the Parties by the Secretariat at least six months before the session at which it is proposed for adoption.

4. Only Parties to the Convention may be parties to a protocol.

5. Any protocol to the Convention shall be binding only on the parties to the protocol in question. Only Parties to a protocol may take decisions on matters exclusively relating to the protocol in question.

6. The requirements for entry into force of any protocol shall be established by that instrument.

Article 34
Signature

This Convention shall be open for signature by all Members of the World Health Organization and by any States that are not Members of the World Health Organization but are members of the United Nations and by regional economic integration organizations at the World Health Organization Headquarters in Geneva from 16 June 2003 to 22 June 2003, and thereafter at United Nations Headquarters in New York, from 30 June 2003 to 29 June 2004.

Article 35
Ratification, acceptance, approval, formal confirmation or accession

1. This Convention shall be subject to ratification, acceptance, approval or accession by States and to formal confirmation or accession by regional economic integration organizations. It shall be open for accession from the day after the date on which the Convention is closed for signature. Instruments of ratification, acceptance, approval, formal confirmation or accession shall be deposited with the Depositary.

2. Any regional economic integration organization which becomes a Party to the Convention without any of its Member States being a Party shall be bound by all the obligations under the Convention. In the case of those organizations, one or more of whose Member States is a Party to the Convention, the organization and its Member States shall decide on their respective responsibilities for the performance of their obligations under the Convention. In such cases, the organization and the Member States shall not be entitled to exercise rights under the Convention concurrently.

3. Regional economic integration organizations shall, in their instruments relating to formal confirmation or in their instruments of accession, declare the extent of their competence with respect to the matters governed by the Convention. These organizations shall also inform the Depositary, who shall in turn inform the Parties, of any substantial modification in the extent of their competence.

Article 36
Entry into force

1. This Convention shall enter into force on the ninetieth day following the date of deposit of the fortieth instrument of ratification, acceptance, approval, formal confirmation or accession with the Depositary.

2. For each State that ratifies, accepts or approves the Convention or accedes thereto after the conditions set out in paragraph 1 of this Article for entry into force have been fulfilled, the Convention shall enter into force on the ninetieth day following the date of deposit of its instrument of ratification, acceptance, approval or accession.

3. For each regional economic integration organization depositing an instrument of formal confirmation or an instrument of accession after the conditions set out in paragraph 1 of this Article for entry into force have been fulfilled, the Convention shall enter into force on the ninetieth day following the date of its depositing of the instrument of formal confirmation or of accession.

4. For the purposes of this Article, any instrument deposited by a regional economic integration organization shall not be counted as additional to those deposited by States Members of the organization.

Article 37
Depositary

The Secretary-General of the United Nations shall be the Depositary of this Convention and amendments thereto and of protocols and annexes adopted in accordance with Articles 28, 29 and 33.

Article 38
Authentic texts

The original of this Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

IN WITNESS WHEREOF the undersigned, being duly authorized to that effect, have signed this Convention.

DONE at GENEVA this twenty-first day of May two thousand and three.

(Fourth plenary meeting, 21 May 2003 –
Committee A, first report)

WHA56.2 Appointment of the Director-General

The Fifty-sixth World Health Assembly,

On the nomination of the Executive Board,

APPOINTS Dr Jong-Wook Lee as Director-General of the World Health Organization.

(Fifth plenary meeting, 21 May 2003)

WHA56.3 Contract of the Director-General[1]

The Fifty-sixth World Health Assembly,

I

Pursuant to Article 31 of the Constitution and Rule 109 of the Rules of Procedure of the World Health Assembly,

APPROVES the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General;

II

Pursuant to Rule 112 of the Rules of Procedure of the World Health Assembly,

AUTHORIZES the President of the Fifty-sixth World Health Assembly to sign the said contract in the name of the Organization.

(Fifth plenary meeting, 21 May 2003)

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[1] Annex 1.

WHA56.4 Expression of appreciation to Dr Gro Harlem Brundtland

The Fifty-sixth World Health Assembly,

Expressing its profound gratitude to Dr Gro Harlem Brundtland for her outstanding and visionary managerial, political and technical leadership, characterized by integrity, strength, endurance and determination;

Appreciating her highly successful efforts to place issues of health and determinants of ill-health at the centre of the global political agenda;

Commending her personal effort to establish evidence of the important role played by health in economic development and poverty reduction;

Paying tribute to her challenge to society as a whole in her endeavours to achieve a healthy life for all, with a special emphasis on underprivileged and vulnerable people;

Acclaiming her success in strengthening the role of WHO as the lead agency in health, in constructive cooperation with others in the international community;

DECLARES Dr Gro Harlem Brundtland Director-General Emeritus of the World Health Organization as from the date of her retirement.

(Fifth plenary meeting, 21 May 2003)

WHA56.5 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

The Fifty-sixth World Health Assembly,

Mindful of the basic principle established in the WHO Constitution, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on the health conditions in the occupied Arab territories;

Recalling with appreciation the report of the Director-General[1] on the health conditions of and assistance to the Arab population in the occupied Arab territories, including Palestine;

Expressing its deep concern at the deterioration of the health conditions as a result of the Israeli military acts against the Palestinian people since 28 September 2000, acts such as firing on civilians and deliberate extra-judicial killing, which caused hundreds of deaths and tens of thousands of injuries among Palestinians, including a large number of children; imposition of siege on Palestinian areas, thus preventing medicines and food from reaching towns, villages and refugee camps; obstruction of the circulation of ambulances, injuring a number of ambulance crew members; and denial of access of injured people to hospitals and health institutions, thus condemning them to death;

[1] Document A56/44.

Expressing its grave concern at the continued acts of aggression which have caused large-scale death and injury among Palestinians, thus increasing the toll of casualties which have so far reached thousands killed and tens of thousands wounded since 28 September 2000;

Expressing its grave concern at the serious violations by the Israeli occupation authorities in the occupied Palestinian territories of international humanitarian law and international public law, as well as their adverse effects on public health;

Stressing the integrity of the entire occupied Palestinian territory and the importance of guaranteeing the freedom of movement of persons, medical products and goods within the Palestinian territory, including the removal of restrictions on the movement into and from East Jerusalem and the freedom of movement to and from the Palestinian territories, particularly for the wounded and sick;

Bearing in mind the adverse effects of the continued closure of the Palestinian territory on the health sector, particularly with regard to the children who have been prevented from receiving vaccination for over 20 months, leading to high risk of infectious diseases and epidemics among children, whereas vaccination and immunization against infectious diseases constitute a basic right of every child in the world;

Noting with deep anxiety and concern the deterioration resulting from the excessive use of force by the Israeli occupation forces against civilians, including medical teams, and its negative impact on health programmes, especially on mother- and child-related programmes, vaccination, reproductive health, family planning, epidemic control, school health, control of drinking-water safety, insect control, mental health and health education;

Expressing its deep concern at the serious deterioration of the economic situation in the Palestinian territory which has become a serious threat to the Palestinian health system, aggravated by the withholding by Israel of funds due to the Palestinian Authority, including health insurance income;

Affirming that the risks menacing public health are increasing as a result of the Israeli military incursions in the occupied Palestinian territories, imposition of closures and curfews on various areas, the refusal by Israel to honour the payment of taxes due to the Palestinian National Authority, the need to secure the resources necessary for assuring basic needs, prevention of every access to places such as education premises, markets and medical clinics, the decrease in the level of vaccinations, the complications imposed on patients suffering from chronic diseases such as cardiovascular conditions, cancer or kidney problems;

Affirming that the Israeli occupation prevents access of the Palestinian people to basic services, including health services;

Affirming that the current situation in the occupied Palestinian territories undermines efforts to maintain public health and endangers people's security, and furthermore that its consequences will certainly have an adverse effect on public health;

Affirming the need to increase health support to and assistance for Palestinian populations in the regions under the control of the Palestinian Authority and for the Arab populations in the occupied territories, including Palestinians and the population in the occupied Syrian Golan;

Reaffirming the right of Palestinian patients and medical staff to benefit from health facilities available in the Palestinian Health Institutions in occupied East Jerusalem;

Affirming the need to provide international protection for the Palestinian people and health assistance to the Arab populations in the occupied territories, including the occupied Syrian Golan;

Having considered the reports on health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine, particularly the Director-General's report,

1. RECOGNIZES that the Israeli occupation is a grave health problem because of the serious threat it poses to the health and lives of Palestinian citizens;

2. STRONGLY CONDEMNS the persistence of the Israeli acts of aggression against Palestinian towns and camps, which have resulted so far in the death and injury of thousands of Palestinian civilians, including women and children;

3. STRONGLY CONDEMNS the firing on ambulances and paramedical personnel by the Israeli army of occupation, preventing ambulances and cars of the International Committee of the Red Cross from reaching the wounded and the dead to transport them to hospitals, thus leaving the wounded bleeding to death in the streets;

4. AFFIRMS the need to support the efforts of the Palestinian Ministry of Health to continue to provide emergency services, to deliver health and disease prevention programmes, to receive further casualties in the future and to deal with thousands of people suffering from physical and mental disabilities;

5. CALLS ON Israel to release all the funds due to the Palestinian Authority, including health insurance dues;

6. URGES Member States, intergovernmental, nongovernmental and regional organizations to extend urgent and generous assistance to bring about health development for the Palestinian people and meet their urgent humanitarian needs;

7. EXTENDS its thanks and appreciation to the Director-General for her report[1] and for her continued efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territories;

8. STRONGLY DENOUNCES the refusal by the Israeli occupation authorities to allow the Director-General to visit the occupied Palestinian territories to undertake her missions in accordance with Health Assembly resolutions;

9. REQUESTS the immediate institution of a fact-finding committee on the deterioration of the health situation in the occupied Palestinian territory, enabled to undertake its role as soon as possible;

10. REQUESTS the Director-General:

(1) to take urgent steps in cooperation with Member States to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, in particular so as to guarantee the free movement of those responsible for health, patients, health workers and emergency services, and the normal provision of medical goods to Palestinian medical premises, including those in Jerusalem;

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[1] Document A56/44.

(2) to continue providing both the necessary technical assistance to support health programmes and projects for the Palestinian people and emergency humanitarian assistance to meet needs arising from the current crisis;

(3) to take the necessary steps and make the contacts needed to obtain funding from various sources including extrabudgetary sources, to meet the urgent health needs of the Palestinian people;

(4) to continue her efforts to implement the special health assistance programme, taking into consideration the health plan of the Palestinian people, and adapt it to the health needs of the Palestinian people;

(5) to report on the implementation of this resolution to the Fifty-seventh World Health Assembly.

(Eighth plenary meeting, 23 May 2003 –
Committee B, first report)

WHA56.6 International Conference on Primary Health Care, Alma-Ata: twenty-fifth anniversary

The Fifty-sixth World Health Assembly,

Having considered the report on the twenty-fifth anniversary of the International Conference on Primary Health Care;[1]

Recalling with appreciation the Declaration adopted at the International Conference on Primary Health Care held in Alma-Ata in 1978, which identified primary health care as the key to the achievement of health for all;

Acknowledging WHO's goal of health for all and the progress made by countries to establish primary health care policies and programmes as a cornerstone of their health care systems, while noting that much still needs to be done to reach the goal of health for all;

Recognizing the dedication, leadership and commitment to achieving the goal of health for all of Member States, organizations of the United Nations system, and nongovernmental organizations,

1. REQUESTS Member States:

(1) to ensure that development of primary health care is adequately resourced in order to contribute to the reduction of health inequalities;

(2) to strengthen human resource capability for primary health care in order to tackle the rising burdens of health conditions;

(3) to support the active involvement of local communities and voluntary groups in primary health care;

[1] Document A56/27.

(4) to support research in order to identify effective methods for monitoring and strengthening primary health care and linking it to overall improvement of the health system;

2. REQUESTS the Director-General:

(1) to celebrate the twenty-fifth anniversary of the Declaration of Alma-Ata by convening a meeting with input from all stakeholders in order to examine the lessons of the past 25 years, review definitions and strategies, and identify future strategic directions for primary health care; and to provide support to the meeting through an extensive prior review of successes and failures, and factors that impact on primary health care;

(2) to continue to incorporate the principles of primary health care into the activities of all WHO's programmes, to ensure that the strategies to attain the development goals of the United Nations Millennium Declaration are implemented, and to respond to the recommendations of the Commission on Macroeconomics and Health, assuring that they are consistent with the principles of primary health care;

(3) to report on progress to the Fifty-seventh World Health Assembly through the Executive Board at its 113th session.

(Ninth plenary meeting, 26 May 2003 –
Committee A, second report)

WHA56.7 Pan African tsetse and trypanosomiasis eradication campaign

The Fifty-sixth World Health Assembly,

Having considered the report on Pan African tsetse and trypanosomiasis eradication campaign;[1]

Acknowledging that pain, suffering and death from trypanosomiasis are a daily threat to more than 60 million people in 37 countries of sub-Saharan Africa, 22 of which are among the least developed countries;

Realizing that trypanosomiasis, which causes an estimated annual loss of US$ 4.5 thousand million, is one of Africa's greatest constraints to socioeconomic development, severely affecting human and livestock health, limiting land use, causing poverty, and perpetuating underdevelopment on the African continent;

Noting that eradication of tsetse flies would significantly contribute to increasing human well-being and productivity of crops and livestock and to reducing rural poverty on the African continent;

Noting further that a multisectoral approach to tsetse fly and trypanosomiasis eradication programmes has in the past been successful in drastically reducing both bovine and human trypanosomiasis;

Realizing, therefore, that eradication of tsetse flies, which transmit the disease to both humans and animals, is the only effective, long-term solution to fight the disease;

[1] Document A56/9.

Recognizing decisions AHG/156 (XXXVI) of 12 July 2000 and AHG/169 (XXXVII) of 11 July 2001 by the Heads of State and Government of the Organization of African Unity (OAU)[1] to free Africa of tsetse flies, and their endorsement of and commitment to OAU's Plan of Action for the Pan African Tsetse and Trypanosomiasis Eradication Campaign (PATTEC);

Aware that the Secretary-General of the United Nations in his report to the United Nations Economic and Social Council on 25 July 2001 acknowledged the problem of trypanosomiasis and called upon all Member States, organizations of the United Nations system, and the international community fully to support OAU's Campaign;

Welcoming resolution GC (45)/RES/12 adopted in September 2001 by the Forty-fifth General Conference of the International Atomic Energy Agency, supporting OAU's Campaign and calling upon Member States to provide technical, financial and material support to African States in their efforts to eradicate tsetse flies;

Noting that the Campaign was officially launched in Ouagadougou on 5 October 2001;

Further noting the adoption by the thirty-first session of the Conference of the Food and Agriculture Organization of the United Nations (2-13 November 2001) of a resolution requesting FAO to support African Member States in their efforts to eradicate tsetse flies and, in particular, OAU's Campaign;

Recalling resolution WHA50.36 on African trypanosomiasis, and welcoming the significant efforts undertaken jointly by OAU, FAO, IAEA and WHO through the Programme Against African Trypanosomiasis to find solutions within the framework of sustainable development to the problems caused by human and animal trypanosomiasis;

Reaffirming that WHO is committed to mobilizing and streamlining its activities to combat trypanosomiasis, particularly in support of surveillance and control, in cooperation with organizations of the United Nations system and other partners, including the private sector,

1. WELCOMES OAU's initiative to eradicate tsetse flies from Africa as an essential step to fighting trypanosomiasis and to removing the threat that this disease represents to the health of African populations;

2. COMMENDS the efforts being made by WHO and other partners, including the private sector, to monitor and control the disease and to implement a programme for the elimination of African trypanosomiasis as a public health problem, which contribute to the global fight against this disease;

3. URGES Member States and competent international organizations to provide support to African Members in their efforts to eradicate tsetse flies and, in particular, to OAU's Plan of Action for the Pan African Tsetse and Trypanosomiasis Eradication Campaign (PATTEC);

4. REQUESTS the Director-General to report on progress made in implementation of this resolution to the Executive Board at its 113th session and to the Fifty-seventh World Health Assembly.

(Ninth plenary meeting, 26 May 2003 –
Committee A, second report)

[1] Now known as the African Union.

WHA56.8 Appointment of the External Auditor

The Fifty-sixth World Health Assembly

1. RESOLVES that the Comptroller and Auditor General of India shall be appointed External Auditor of the accounts of the World Health Organization for the financial periods 2004-2005 and 2006-2007 and that he shall conduct his audits in accordance with the principles incorporated in Regulation XIV and the Appendix to the Financial Regulations, provided that, should the need arise, he may designate a representative to act in his absence;

2. EXPRESSES its thanks to the Auditor-General of the Republic of South Africa for the work he has performed for the Organization in his audit of the accounts for the financial periods 2000-2001 and 2002-2003.

(Ninth plenary meeting, 26 May 2003 – Committee B, second report)

WHA56.9 Unaudited interim financial report on the accounts of WHO for 2002

The Fifty-sixth World Health Assembly,

Having examined the unaudited interim financial report for the year 2002 of the financial period 2002-2003;[1]

Having noted the first report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-sixth World Health Assembly,[2]

ACCEPTS the Director-General's unaudited interim financial report for the year 2002.

(Ninth plenary meeting, 26 May 2003 – Committee B, second report)

WHA56.10 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Fifty-sixth World Health Assembly,

Having considered the third report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-sixth World Health Assembly on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution;[3]

Noting that, at the time of opening of the Fifty-sixth World Health Assembly, the voting rights of Afghanistan, Antigua and Barbuda, Armenia, Central African Republic, Chad, Comoros, Djibouti, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kazakhstan, Kyrgyzstan, Liberia, Nauru, Niger,

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[1] Documents A56/28 and A56/28 Add.1.

[2] Document A56/47.

[3] Document A56/32.

Nigeria, Republic of Moldova, Somalia, Suriname, Tajikistan, Togo, Turkmenistan and Ukraine remained suspended, such suspension to continue until the arrears of the Member State concerned have been reduced, at the present or future Health Assemblies, to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that, in accordance with resolution WHA55.4, the voting privileges of Argentina have been suspended as from 19 May 2003 at the opening of the Fifty-sixth World Health Assembly, such suspension to continue until the arrears have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that Belarus, Burundi, Peru, Saint Lucia and Venezuela were in arrears at the time of the opening of the Fifty-sixth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of these countries should be suspended at the opening of the Fifty-seventh World Health Assembly;

Having been informed that as Burundi had subsequently paid its arrears in full it would no longer be included on the list of Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution,

DECIDES:

(1) that, in accordance with the statement of principles in resolution WHA41.7, if, by the time of the opening of the Fifty-seventh World Health Assembly, Belarus, Peru, Saint Lucia and Venezuela are still in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension which takes effect as aforesaid shall continue at the Fifty-seventh and subsequent Health Assemblies, until the arrears of Belarus, Peru, Saint Lucia and Venezuela have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

(3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Ninth plenary meeting, 26 May 2003 –
Committee B, second report)

WHA56.11 Arrears in payment of contributions: Kazakhstan

The Fifty-sixth World Health Assembly,

Having considered the third report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, with respect to the request of Kazakhstan for the

settlement of its outstanding contributions,[1] and the terms of that proposal as set forth in the report on special arrangements for settlement of arrears,[2]

1. DECIDES to restore the voting privileges of Kazakhstan at the Fifty-sixth World Health Assembly;

2. ACCEPTS that Kazakhstan shall pay its outstanding contributions, totalling US$ 4 615 253, in 10 annual instalments (with a minimum payment of US$ 200 000 per year), payable in each of the years 2003 to 2012, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period, and subject to payment of at least half the total amount of arrears, i.e. US$ 2 307 626, by the end of 2007;

3. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if Kazakhstan does not meet the requirements laid down in paragraph 2 above;

4. REQUESTS the Director-General to report to the Fifty-seventh World Health Assembly on the prevailing situation;

5. REQUESTS the Director-General to communicate this resolution to the Government of Kazakhstan.

(Ninth plenary meeting, 26 May 2003 –
Committee B, second report)

WHA56.12 Assessments for 2002 and 2003

The Fifty-sixth World Health Assembly,

Having considered the recommendation of the Executive Board at its 111th session,[3]

RESOLVES that:

(1) the assessment of the Democratic Republic of Timor-Leste shall be US$ 1053 for 2002 and US$ 4213 for 2003;

(2) as an ad hoc measure the assessment for 2003 for Afghanistan and Argentina shall be amended to US$ 4213 for Afghanistan and US$ 4 026 622 for Argentina;

(3) the difference of US$ 611 135, resulting from the revised contribution for Afghanistan and Argentina, shall be financed from the Miscellaneous Income account.

(Ninth plenary meeting, 26 May 2003 –
Committee B, second report)

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[1] Document A56/32.

[2] Document A56/33.

[3] Decision EB111(3).

WHA56.13 Real Estate Fund

The Fifty-sixth World Health Assembly,

Having considered the report on the Real Estate Fund;[1]

Recalling that paragraph 2 of resolution WHA55.8 authorized the Director-General to proceed with the construction of a new building at headquarters at a cost then estimated at CHF 55 000 000, of which WHO's share was estimated at CHF 27 500 000, on the understanding that if WHO's share were likely to exceed by more than 10% the aforementioned amount, further authority would be sought from the Health Assembly;

Recalling that paragraph 3 of resolution WHA55.8 approved the use of the Real Estate Fund for the repayment over a 50-year period of WHO's share of the interest-free loan to be provided by the Swiss authorities with effect from the first year of completion of the building;

Noting that the costs of a new building at headquarters are now estimated at some CHF 66 000 000, of which WHO's share is estimated at CHF 33 000 000;

Noting that the Swiss authorities are presenting to their parliament for approval a proposal consisting of an interest-free 50-year reimbursable loan of CHF 59 800 000, of which WHO's share is CHF 29 900 000;

Further noting that negotiations are continuing with the Swiss authorities in respect of the value of compensation for the demolition of the V building, the amount of which is expected to cover the CHF 3 100 000 difference between WHO's share of the estimated cost of the building and WHO's share of the interest-free reimbursable loan,

1. REITERATES its appreciation to the Swiss Confederation and to the Republic and Canton of Geneva for the continued expression of their hospitality;

2. CONFIRMS its authorization to the Director-General to proceed with the construction of the new building at headquarters at a cost which is now estimated at CHF 66 000 000, of which WHO's share is CHF 33 000 000, on the understanding that if WHO's share were likely to exceed by more than 5% the aforementioned amount, further authority would be sought from the Health Assembly;

3. ALSO CONFIRMS its approval of the use of the Real Estate Fund for the repayment over a 50-year period of WHO's share of the interest-free loan to be provided by the Swiss authorities with effect from the first year of completion of the building, on the understanding that the remainder of WHO's share of the total cost will be covered by the compensation to be provided to WHO by the Swiss authorities for demolition of the V building.

(Ninth plenary meeting, 26 May 2003 –
Committee B, second report)

[1] Document A56/5.

WHA56.14 Real Estate Fund: Regional Office for Africa[1]

The Fifty-sixth World Health Assembly,

Having considered the report of the Director-General on the Real Estate Fund;

Noting that the Regional Office for Africa has moved a substantial part of its operations back to the Regional Office in Brazzaville, but noting also that both office and staff accommodation is inadequate to meet the present and future needs of the regional office,

AUTHORIZES the Director-General:

(1) to proceed with the construction within the Djoué compound of both new office space to accommodate some 180 staff members and new conference facilities, including a conference room with capacity for 600 people and office amenities, at a total estimated cost of US$ 2 330 000, to be financed from the Real Estate Fund;

(2) to proceed with the purchase and renovation of 10 new villas, together with the related acquisition of land, the construction of 24 apartments in two blocks of flats and of related facilities, and the refurbishment and extension of existing residential homes, at a total estimated cost of US$ 3 000 000, to be financed from the Real Estate Fund.

(Ninth plenary meeting, 26 May 2003 –
Committee B, second report)

WHA56.15 Assignment of the Democratic Republic of Timor-Leste to the South-East Asia Region

The Fifty-sixth World Health Assembly,

Having considered the request from the Government of the Democratic Republic of Timor-Leste for the inclusion of that country in the South-East Asia Region,

RESOLVES that Timor-Leste shall form part of the South-East Asia Region.

(Tenth plenary meeting, 28 May 2003 –
Committee B, third report)

[1] See Annex 2.

WHA56.16 Reassignment of Cyprus from the Eastern Mediterranean Region to the European Region

The Fifty-sixth World Health Assembly,

Having considered the request from the Government of Cyprus for the inclusion of that country in the European Region,

RESOLVES that Cyprus shall form part of the European Region.

(Tenth plenary meeting, 28 May 2003 – Committee B, third report)

WHA56.17 Human resources: gender balance

The Fifty-sixth World Health Assembly,

Having noted the report on gender balance;[1]

Recalling resolution WHA50.16 on employment and participation of women in the work of WHO;

Concerned that the targets set have not been reached, and that progress across the Organization has been uneven,

1. REAFFIRMS the target of 50% for appointments of women to professional and higher-category posts;

2. REQUESTS the Director-General to redouble efforts in order to achieve the target of parity in gender distribution among professional staff, to raise the proportion of women at senior level, and to report on an action plan for recruitment that integrates gender and geographical balance to the Executive Board at its 113th session.

(Tenth plenary meeting, 28 May 2003 – Committee B, third report)

WHA56.18 Salaries of staff in ungraded posts and of the Director-General

The Fifty-sixth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,

1. ESTABLISHES the salary for ungraded posts at US$ 169 366 per annum before staff assessment, resulting in a modified net salary of US$ 115 207 (dependency rate) or US$ 104 324 (single rate);

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[1] Document A56/39.

2. ESTABLISHES the salary for the Director-General at US$ 228 403 per annum before staff assessment, resulting in a modified net salary of US$ 151 810 (dependency rate) or US$ 135 000 (single rate);

3. DECIDES that those adjustments in remuneration shall take effect on 1 January 2003.

(Tenth plenary meeting, 28 May 2003 –
Committee B, third report)

WHA56.19 Prevention and control of influenza pandemics and annual epidemics

The Fifty-sixth World Health Assembly,

Having considered the report on influenza;[1]

Recalling resolutions WHA22.47 and WHA48.13;

Recognizing that influenza viruses are responsible for seasonal epidemics that sicken millions worldwide and cause fatal complications in up to one million people each year;

Further recognizing that many of these deaths could be prevented through increased use, particularly in people at high risk, of existing vaccines, which are safe and highly effective;

Welcoming the contribution of global influenza surveillance, coordinated by WHO, to the annual determination of the antigenic composition of influenza vaccines and to early recognition of conditions conducive to a pandemic, and the assistance provided by WHO to timely manufacturing of influenza vaccines;

Expressing concern that the health burden and economic impact of influenza in developing countries are poorly documented, and that recent evidence suggests higher rates of fatal complications associated with poor nutritional and health status and limited access to health services;

Further concerned by the general lack of national and global preparedness for a future influenza pandemic, particularly in view of the recurrence of such pandemics and the high mortality, social disruption and economic costs that they invariably cause and which may be exacerbated by rapid international travel, the recent worldwide increase in the size of at-risk populations and the development of resistance to first-line antiviral drugs;

Recognizing the need for improved vaccine formulations, increased manufacturing capacity for vaccines, more equitable access to antiviral drugs, and strengthened disease surveillance as part of national and global pandemic preparedness;

Noting that better use of vaccines for seasonal epidemics will help to ensure that manufacturing capacity meets demand in a future pandemic, and that pandemic preparedness plans will help to make the response to seasonal epidemics more rational and cost-effective and to prevent numerous deaths;

Noting with satisfaction the consensus reached by the WHO Consultation on Global Priorities in Influenza Surveillance and Control (Geneva, May 2002) on the first Global agenda on influenza

[1] Document A56/23.

surveillance and control, which provides a plan for coordinated activities to improve preparedness for both seasonal epidemics and a future pandemic;[1]

Further noting with satisfaction WHO's work on influenza pandemic preparedness planning and its intention to draw up a model plan,

1. URGES Member States:

(1) where national influenza vaccination policies exist, to establish and implement strategies to increase vaccination coverage of all people at high risk, including the elderly and persons with underlying diseases, with the goal of attaining vaccination coverage of the elderly population of at least 50% by 2006 and 75% by 2010;

(2) where no national influenza vaccination policy exists, to assess the disease burden and economic impact of annual influenza epidemics as a basis for framing and implementing influenza prevention policies within the context of other national health priorities;

(3) to draw up and implement national plans for preparedness for influenza pandemics, giving particular attention to the need to ensure adequate supplies of vaccine, antiviral agents, and other vital medicines, as outlined in the Global agenda on influenza surveillance and control;

(4) to contribute to heightened preparedness for epidemics and pandemics through strengthening of national surveillance and laboratory capacity and, where appropriate, increased support to national influenza centres;

(5) to support research and development on improved influenza vaccines, and also effective antiviral preparations, particularly concerning their suitability for use in developing countries, in order to obtain an influenza-vaccine formulation that confers long-lasting and broad protection against all influenza virus strains;

2. REQUESTS the Director-General:

(1) to continue to combat influenza by advocating new partnerships with organizations of the United Nations system, bilateral development agencies, nongovernmental organizations and the private sector;

(2) to continue to provide leadership in coordinating the prioritized activities for epidemic and pandemic preparedness set out in the Global agenda on influenza surveillance and control;

(3) to provide support to developing countries in assessing the disease burden and economic impact of influenza, and in framing and implementing appropriate national policies for influenza prevention;

(4) to continue to strengthen global influenza surveillance as a crucial component of preparedness for seasonal epidemics and pandemics of influenza;

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[1] Global agenda on influenza – adopted version. Part I. *Weekly Epidemiological Record* 2002; 77:179-182. Adoption of Global agenda on influenza – Part II. *Weekly Epidemiological Record* 2002; 77:191-195.

(5) to provide technical support to Member States in the preparation of national pandemic preparedness plans, including guidance on estimating the demand for vaccines and antiviral drugs;

(6) to search jointly with other international and national partners, including those in the private sector, for solutions to reduce the present global shortage of, and inequitable access to, influenza vaccines and antiviral drugs and also to make them more affordable, for both epidemics and global pandemics;

(7) to keep the Executive Board and Health Assembly informed of progress.

(Tenth plenary meeting, 28 May 2003 –
Committee A, third report)

WHA56.20 Reducing global measles mortality

The Fifty-sixth World Health Assembly,

Alarmed by the unacceptable burden of nearly 800 000 measles deaths annually, occurring mostly in infants and young children living in developing countries;

Recognizing that the current disease burden of measles is the result of underutilization of measles vaccine caused by inadequately supported immunization programmes and disease surveillance systems;

Stressing the importance of achieving the goal adopted by the United Nations General Assembly special session on children (2002) to reduce deaths due to measles by half by 2005, compared with the 1999 level, and the target contained in the United Nations Millennium Declaration to reduce the under-five child mortality rate by two-thirds by the year 2015;

Recognizing the availability of safe, effective and inexpensive measles vaccines and proven strategies to reduce measles mortality;

Welcoming the remarkable progress that has been made by the Measles Initiative partnership to reduce measles deaths in Africa;

Noting the critical importance of routine immunization services as the foundation of a strategy to reduce measles deaths in a sustainable manner, and the essential role of integrated epidemiological and laboratory surveillance for measles in guiding control efforts;

Considering that the strategic directions for child and adolescent health and development identify measles as one of the five preventable communicable diseases that account for the vast majority of childhood deaths,[1]

[1] Strategic directions for improving the health and development of children and adolescents. Document WHO/FCH/CAH/02.21 Rev.1.

1. URGES Member States:

(1) to implement fully the WHO-UNICEF strategic plan for measles mortality reduction 2001-2005 within the national immunization programmes of countries with high measles mortality;

(2) to provide the financial support necessary for full implementation of national immunization programmes in which the strategy to reduce measles mortality is embedded, including measles vaccine for routine and supplementary immunization activities and strengthening of epidemiological and laboratory surveillance for measles and other vaccine-preventable diseases;

(3) to use the strategic approach of reducing global measles mortality as a tool for strengthening national immunization programmes, with special emphasis on improving access to immunization services, ensuring safe immunization practices, and enhancing human-resource capability, laboratory networks, epidemiological surveillance and cold-chain systems;

2. REQUESTS the Director-General:

(1) to work with Member States through regional offices to strengthen national immunization programmes and disease-surveillance systems, using the status of measles control as one of the leading indicators of progress in reducing child mortality;

(2) to strengthen partnerships at global, regional and subregional levels with UNICEF and other international bodies, nongovernmental organizations and the private sector in order to mobilize the additional resources needed to implement fully the WHO-UNICEF strategic plan for measles mortality reduction and the Expanded Programme on Immunization;

(3) to report to the Fifty-seventh World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

(Tenth plenary meeting, 28 May 2003 –
Committee A, third report)

WHA56.21 Strategy for child and adolescent health and development[1]

The Fifty-sixth World Health Assembly,

Having considered the report on the strategy for child and adolescent health and development;[2]

Recognizing the right of children and adolescents to the highest attainable standard of health and access to health care as set forth in internationally agreed human-rights instruments;

Recalling and recognizing the outcomes of the World Summit for Children (New York, 1990), the Declaration on the Elimination of Violence against Women (1993),[3] the International Conference

[1] See Annex 3.

[2] Document A56/15.

[3] United Nations General Assembly resolution 48/104.

on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), the Fourth World Conference on Women (Beijing, 1995), the World Food Summit (Rome, 1996), the Millennium Summit (New York, 2000), the United Nations General Assembly special session on HIV/AIDS (2001), and the United Nations General Assembly special session on children (2002), their recommendations and respective follow-ups and reports;

Welcoming formulation of the Strategic directions for improving the health and development of children and adolescents;[1]

Concerned that the specific needs of neonates and adolescents have not been adequately addressed and that additional efforts will be needed to achieve international goals for maternal, child and adolescent health and development;

Recognizing that children and adolescents are the basic fundamental resources for human, social and economic development;

Further recognizing the right of children, including adolescents, to freedom of expression, and to having their views taken into account in all matters affecting them, in accordance with the age and maturity of the child;

Also recognizing that parents, families, legal guardians and other caregivers have the primary role and responsibility for the well-being of children, and must be supported in the performance of their child-rearing responsibilities;

Mindful that interventions exist to meet the health needs of pregnant women, mothers, neonates, children and adolescents, and concerned that in developing countries these population groups have limited access to such interventions;

Acknowledging that the Convention on the Rights of the Child contains a comprehensive set of international legal standards for the protection and well-being of children, and also that it is an important framework for addressing child and adolescent health and development,

1. URGES Member States:

(1) to strengthen and expand efforts to meet international targets for the reduction of maternal and child mortality, and malnutrition;

(2) to make improvements in neonatal health, child survival and adolescent health and development a priority through advocacy at the highest level, scaling up programmes, increasing allocation of national resources, creating partnerships, and assuring sustained political commitment;

(3) to strive for full coverage of their maternal, neonate, child and adolescent populations with interventions known to be effective, especially interventions that help parents, other caregivers, families and communities to care for their young and that improve the quality of health services and health systems;

(4) to promote access by children and adolescents, parents, families, legal guardians, and other caregivers to a full range of information and services to promote child health and survival,

[1] Document WHO/FCH/CAH/02.21 Rev.1.

development, including psychological development, protection and participation, recognizing that many children live without parental support and that special measures should be taken to support such children and to build and strengthen their own abilities;

2. REQUESTS the Director-General:

(1) to give the fullest possible support to achievement of the internationally agreed child-health and development goals;

(2) to continue to advocate a public-health approach to reduction of common diseases, including the simple and effective strategies of immunization, Integrated Management of Childhood Illnesses, improved maternal, child and adolescent nutrition, and supply of water and sanitation;

(3) to promote needed research, including on the determinants of behaviour, and to prepare guidelines and best practices for use by Member States in the full implementation of cost-effective approaches to achieving international goals for neonate, child and adolescent health;

(4) to maintain the Organization's commitment to, and support for, achieving and sustaining high levels of coverage with proven interventions, through efficient, integrated or combined delivery mechanisms;

(5) to advocate higher priority for maternal and neonatal health and adolescent health and development;

(6) to provide support for further research into determinants of adolescents' lifestyles and effective interventions leading to better health for adolescents;

(7) to report to the Fifty-ninth World Health Assembly in 2006, through the Executive Board, on WHO's contribution to implementation of the strategy for child and adolescent health and development, with particular emphasis on actions related to poverty reduction and the attainment of internationally agreed child-health and development goals.

(Tenth plenary meeting, 28 May 2003 –
Committee A, third report)

WHA56.22 Strategic approach to international chemicals management: participation of global health partners

The Fifty-sixth World Health Assembly,

Recalling the first principle of the Rio Declaration on Environment and Development, namely, that "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature";

Noting that the Bahia Declaration on Chemical Safety and the Priorities for Action Beyond 2000 of the Intergovernmental Forum on Chemical Safety emphasized the essential role of sound management of chemicals in sustainable development and the protection of human health and the environment;

Further noting that the World Summit on Sustainable Development Plan of Implementation, paragraph 23(b) calls for further development of a strategic approach to international chemicals management and urges international organizations dealing with chemical management to cooperate closely in this regard;

Fully supporting the UNEP Governing Council Decision 22/4 to further develop a strategic approach to international chemicals management following an open, transparent and inclusive process and providing all stakeholders opportunities to participate; and the invitation to a range of international organizations, including WHO, to collaborate actively in the further development of the strategic approach;

Noting the involvement of WHO in the Steering Committee of the strategic approach to international chemicals management established to act as a facilitative steering mechanism to deal with practical aspects of the strategic approach;

Noting also the role of WHO as the administering organization for the Intergovernmental Forum on Chemical Safety;

Mindful of WHO's contribution to the international management of chemicals through the International Programme on Chemical Safety, a cooperative venture between ILO, WHO and UNEP;

Recalling resolution WHA45.32 on the International Programme, which emphasized the need to establish or strengthen governmental mechanisms to provide liaison and coordination between authorities and institutions involved in chemical safety activities, and resolution WHA42.26 on WHO's contribution to the international efforts towards sustainable development, which considered that equitable health development is an essential prerequisite for socioeconomic development;

Recognizing the need for health interests at country level to be reflected in, and addressed by, the strategic approach to international chemicals management,

1. URGES Member States to take full account of the health aspects of chemical safety in further development of the strategic approach to international chemicals management;

2. REQUESTS the Director-General:

(1) to support the continuing roles of WHO and the Intergovernmental Forum on Chemical Safety in overseeing development of the strategic approach through membership of its Steering Committee;

(2) to contribute to the content of the strategic approach, in accordance with the invitation of the UNEP Governing Council, through initial submission of possible health-focused elements and participation of WHO in preparatory meetings and the final conference;

(3) to submit a progress report to the Health Assembly before the estimated date of completion of the strategic approach;

(4) when completed, to submit the strategic approach to international chemicals management to the Health Assembly for consideration.

(Tenth plenary meeting, 28 May 2003 –
Committee B, fourth report)

WHA56.23 Joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission[1]

The Fifty-sixth World Health Assembly,

Recalling resolution WHA40.20 on the Codex Alimentarius Commission and resolution WHA53.15 on food safety;

Having considered the report on the joint FAO/WHO evaluation of the Codex Alimentarius Commission and other FAO and WHO work on food standards;

Acknowledging with appreciation the statement of the Codex Alimentarius Commission on the outcome of the joint FAO/WHO evaluation annexed to the present resolution;

Welcoming the recommendation to give higher priority to setting science-based standards for food safety, nutrition-related issues and health;

Noting with satisfaction the excellent collaboration between WHO and FAO in the areas of food safety and nutrition;

Aware that the rise in the global distribution of food is linked to an increased need for internationally agreed assessments and guidelines related to food safety and nutrition;

Recognizing that one of the prerequisites for economic development is a safe food-production system for both domestic and export markets based on regulatory frameworks protecting consumers' health;

Conscious of the need for full participation of developing countries in setting globally relevant standards;

Emphasizing the lead responsibility of WHO, in collaboration with FAO, in providing sound scientific assessments of hazards in food and nutrition as a basis for managing risk at national and international levels;

Stressing the urgent need to reinforce the participation of the health sector in standard-setting activities related to food in order to promote and protect consumers' health,

1. ENDORSES WHO's increased direct involvement in the Codex Alimentarius Commission and an enhanced capacity within WHO for risk assessment;

2. URGES Member States:

(1) to participate actively in international standard-setting in the framework of the Codex Alimentarius Commission, especially in the areas of food safety and nutrition;

(2) to make full use of Codex standards for the protection of human health throughout the food chain, including assistance with making healthy choices regarding nutrition and diet;

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[1] See Annex 4.

(3) to stimulate collaboration between all sectors involved at national level in setting standards based on the Codex Alimentarius related to food safety and nutrition, with particular focus on the health sector and fully involving all stakeholders;

(4) to facilitate the participation of national experts in international standard-setting activities;

3. INVITES the regional committees to review regional policies and strategies for strengthening capacity in the areas of standard-setting for food safety and of nutrition information, in collaboration with FAO;

4. CALLS ON donors to increase funding for WHO's activities related to the setting of standards for food, with special attention to least developed countries;

5. REQUESTS the Director-General:

(1) to support the development and implementation of an action plan to address the recommendations in the Codex Evaluation Report and, in collaboration with FAO, to consider means to improve the efficiency of the Codex standard-setting process by meeting the unique governance needs of Codex within the overall structure of WHO and FAO;

(2) to strengthen WHO's role:

(a) in the management of the Codex Alimentarius Commission and to give a higher profile to the Commission and related work throughout the Organization;

(b) in complementing the work of the Codex Alimentarius Commission with other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in Health Assembly resolutions and to the International Health Regulations;

(c) in risk assessment, including through the system of joint FAO/WHO expert bodies and consultations and through a coordinating function in WHO;

(d) in supporting the capacity of food-safety systems to protect human health throughout the food chain;

(e) in supporting analysis of links between data on foodborne disease and foodborne contamination;

(f) in collaboration with FAO, in providing special support to developing countries for generating data for development of global Codex Alimentarius standards;

(3) to provide support to Member States, particularly developing and least developed countries, in strengthening capacity in the above areas;

(4) to stimulate the establishment of networks between national and regional food-safety regulatory authorities and particularly at country level;

(5) to continue to foster collaboration with FAO, including a more coordinated approach between WHO and FAO to capacity-building, especially within the framework of the Joint FAO/WHO Food Standards Programme;

(6) to reallocate resources for WHO's activities related to the setting of food standards based on the Codex Alimentarius, with special attention to least developed countries.

ANNEX

STATEMENT OF THE CODEX ALIMENTARIUS COMMISSION ON THE OUTCOME OF THE JOINT FAO/WHO EVALUATION OF THE CODEX ALIMENTARIUS AND OTHER FAO AND WHO WORK ON FOOD STANDARDS

1. The Codex Alimentarius Commission, having considered the report and recommendations of the joint FAO/WHO evaluation of the Codex Alimentarius and other FAO and WHO work on food standards,[1] expressed its appreciation to the parent Organizations for having initiated the Evaluation and ensuring that it was carried out in a consultative, efficient and effective manner. It also expressed its appreciation to the Evaluation Team and Expert Panel for their excellent report, the depth of the analysis and the comprehensive proposals and recommendations contained therein.

2. The Commission noted with satisfaction the finding of the Evaluation that its food standards had a very high importance to Members as a vital component of food control systems designed to protect consumer health and to ensure fair practices in the food trade. It endorsed the view that standards were a fundamental prerequisite in consumer protection but had to be looked at in the context of the total system throughout the food chain, especially for food safety.

3. The Commission recalled that Codex standards were used as references for Member Nations in relation to their obligations under the WTO Agreement on Technical Barriers to Trade and the Agreement on the Application of Sanitary and Phytosanitary Measures. In this regard, it recognized that many Member Nations with less developed economies or with economies in transition were able to use Codex standards directly as a basis for domestic legislation and standard-setting in conformity with these Agreements. It noted that this was particularly true when standards were based on global data, including those derived from developing countries.

4. The Commission supported the overall thrust of the Evaluation report and expressed its commitment to the **implementation** of strategies that would meet the objectives of the recommendations contained therein. It strongly agreed that these recommendations should be reviewed expeditiously. The Commission noted that since the 1991 Joint FAO/WHO Conference on Food Standards, Chemicals in Food and Food Trade, significant changes had been made in the Commission's priorities and programmes, with increased emphasis on food safety issues. This emphasis had resulted in an increased output of health-related standards and was now being extended to the whole food chain; this process would continue to be developed.

5. Noting the Evaluation's recommendations concerning the Commission's mandate, the Commission was of the opinion that its existing **mandate** to protect consumers' health and to ensure fair practices in the food trade continued to be appropriate but might be discussed in the future. Within this mandate, the Commission emphasized that its first priority would be the development of standards having an impact on consumer health and safety.

6. In order to maintain the strong support from all Member Nations and stakeholders, the Commission **agreed** that in their response to the Evaluation, the Commission and its parent Organizations should work towards:

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[1] Report of the evaluation of the Codex Alimentarius and other FAO and WHO food standards work. FAO and WHO, 15 November 2002.

- greater efficiency and effectiveness in the development of Codex standards, whilst maintaining transparency and inclusiveness and procedural consistency in the process of their development;
- increased participation of developing Member Nations and Member Nations in economic transition in the work of the Codex Alimentarius Commission throughout the standards development process;
- greater usefulness of Codex standards to Member Nations in terms of relevance to their needs and timeliness;
- strengthening of the scientific base for risk analysis, including food safety risk assessment, to improve efficiency and effectiveness in providing expert scientific advice to the Commission and Member Nations and to improve risk communication; and
- more effective capacity building for the development of national food-control systems.

7. The Commission agreed that it should have greater independence, within the overall structure of FAO and WHO, for proposing and executing its **work programme and budget**, once approved by the two parent organizations.

8. The Commission concurred with the views expressed in the Evaluation Report that the Codex **Secretariat** was hard working, efficient and Member-oriented, but overworked and with insufficient resources to support the present activities of Codex. It strongly supported the recommendation that the Secretariat be expanded and that the seniority and composition of its staff should match the Commission's increased requirements.

9. On the matter of **expert advice** to Codex, the Commission agreed fully with the view that this was a very important element to all Member Nations and to the Commission itself. It expressed the view that there needed to be sufficient capacity within the parent Organizations to ensure that scientific advice was provided on a timely basis. It also agreed that this work needed to have greater identity within the Organizations, stronger links to Codex priorities, and internal coordination as well as significantly increased resources. Its independence from external influences and its transparency need to be further reinforced within FAO/WHO. The Commission stated that there should also be greater distinction between the function of risk assessment undertaken by experts and that of risk management undertaken by Codex committees, while noting the linkages that needed to exist between these functions. The Commission emphasized that the provision of expert scientific advice was a joint responsibility of FAO and WHO and should continue to be so. It strongly recommended that WHO markedly increase its contribution to health risk assessment carried out by FAO/WHO expert committees and FAO/WHO expert consultations. It also recommended that FAO strengthen its input in areas reflecting its responsibility and expertise. The Commission welcomed the statement by Dr Brundtland, Director-General of WHO in her opening remarks to the present session that FAO and WHO would prepare for and convene as an immediate priority, the consultation requested by the Codex Alimentarius Commission at its 24th Session[1] on strengthening scientific support for Codex decision-making.

10. In the area of **capacity building**, the Commission welcomed the valuable initiatives described in the report, including the Standards and Trade Development Facility (STDF) operated by WTO in collaboration with the World Bank, FAO, WHO, OIE, and in particular the new FAO/WHO Trust Fund to make possible effective participation in Codex. It called upon FAO and WHO to undertake a major effort to mobilize extrabudgetary funds and to foster coordinated bilateral assistance in capacity building. It also called for a more coordinated approach for capacity building between FAO and WHO, and requested the parent bodies urgently to analyse their existing means of providing capacity building and to inform the Codex Alimentarius Commission on how they will improve coordination and distribution of work drawing on their mutual strengths and synergies.

[1] ALINORM 01/41, paragraph 61.

11. The Commission called upon **FAO** and **WHO** to provide additional Regular Programme resources, supplemented with extrabudgetary resources where necessary, to strengthen Codex and Codex-related work throughout the two Organizations.

12. The Commission called upon **Member Governments** to support the follow-up to the Evaluation process, including through their statements made and positions taken in the Health Assembly and the Council and Conference of FAO.

13. The Commission reiterated its **commitment** to pursue with all speed full consideration of the recommendations addressed to it in the Evaluation report and in this regard:

- invited **Member Nations** and interested international organizations to submit written comments to the Secretariat;
- requested the Secretariat to analyse the comments dealing with the **Codex Committee structures and their mandates** and to provide options for consideration by the Commission at its next Regular Session;
- requested the Secretariat to analyse the comments dealing with the functions of the **Executive Committee**, and to provide options for consideration by the Commission at its next Regular Session;
- requested the Secretariat to analyse comments dealing with **standards management** and the procedures for **standards development**, including the establishment of priorities recommended by developing Member Nations, and to recommend strategies for the early implementation of more efficient and effective processes, providing options for consideration by the Commission at its next Regular Session;
- requested the Secretariat to identify a strategy for consideration by the Commission at its next Regular Session on the implementation of the recommendations dealing with the revision of the **Rules of Procedure** and other internal procedures; and
- requested the Secretariat to analyse the comments on those recommendations in the Evaluation Report not covered by the above and to provide options on how to proceed.

(Tenth plenary meeting, 28 May 2003 –
Committee B, fifth report)

WHA56.24 Implementing the recommendations of the *World report on violence and health*

The Fifty-sixth World Health Assembly,

Recalling resolution WHA49.25, which declared violence a leading worldwide public health problem, and resolution WHA50.19, which endorsed and requested continued development of the WHO plan of action for a science-based public health approach to violence prevention and health;

Noting that a meeting of bodies of the United Nations system on collaboration for the prevention of interpersonal violence (Geneva, 15-16 November 2001) invited WHO to facilitate a better coordinated response to interpersonal violence, as a result of which WHO published the *Guide to United Nations resources and activities for the prevention of interpersonal violence*;[1]

[1] *Guide to United Nations resources and activities for the prevention of interpersonal violence*, Geneva, World Health Organization, 2002.

Recalling that WHO is a core partner, with UNICEF and the Office of the United Nations High Commissioner for Human Rights, of a working group to support the United Nations Study on Violence against Children, and that WHO is active in the prevention of violence against young people, women, the disabled and the elderly;

Recognizing that the prevention of violence is a prerequisite of human security and dignity and that urgent action by governments is needed to prevent all forms of violence and reduce their consequences for health and for socioeconomic development;

Noting that the *World report on violence and health*[1] provides an up-to-date description of the impact of violence on public health, reviews its determinants and effective interventions, and makes recommendations for public health policy and programmes,

1. TAKES NOTE of the nine recommendations for prevention of violence contained in the *World report on violence and health* and attached to this resolution, and encourages Member States to consider adopting them;

2. URGES Member States to promote the *World report on violence and health* and actively to make use of the conclusions and recommendations of the report to improve activities to prevent and expose instances of violence, and to provide medical, psychological, social and legal assistance and rehabilitation for persons suffering as a result of violence;

3. ENCOURAGES all Member States that have not already done so to appoint within the ministry of health a focal point for the prevention of violence;

4. ENCOURAGES Member States to prepare in due time a report on violence and violence prevention that describes the magnitude of the problem, the risk factors, current efforts to prevent violence, and future action to encourage a multisectoral response;

5. REQUESTS the Director-General:

(1) to cooperate with Member States in establishing science-based public health policies and programmes for the implementation of measures to prevent violence and to mitigate its consequences at individual and societal levels;

(2) to encourage urgent research to support evidence-based approaches for prevention of violence and mitigation of its consequences at individual, family and societal levels, particularly research on multilevel risk factors for violence, and evaluation of model prevention programmes;

(3) in collaboration with other organizations of the United Nations system and other international agencies, to continue work on integrating a science-based public health approach to violence prevention into other major global prevention initiatives;

(4) using the resources available and benefiting from opportunities for cooperation:

(a) to support and coordinate efforts to draw up or revise normative documents and guidelines for prevention policy and programmes, as appropriate;

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[1] *World report on violence and health*, Geneva, World Health Organization, 2002.

(b) to provide technical support for strengthening of trauma and care services to survivors or victims of violence;

(c) to continue advocating the adoption and expansion of a public health response to all forms of violence;

(d) to establish networks to promote the integrated prevention of violence and injuries;

6. FURTHER REQUESTS the Director-General to report to the Fifty-eighth World Health Assembly, through the Executive Board, on progress towards implementing the *World report on violence and health.*

ANNEX

RECOMMENDATIONS FOR THE PREVENTION OF VIOLENCE

1. Create, implement and monitor a national action plan for violence prevention.

2. Enhance capacity for collecting data on violence.

3. Define priorities for, and support research on, the causes, consequences, costs and prevention of violence.

4. Promote primary prevention responses.

5. Strengthen responses for victims of violence.

6. Integrate violence prevention into social and educational policies, and thereby promote gender and social equality.

7. Increase collaboration and exchange of information on violence prevention.

8. Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights.

9. Seek practical, internationally agreed responses to the global drugs trade and the global arms trade.

(Tenth plenary meeting, 28 May 2003 –
Committee B, fifth report)

WHA56.25 The role of contractual arrangements in improving health systems' performance

The Fifty-sixth World Health Assembly,

Having considered the report on the role of contractual arrangements in improving health systems' performance,[1]

Noting that the performance of health systems must be strengthened in order further to improve the health of populations, ensure equitable financing of health, and meet the legitimate expectations of the population;

Considering that the reform of health systems has generally involved institutional restructuring, with a diversification of the agents involved in the field of health, in the public and private sectors, and among associations;

Noting that cultural change within health services, such as greater focus on patient needs, a broader population-health approach, and emphasis on addressing health inequalities, is often required to improve performance, and that health-system culture may be unaffected by structural change;

Recognizing the important role of government stewardship in regulation of contractual arrangements in the health sector,

1. URGES Member States:

(1) to ensure that contractual arrangements in the field of health adopt rules and principles that are in harmony with national health policy;

(2) to frame contractual policies that maximize impact on the performance of health systems and harmonize the practices of all parties in a transparent way, in order to avoid adverse effects;

(3) to share their experiences on contractual arrangements involving the public and private sectors and nongovernmental organizations in the provision of health services;

2. REQUESTS the Director-General:

(1) to create an evidence base so as to permit evaluation of the impact of differing types of contractual arrangements on the performance of health systems and identification of best practices, taking account of sociocultural differences;

(2) to provide, in response to requests from Member States, technical support in strengthening capacities and expertise in the development of contractual arrangements;

(3) to develop, in response to requests from Member States, methods and tools tailored to country realities to provide support to Member States in establishing a system of supervision in order to ensure the provision of high-quality health services, for example by accreditation, licensing and registration of public and private-sector and nongovernmental organizations in the health sector;

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[1] Document A56/22.

(4) to facilitate the exchange of experience among Member States;

(5) to report to the Executive Board at its 117th session and to the Fifty-ninth World Health Assembly on the ways in which contractual arrangements and other strategies to strengthen health systems improve the performance of health systems in Member States.

(Tenth plenary meeting, 28 May 2003 –
Committee B, fifth report)

WHA56.26 Elimination of avoidable blindness

The Fifty-sixth World Health Assembly,

Having considered the report on elimination of avoidable blindness;[1]

Recalling resolutions WHA22.29, WHA25.55 and WHA28.54 on prevention of blindness, WHA45.10 on disability prevention and rehabilitation, and WHA51.11 on the global elimination of blinding trachoma;

Recognizing that 45 million people in the world today are blind and that a further 135 million people are visually impaired;

Acknowledging that 90% of the world's blind and visually impaired people live in the poorest countries;

Noting the significant economic impact of this situation on both communities and countries;

Aware that most of the causes of blindness are avoidable and that the treatments available are among the most successful and cost-effective of all health interventions;

Recalling that, in order to tackle avoidable blindness and avoid further increase in numbers of blind and visually impaired people, the Global Initiative for the Elimination of Avoidable Blindness, known as Vision 2020 – the Right to Sight, was launched in 1999 to eliminate avoidable blindness;

Appreciating the efforts made by Member States in recent years to prevent avoidable blindness, but mindful of the need for further action,

1. URGES Member States:

(1) to commit themselves to supporting the Global Initiative for the Elimination of Avoidable Blindness by setting up, not later than 2005, a national Vision 2020 plan, in partnership with WHO and in collaboration with nongovernmental organizations and the private sector;

(2) to establish a national coordinating committee for Vision 2020, or a national blindness prevention committee, which may include representative(s) from consumer or patient groups, to help develop and implement the plan;

(3) to commence implementation of such plans by 2007 at the latest;

[1] Document A56/26.

(4) to include in such plans effective information systems with standardized indicators and periodic monitoring and evaluation, with the aim of showing a reduction in the magnitude of avoidable blindness by 2010;

(5) to support the mobilization of resources for eliminating avoidable blindness;

2. REQUESTS the Director-General:

(1) to maintain and strengthen WHO's collaboration with Member States and the partners of the Global Initiative for the Elimination of Avoidable Blindness;

(2) to ensure coordination of the implementation of the Global Initiative, in particular by setting up a monitoring committee grouping all those involved, including representatives of Member States;

(3) to provide support for strengthening national capability, especially through development of human resources, to coordinate, assess and prevent avoidable blindness;

(4) to document, from countries with successful blindness prevention programmes, good practices and blindness prevention systems or models that could be applied or modified in other developing countries;

(5) to report to the Fifty-ninth World Health Assembly on the progress of the Global Initiative.

(Tenth plenary meeting, 28 May 2003 –
Committee B, fifth report)

WHA56.27 Intellectual property rights, innovation and public health

The Fifty-sixth World Health Assembly,

Having considered the report on intellectual property rights, innovation and public health;[1]

Considering that available data indicates that of some 1400 new products developed by the pharmaceutical industry between 1975 and 1999, only 13 were for tropical diseases and three were for tuberculosis;

Aware that the developed countries represent nearly 90% of global pharmaceutical sales, whereas of the 14 million global deaths due to infectious diseases, 90% occur in the developing countries;

Concerned about the insufficient research and development in so-called "neglected diseases" and "poverty-related diseases", and noting that research and development in the pharmaceutical sector must address public health needs and not only potential market gains;

Mindful of concerns about the current patent protection system, especially as regards access to medicines in developing countries;

[1] Document A56/17.

Recalling that, in accordance with the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) does not and should not prevent Members from taking measures to protect public health and, in particular, to promote access to medicines for all;

Noting that the TRIPS Agreement contains flexibilities and that in order to use them adequately, Member States need to adapt national patent legislation;

Reaffirming resolution WHA52.19 on the revised drug strategy, resolution WHA54.11 on WHO medicines strategy and resolution WHA55.14 on ensuring accessibility of essential medicines;

Considering that Member States should urge the pharmaceutical industry to reinvigorate its efforts to develop innovations that add real therapeutic advantage in treating the world's major killer diseases, especially in developing countries;

Recognizing the importance of intellectual property rights in fostering research and development in innovative medicines, and the important role played by intellectual property with regard to the development of essential medicines;

Taking into account that in order to tackle new public health problems with international impact, such as the emergence of severe acute respiratory syndrome (SARS), access to new medicines with potential therapeutic effect and to health innovations and discoveries should be universally available without discrimination;

Further considering the continuing efforts of WTO Members to reach a solution for paragraph 6 of the Doha Declaration which recognizes that "WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement";

Reasserting the need to accomplish target 7 of Millennium Development Goal 6 and target 17 of Millennium Development Goal 8;

Noting resolutions 2001/33 and 2003/29 of the Commission on Human Rights on access to medicines in the context of pandemics such as HIV/AIDS,

1. URGES Member States:

(1) to reaffirm that public health interests are paramount in both pharmaceutical and health policies;

(2) to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS);

(3) to maintain efforts aimed at reaching, within WTO and before the Fifth WTO Ministerial Conference, a consensus solution for paragraph 6 of the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), with a view to meeting the needs of the developing countries;

(4) to seek to establish conditions conducive to research and development that spur the development of new medicines for diseases that affect developing countries;

2. REQUESTS the Director-General:

(1) to continue to support Member States in the exchange and transfer of technology and research findings, according high priority to access to antiretroviral drugs to combat HIV/AIDS, and medicines to control tuberculosis, malaria and other major health problems, in the context of paragraph 7 of the Doha Declaration which promotes and encourages technology transfer;

(2) by the time of the 113th session of the Executive Board (January 2004), to establish the terms of reference for an appropriate time-limited body to collect data and proposals from the different actors involved and produce an analysis of intellectual property rights, innovation, and public health, including the question of appropriate funding and incentive mechanisms for the creation of new medicines and other products against diseases that disproportionately affect developing countries, and to submit a progress report to the Fifty-seventh World Health Assembly and a final report with concrete proposals to the Executive Board at its 115th session (January 2005);

(3) to cooperate with Member States, at their request, and with international organizations in monitoring and analysing the pharmaceutical and public health implications of relevant international agreements, including trade agreements, so that Member States may effectively assess and subsequently develop pharmaceutical and health policies and regulatory measures that address their concerns and priorities, and are able to maximize the positive, and mitigate the negative, impact of those agreements;

(4) to encourage developed countries to make renewed commitments to investing in biomedical and behavioural research, including, where possible, appropriate research with developing-country partners.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

WHA56.28 Revision of the International Health Regulations

The Fifty-sixth World Health Assembly,

Having considered the report on the revision of the International Health Regulations;[1]

Recalling resolutions WHA48.7, WHA48.13, WHA54.14, and WHA55.16, which respond to the need to ensure global health security at a time when the threat of infectious diseases is resurging;

Taking into account also the existence of new risks and threats to health arising from the potential deliberate use of agents for terrorism purposes;

Recognizing the part played by animals in the transmission and pathogenesis of some diseases which occur in humans;

Affirming the additional threat posed by the substantial growth in international travel and trade, which provide greater opportunities for infectious diseases to evolve and spread;

[1] Documents A56/25 and A56/25 Add.1.

Underscoring the continued importance of the International Health Regulations as an instrument for ensuring the maximum possible protection against the international spread of disease with minimum interference in international traffic;

Acknowledging the close links between the Regulations and WHO's outbreak alert and response activities, which have identified the principal challenges to be met in revising the Regulations;

Concerned that experiences following the emergence and rapid international spread of severe acute respiratory syndrome (SARS) have given concrete expression to the magnitude of these challenges, the inadequacy of the current Regulations, and the urgent need for WHO and its international partners to undertake specific actions not addressed by the Regulations,

1. EXPRESSES its satisfaction with the procedures and activities planned for finalizing the draft revised Regulations for adoption by the Fifty-eighth World Health Assembly in 2005;

2. DECIDES:

(1) in accordance with Rule 42 of its Rules of Procedure, to establish an intergovernmental working group open to all Member States to review and recommend a draft revision of the International Health Regulations for consideration by the Health Assembly under Article 21 of the WHO Constitution;

(2) that regional economic integration organizations constituted by sovereign States, Members of WHO, to which their Member States have transferred competence over matters governed by this resolution, including the competence to enter into international legally binding regulations, may participate, in accordance with Rule 55 of the Rules of Procedure of the World Health Assembly, in the work of the intergovernmental working group referred to under paragraph 2(1);

3. URGES Member States:

(1) to give high priority to the work on the revision of the International Health Regulations and to provide resources and cooperation necessary to facilitate the progress of such work;

(2) to establish immediately a national standing task force or equivalent group and, within it, to designate an official or officials having operational responsibilities and accessible at all times by telephone or electronic communication, to ensure the speed, particularly during emergencies, of both reporting to WHO and consultation with national authorities when urgent decisions must be made;

(3) to ensure collaboration, when appropriate, with veterinary, agricultural and other relevant agencies involved in animal care, in research on, and planning and implementation of, preventive and control measures;

4. REQUESTS the Director-General:

(1) to take into account reports from sources other than official notifications, and to validate those reports according to established epidemiological principles;

(2) to alert, when necessary and after informing the government concerned, the international community, on the basis of criteria and procedures jointly developed with Member States, to the

presence of a public health threat that may constitute a serious threat to neighbouring countries or to international health;

(3) to collaborate with national authorities in assessing the severity of the threat and the adequacy of control measures and, when necessary, in conducting on-the-spot studies by a WHO team, with the purpose of ensuring that appropriate control measures are being employed;

5. FURTHER REQUESTS the Director-General:

(1) to complete the technical work required to facilitate reaching of agreement on the revised International Health Regulations, having incorporated technical input from relevant disciplines and agencies, including those involved in veterinary work, animal care and relevant agricultural professions;

(2) to fully utilize technical consultations and electronic communications already in place to bring to the intergovernmental working group a text that has as much consensus as possible;

(3) to keep Member States informed about the technical work on the revision of the Regulations through the regional committees and other mechanisms;

(4) to convene the intergovernmental working group on revision of the International Health Regulations at the appropriate time and on the agreement of the Executive Board at its 113th session in January 2004, having regard to the progress achieved on the technical work and the other commitments of the Organization;

(5) to facilitate the participation of the least developed countries in the work of any intergovernmental working group and in intergovernmental technical consultations;

(6) to invite, as observers at the sessions of the intergovernmental working group on the revision of the International Health Regulations, in accordance with Rule 48 of the Rules of Procedure of the World Health Assembly, representatives of non-Member States, of liberation movements referred to in resolution WHA27.37, of organizations of the United Nations system, of intergovernmental organizations with which WHO has established effective relations, and of nongovernmental organizations in official relations with WHO, who will attend the sessions of that body in accordance with the relevant Rules of Procedure and resolutions of the Health Assembly.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

WHA56.29 Severe acute respiratory syndrome (SARS)

The Fifty-sixth World Health Assembly,

Having considered the report on the emergence of severe acute respiratory syndrome (SARS) and the international response;[1]

[1] Document A56/48.

Recalling resolutions WHA48.13 on new, emerging and re-emerging infectious diseases, WHA54.14 on global health security – epidemic alert and responses, EB111.R13 on revision of the International Health Regulations, and EB111.R6 on the prevention and control of influenza pandemics and annual epidemics;

Deeply concerned that SARS, as the first severe infectious disease to emerge in the twenty-first century, poses a serious threat to global health security, the livelihood of populations, the functioning of health systems, and the stability and growth of economies;

Deeply appreciative of the dedication in responding to SARS of health care workers in all countries, including WHO staff member, Dr Carlo Urbani, who in late February 2003 first brought SARS to the attention of the international community, and died of SARS on 29 March 2003;

Recognizing the need for Member States to take individual and collective actions to implement effective measures to contain the spread of SARS;

Acknowledging that the control of SARS requires intensive regional and global collaboration, effective strategies and additional resources at local, national, regional and international levels;

Appreciating the crucial role of WHO in a worldwide campaign to control and contain the spread of SARS;

Acknowledging the great effort made by affected countries, including those with limited resources, and other Member States in containing SARS;

Acknowledging the willingness of the scientific community, facilitated by WHO, to collaborate urgently, which led to the exceptionally rapid progress in the understanding of a new disease;

Noting, however, that much about the causative agent and the clinical and epidemiological features of SARS remains to be elucidated, and that the future course of the outbreak cannot as yet be predicted;

Noting that national and international experiences with SARS contribute lessons that can improve preparedness for responding to, and mitigating the public health, economic, and social consequences of the next emerging infectious disease, the next influenza pandemic, and the possible use of a biological agent to cause harm;

Seeking to apply the spirit of several regional and international efforts in fighting the SARS epidemic, including the ASEAN +3[1] Ministers of Health Special Meeting on Severe Acute Respiratory Syndrome (SARS) (Kuala Lumpur, 26 April 2003), the Special ASEAN-China Leaders Meeting on the Severe Acute Respiratory Syndrome (SARS) (Bangkok, 29 April 2003), Emergency Meeting of SAARC[2] Health Ministers on the SARS Epidemic (Malé, 29 April 2003), ASEAN +3 Aviation Forum on the Prevention and Containment of SARS (Manila, 15-16 May 2003), and the Extraordinary Council of European Union Health Ministers (Brussels, 6 May 2003),

[1] Member States of ASEAN, together with China, Japan, and the Republic of Korea.

[2] South Asian Association for Regional Cooperation.

1. URGES Members States:

(1) to commit fully to controlling SARS and other emerging and re-emerging infectious diseases, through political leadership, the provision of adequate resources, including through international cooperation, intensified multisectoral collaboration and public information;

(2) to apply WHO recommended guidelines on surveillance, including case definitions, case management and international travel;[1]

(3) to report cases promptly and transparently and to provide requested information to WHO;

(4) to enhance collaboration with WHO and other international and regional organizations in order to support epidemiological and laboratory surveillance systems, and to foster effective and rapid responses to contain the disease;

(5) to strengthen, to the extent possible, capacity for SARS surveillance and control by developing or enhancing existing national programmes for communicable disease control;

(6) to ensure that those with operational responsibilities can be contacted by telephone or through electronic communications at all times;

(7) to continue to collaborate with and, when appropriate, provide assistance to WHO's Global Outbreak Alert and Response Network as the operational arm of the global response;

(8) to request the support of WHO when appropriate, and particularly when control measures employed are ineffective in halting the spread of disease;

(9) to use their experience with SARS preparedness and response to strengthen epidemiological and laboratory capacity as part of preparedness plans for responding to the next emerging infection, the next influenza pandemic, and the possible deliberate use of a biological agent to cause harm;

(10) to exchange information and experience on epidemics and the prevention and control of emerging and re-emerging infectious diseases in a timely manner, including among countries sharing land borders;[2]

(11) to mitigate the adverse impact of the SARS epidemic on the health of the population, health systems and socioeconomic development;

2. REQUESTS the Director-General:

(1) to further mobilize and sustain global efforts to control the SARS epidemic;

(2) to update and standardize guidelines on international travel, in particular those related to aviation, through enhanced collaboration with other international and regional organizations;

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[1] Travel to and from areas affected by SARS, in-flight management of suspected SARS cases who develop symptoms while on board, including aircraft disinfection techniques.

[2] WHO regards any country with an international airport, or sharing a border with an area having recent local transmission of SARS, as being at risk of imported cases.

(3) to update guidelines on surveillance, including case definitions, clinical and laboratory diagnosis, and management, and on effective preventive measures;

(4) to review and update, on the basis of epidemiological data and information provided by Member States, the classification of "areas with recent local transmission", through close interactive consultation with the Member States concerned, and in a manner that safeguards the health of populations while minimizing public misunderstanding and negative socioeconomic impact;

(5) to mobilize global scientific research to improve understanding of the disease and to develop control tools such as diagnostic tests, drugs and vaccines that are accessible to and affordable by Member States, especially developing countries and countries with economies in transition;

(6) to collaborate with Member States in their efforts to mobilize financial and human resources and technical support in order to develop or enhance national, regional and global systems for epidemiological surveillance and to ensure effective responses to emerging and re-emerging diseases, including SARS;

(7) to respond appropriately to all requests for WHO's support for surveillance, prevention, and control of SARS in conformity with WHO's Constitution;

(8) to strengthen the functions of WHO's Global Outbreak Alert and Response Network;

(9) to strengthen the global network of WHO collaborating centres in order to carry out research and training on the management of emerging and re-emerging diseases, including SARS;

(10) to take into account evidence, experiences, knowledge and lessons acquired during the SARS response when revising the International Health Regulations;

(11) to report to the Fifty-seventh World Health Assembly through the Executive Board at its 113th session on progress made in the implementation of this resolution.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

WHA56.30 Global health-sector strategy for HIV/AIDS[1]

The Fifty-sixth World Health Assembly,

Having considered the draft global health-sector strategy for HIV/AIDS;

Mindful of WHO's role, as a cosponsor of UNAIDS, in ensuring that the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS (June 2001) is followed up;

[1] See Annex 5.

Deeply concerned about the unprecedented burden the HIV/AIDS epidemic is placing on the health sector, and acknowledging the central role of that sector in providing an expanded, multisectoral response;

Conscious of the opportunities and challenges presented by the availability of new resources to Member States through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and from the World Bank, bilateral agencies, foundations and other donors;

Acutely aware of the need to strengthen health-sector capacity in order: (a) to absorb and manage resources; (b) to improve planning, prioritization, development of human resources, programme management, integration and implementation of key interventions, mobilization of nongovernmental organizations, and assurance of service quality and sustainability; and (c) to support research as part of national responses;

Equally conscious of the need simultaneously to expand activities in prevention, treatment, care, support, surveillance, monitoring and evaluation, as essential and mutually supportive elements of a strengthened overall response to the HIV/AIDS epidemic;

Aware of the corresponding increase in demand by Member States for technical support, normative guidance and strategic information in order to make optimal use of resources and to maximize the impact of interventions;

Recalling that resolution WHA53.14 requested the Director-General, *inter alia*, to develop a global health-sector strategy for HIV/AIDS and sexually transmitted infections,

1. TAKES NOTE of the global health-sector strategy for HIV/AIDS;

2. EXHORTS Member States, as a matter of urgency:

(1) to adopt and implement the strategy as appropriate to national circumstances as part of national, multisectoral responses to the HIV/AIDS epidemic;

(2) to strengthen existing, or to establish new, structures, and to mobilize and engage all concerned parties, within and beyond the health sector, in order to implement the strategy through the health, and other concerned, sectors and to monitor and evaluate its effectiveness;

(3) to take all necessary steps, including the mobilization of resources, to fulfil their obligations under the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS, including those related to access to care and treatment; and efforts to prevent HIV infection;

(4) to strengthen measures of cooperation and support, both bilaterally and multilaterally, to fight the HIV/AIDS epidemic either directly among themselves, or through WHO or other competent international and regional institutions;

(5) to reaffirm that public health interests are paramount in both pharmaceutical and health policies, to recognize the difficulties faced by developing countries in effective use of compulsory licensing in accordance with the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), and, when necessary, to use the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in order to meet the needs of developing countries for drugs against HIV/AIDS;

3. REQUESTS the Director-General:

(1) to provide support to Member States, on request, in implementing the strategy and evaluating its impact and effectiveness;

(2) to cooperate with those Member States that request technical support in the preparation of their submissions to the Global Fund to Fight AIDS, Tuberculosis and Malaria;

(3) to take the necessary steps to assure that offers of bilateral and multilateral collaboration and support submitted by one or more Member States with regard to fighting the HIV/AIDS epidemic are widely disseminated and promoted among the rest of the Member States, and periodically to assess at the Health Assembly the impact of this procedure;

(4) to support, mobilize, and facilitate efforts of Member States and all other concerned parties to achieve the goal of providing in a poverty-focused manner, equitably and to those most vulnerable, effective antiretroviral treatment within the context of strengthening national health systems, while maintaining a proper balance of investment between prevention, care, and treatment, and bearing in mind WHO's target of reaching at least three million people with HIV in developing countries by 2005;[1]

(5) further to mobilize Member States and all parties in support of actions taken by countries with an AIDS epidemic, especially developing countries, to obtain affordable and accessible drugs to combat HIV/AIDS;

(6) report to the Fifty-seventh World Health Assembly through the Executive Board at its 113th session on progress made in the implementation of this resolution.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

WHA56.31 Traditional medicine

The Fifty-sixth World Health Assembly,

Having considered the report on traditional medicine,[2]

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43 and WHA54.11;

Noting that the terms "complementary", "alternative", "nonconventional" or "folk" medicine are used to cover many types of nonconventional health care which involve varying levels of training and efficacy;

Noting that the term "traditional medicine" covers a wide range of therapies and practices which vary greatly from country to country and from region to region;

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[1] See document A56/12.

[2] Document A56/18.

Aware that traditional, complementary, or alternative medicine has many positive features, and that traditional medicine and its practitioners play an important role in treating chronic illnesses and improving the quality of life of those suffering from minor illness or from certain incurable diseases;

Recognizing that traditional medicinal knowledge is the property of communities and nations where that knowledge originated, and should be fully respected;

Noting that the major challenges to the use of traditional medicine include the lack of organized networks of traditional practitioners, and of sound evidence of the safety, efficacy and quality of traditional medicine; and the need for measures to ensure proper use of traditional medicine and to protect and preserve the traditional knowledge and natural resources necessary for its sustainable application, and for training and licensing of traditional practitioners;

Noting further that many Member States have taken action to support the proper use of traditional medicine in their health systems,

1. TAKES NOTE of WHO's strategy for traditional medicine, and its four main objectives of framing policy, enhancing safety, efficacy and quality, ensuring access, and promoting rational use;[1]

2. URGES Member States, in accordance with established national legislation and mechanisms:

(1) to adapt, adopt and implement, where appropriate, WHO's traditional-medicine strategy as a basis for national traditional-medicine programmes or work plans;

(2) where appropriate, to formulate and implement national policies and regulations on traditional and complementary and alternative medicine in support of the proper use of traditional medicine, and its integration into national health-care systems, depending on the circumstances in their countries;

(3) to recognize the role of certain traditional practitioners as one of the important resources of primary health care services, particularly in low-income countries, and in accordance with national circumstances;

(4) to set up or expand and strengthen existing national drug-safety monitoring systems to monitor herbal medicines and other traditional practices;

(5) to provide adequate support for research on traditional remedies;

(6) to take measures to protect, preserve and improve if necessary traditional medical knowledge and medicinal plant resources for sustainable development of traditional medicine, depending on the circumstances in each country; such measures might include, where appropriate, the intellectual property rights of traditional practitioners over traditional-medicine formulas and texts, as provided for under national legislation consistent with international obligations, and the engagement of WIPO in discussions on development of national *sui generis* protection systems, as appropriate;

(7) to promote and support, if necessary and in accordance with national circumstances, provision of training and, if necessary, retraining of traditional medicine practitioners, and of a system for the qualification, accreditation or licensing of traditional-medicine practitioners;

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[1] WHO traditional medicine strategy 2002-2005. Document WHO/EDM/TRM/2002.1.

(8) to provide reliable information on traditional medicine and complementary and alternative medicine to consumers and providers in order to promote their sound use;

(9) where appropriate, to ensure safety, efficacy and quality of herbal medicines by determining national standards for, or issuing monographs on, herbal raw materials and traditional medicine formulas;

(10) to encourage where appropriate the inclusion of herbal medicines in national essential drug lists, with a focus on a country's demonstrated public health needs and on verified safety, efficacy and quality of herbal medicines;

(11) to promote where appropriate traditional-medicine education in medical schools;

3. REQUESTS the Director-General:

(1) to facilitate the efforts of interested Member States to formulate national policies and regulations on traditional and complementary and alternative medicine, and to promote exchange of information and collaboration on national policy and regulation of traditional medicine among Member States;

(2) to provide technical support for development of methodology to monitor or ensure product safety, efficacy and quality, preparation of guidelines, and promotion of exchange of information;

(3) to provide technical support to Member States in defining indications for treatment of diseases and conditions by means of traditional medicine;

(4) to seek, together with WHO collaborating centres, evidence-based information on the safety, efficacy, quality and cost-effectiveness of traditional therapies so as to provide guidance to Member States on the definition of products to be included in national directives and proposals on traditional-medicine policy as used in national health systems;

(5) to organize regional training courses where appropriate on quality control of traditional medicines;

(6) to collaborate with other organizations of the United Nations system and nongovernmental organizations in various areas related to traditional medicine, including research, protection of traditional medical knowledge and conservation of medicinal plants resources;

(7) to promote the important role of WHO collaborating centres on traditional medicine in implementing WHO's traditional-medicine strategy, particularly in strengthening research and training of human resources;

(8) to allocate sufficient resources to traditional medicine at global, regional and country levels of the Organization;

(9) to report to the Fifty-eighth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

WHA56.32 Appropriation resolution for the financial period 2004-2005

The Fifty-sixth World Health Assembly

1. RESOLVES to appropriate for the financial period 2004-2005 an amount of US$ 960 111 000 under the regular budget as follows:

Appropriation section	Purpose of appropriation	Amount
		US$
1.	Communicable diseases	93 025 000
2.	Noncommunicable diseases and mental health	69 616 000
3.	Family and community health	60 340 000
4.	Sustainable development and healthy environments	81 802 000
5.	Health technology and pharmaceuticals	49 728 000
6.	Evidence and information for policy	175 451 000
7.	External relations and governing bodies	44 055 000
8.	General management	139 294 000
9.	Director-General, Regional Directors and independent functions	21 670 000
10.	WHO's presence in countries	111 130 000
11.	Miscellaneous	34 000 000
	Effective working budget	880 111 000
12.	Transfer to Tax Equalization Fund	80 000 000
	Total	960 111 000

2. RESOLVES to finance the regular budget for the financial period 2004-2005 as follows:

Source of financing	Amount
	US$
Miscellaneous Income	21 636 000
Regular budget net assessments on Members (see also paragraph 3(3) below)	863 100 890
Net transfer to the Tax Equalisation Fund	75 374 110
Total	960 111 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2004-2005; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations approved under paragraph 3 shall be available for the payment of obligations incurred during the financial period 1 January 2004 to 31 December 2005 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 2004-2005 to sections 1 to 11;

(3) in establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization; the total amount of such tax reimbursements is estimated at US$ 4 625 890;

4. DECIDES:

(1) that notwithstanding the provisions of Financial Regulation 5.1, an amount of US$ 12 364 000 shall be financed directly by the Miscellaneous Income account to provide an adjustment mechanism for the benefit of those Member States that will experience an increase in the rate of assessment between that applicable for the financial period 2000-2001 and for the financial period 2004-2005 and notify the Organization that they wish to benefit from the adjustment mechanism;[1]

(2) that the amount required to meet payments under the financial incentive scheme for 2004 and for 2005 in accordance with Financial Regulation 6.5, estimated at US$ 1 000 000, shall be financed directly by the Miscellaneous Income account;

(3) that the level of the Working Capital Fund shall remain at US$ 31 000 000 as decided previously under resolution WHA52.20;

5. REQUESTS the Director-General to provide budget information on staffing and categories of expenditure resulting from the operational planning for 2004-2005 to the Executive Board at its 113th session;

6. NOTES that the expenditure in the programme budget for 2004-2005 to be financed from sources other than the regular budget is estimated at US$ 1 824 500 000, leading to a total effective budget under all sources of funds of US$ 2 704 611 000.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

[1] See resolution WHA56.34.

WHA56.33 Scale of assessments for the financial period 2004-2005

The Fifty-sixth World Health Assembly

1. DECIDES to accept henceforth the latest available United Nations scale of assessment for assessed contributions of Member States, with a maximum assessment rate of 22% and a minimum assessment rate of 0.001%, taking into account differences in membership between WHO and the United Nations;

2. DECIDES that the scale of assessments for the years 2004 and 2005 shall be as follows:

(1) Members and Associate Members	(2) WHO scale 2004-2005 %
Afghanistan	0.00890
Albania	0.00300
Algeria	0.06890
Andorra	0.00390
Angola	0.00200
Antigua and Barbuda	0.00200
Argentina	1.13050
Armenia	0.00200
Australia	1.60090
Austria	0.93180
Azerbaijan	0.00390
Bahamas	0.01180
Bahrain	0.01770
Bangladesh	0.00980
Barbados	0.00890
Belarus	0.01870
Belgium	1.11090
Belize	0.00100
Benin	0.00200
Bhutan	0.00100
Bolivia	0.00790
Bosnia and Herzegovina	0.00390
Botswana	0.00980
Brazil	2.35160
Brunei Darussalam	0.03250
Bulgaria	0.01280
Burkina Faso	0.00200
Burundi	0.00100
Cambodia	0.00200
Cameroon	0.00890
Canada	2.51690
Cape Verde	0.00100
Central African Republic	0.00100
Chad	0.00100

(1) Members and Associate Members	(2) WHO scale 2004-2005 %
Chile	0.20860
China	1.50740
Colombia	0.19780
Comoros	0.00100
Congo	0.00100
Cook Islands[a]	0.00100
Costa Rica	0.01970
Côte d'Ivoire	0.00890
Croatia	0.03840
Cuba	0.02950
Cyprus	0.03740
Czech Republic	0.19970
Democratic People's Republic of Korea	0.00890
Democratic Republic of the Congo	0.00390
Denmark	0.73700
Djibouti	0.00100
Dominica	0.00100
Dominican Republic	0.02260
Ecuador	0.02460
Egypt	0.07970
El Salvador	0.01770
Equatorial Guinea	0.00100
Eritrea	0.00100
Estonia	0.00980
Ethiopia	0.00390
Fiji	0.00390
Finland	0.51360
France	6.36210
Gabon	0.01380
Gambia	0.00100
Georgia	0.00490
Germany	9.61200
Ghana	0.00490
Greece	0.53030
Grenada	0.00100
Guatemala	0.02660
Guinea	0.00300
Guinea-Bissau	0.00100
Guyana	0.00100
Haiti	0.00200
Honduras	0.00490
Hungary	0.11810
Iceland	0.03250

[a] Not a Member of the United Nations.

(1) Members and Associate Members	(2) WHO scale 2004-2005 %
India	0.33550
Indonesia	0.19680
Iran (Islamic Republic of)	0.26760
Iraq	0.13380
Ireland	0.28930
Israel	0.40830
Italy	4.98340
Jamaica	0.00390
Japan	19.20220
Jordan	0.00790
Kazakhstan	0.02750
Kenya	0.00790
Kiribati	0.00100
Kuwait	0.14460
Kyrgyzstan	0.00100
Lao People's Democratic Republic	0.00100
Latvia	0.00980
Lebanon	0.01180
Lesotho	0.00100
Liberia	0.00100
Libyan Arab Jamahiriya	0.06590
Lithuania	0.01670
Luxembourg	0.07870
Madagascar	0.00300
Malawi	0.00200
Malaysia	0.23120
Maldives	0.00100
Mali	0.00200
Malta	0.01480
Marshall Islands	0.00100
Mauritania	0.00100
Mauritius	0.01080
Mexico	1.06850
Micronesia (Federated States of)	0.00100
Monaco	0.00390
Mongolia	0.00100
Morocco	0.04330
Mozambique	0.00100
Myanmar	0.00980
Namibia	0.00690
Nauru	0.00100
Nepal	0.00390
Netherlands	1.71010
New Zealand	0.23710
Nicaragua	0.00100
Niger	0.00100

(1) Members and Associate Members	(2) WHO scale 2004-2005 %
Nigeria	0.06690
Niue[a]	0.00100
Norway	0.63560
Oman	0.06000
Pakistan	0.06000
Palau	0.00100
Panama	0.01770
Papua New Guinea	0.00590
Paraguay	0.01570
Peru	0.11610
Philippines	0.09840
Poland	0.37190
Portugal	0.45460
Puerto Rico[a,b]	0.00100
Qatar	0.03340
Republic of Korea	1.82130
Republic of Moldova	0.00200
Romania	0.05710
Russian Federation	1.18070
Rwanda	0.00100
Saint Kitts and Nevis	0.00100
Saint Lucia	0.00200
Saint Vincent and the Grenadines	0.00100
Samoa	0.00100
San Marino	0.00200
Sao Tome and Principe	0.00100
Saudi Arabia	0.54510
Senegal	0.00490
Serbia and Montenegro	0.01970
Seychelles	0.00200
Sierra Leone	0.00100
Singapore	0.38670
Slovakia	0.04230
Slovenia	0.07970
Solomon Islands	0.00100
Somalia	0.00100
South Africa	0.40140
Spain	2.47830
Sri Lanka	0.01570
Sudan	0.00590
Suriname	0.00200

[a] Not a Member of the United Nations.

[b] Associate Member of WHO.

(1) Members and Associate Members	(2) WHO scale 2004-2005 %
Swaziland	0.00200
Sweden	1.01030
Switzerland	1.25350
Syrian Arab Republic	0.07870
Tajikistan	0.00100
Thailand	0.28930
The former Yugoslav Republic of Macedonia	0.00590
Timor-Leste	0.00100
Togo	0.00100
Tokelau[a,b]	0.00100
Tonga	0.00100
Trinidad and Tobago	0.01570
Tunisia	0.02950
Turkey	0.43290
Turkmenistan	0.00300
Tuvalu	0.00100
Uganda	0.00490
Ukraine	0.05210
United Arab Emirates	0.19870
United Kingdom of Great Britain and Northern Ireland	5.44700
United Republic of Tanzania	0.00390
United States of America	22.00000
Uruguay	0.07870
Uzbekistan	0.01080
Vanuatu	0.00100
Venezuela	0.20470
Viet Nam	0.01570
Yemen	0.00590
Zambia	0.00200
Zimbabwe	0.00790

(Tenth plenary meeting, 28 May 2003 – Committee A, fourth report)

[a] Not a Member of the United Nations.

[b] Associate Member of WHO.

WHA56.34 Adjustment mechanism

The Fifty-sixth World Health Assembly

DECIDES:

(1) to establish an adjustment mechanism that shall be available to compensate those Member States that will experience an increase in their rate of assessment because of the change in the WHO scale of assessments for 2004-2005[1] and for 2006-2007 as compared with the WHO scale of assessment for 2000-2001;

(2) that the compensation shall be available to Member States that notify the Director-General before the beginning of the year concerned that they wish to benefit from such mechanism;

(3) that the maximum available to each Member State referred to in paragraph (1) shall be limited to the amount corresponding to the increase resulting from a change in the WHO scale of assessment between 2000-2001 and 2004-2005 and between 2000-2001 and 2006-2007 applied to the sum of US$ 858 475 000;

(4) that the amount calculated in accordance with paragraph (3) shall be limited to a maximum of 60% of the increase in 2004, a maximum of 40% of the increase in 2005, a maximum of 40% of the increase in 2006, and a maximum of 30% of the increase in 2007;

(5) that the amounts calculated in accordance with paragraphs (3) and (4) shall be applied as a credit to Member States' accounts on 1 January of the year to which the credit relates;

(6) that a further transfer to the adjustment mechanism from Miscellaneous Income of US$ 8 655 000 shall be incorporated in the appropriation resolution for the biennium 2006-2007.

(Tenth plenary meeting, 28 May 2003 –
Committee A, fourth report)

WHA56.35 Representation of developing countries in the Secretariat

The Fifty-sixth World Health Assembly,

Recalling resolution WHA55.24;

Having considered the report by the Director-General on representation of developing countries in the Secretariat;[2]

Guided by the Purposes and Principles of the Charter of the United Nations, in particular the principle of the sovereign equality of its Member States;

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[1] See resolution WHA56.33.

[2] Document A56/40.

Reaffirming the principle of equitable participation of all Members of the Organization in its work, including the Secretariat and various committees and bodies;

Bearing in mind the principle of gender balance;

Bearing in mind Article 35 of the Constitution of WHO,

1. EXPRESSES CONCERN over existing imbalance in the distribution of posts in WHO's Secretariat between developing and the developed countries, and the continued under-representation and non-representation of several countries, in particular developing countries, in WHO's Secretariat;

2. APPROVES the updating of the various elements of the WHO formula for appointment of staff incorporating the latest information available on membership, contributions and population;

3. APPROVES the following formula for appointment of staff to WHO's Secretariat:

(1) contribution 45%

(2) membership 45%

(3) population 10%

(4) an upper limit of the desirable range that would be subject to a minimum figure based on population, as follows:

up to 1 million	0.379% of 1580, or an upper limit of 6
over 1 million and up to 25 million	0.506% of 1580, or an upper limit of 8
over 25 million and up to 50 million	0.632% of 1580, or an upper limit of 10
over 50 million and up to 100 million	0.759% of 1580, or an upper limit of 12
over 100 million	0.886% of 1580, or an upper limit of 14;

4. SETS a target of 60% of all vacancies arising and posts created over the next two years in the professional and higher graded categories, irrespective of their source of funding, for the appointment of nationals of unrepresented and under-represented countries, in particular developing countries, on the basis of the formula set out in paragraph 3 in all categories of posts, particularly posts in grades P-5 and above, taking into account geographical representation and gender balance;

5. REQUESTS the Director-General:

(1) to give preference to candidates from unrepresented and under-represented countries, in particular developing countries, on the basis of the formula set out in paragraph 3 in all categories of posts, particularly posts in grades P-5 and above, taking into account geographical representation and gender balance;

(2) to submit a report to the Fifty-seventh World Health Assembly on implementation of this resolution.

(Eleventh plenary meeting, 28 May 2003 –
Committee B, sixth report)

DECISIONS

WHA56(1) Composition of the Committee on Credentials

The Fifty-sixth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Azerbaijan, Brazil, Congo, Equatorial Guinea, Haiti, Nepal, Norway, Oman, Portugal, Samoa, Sri Lanka, Zambia.

(First plenary meeting, 19 May 2003)

WHA56(2) Composition of the Committee on Nominations

The Fifty-sixth World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Albania, Bhutan, Cape Verde, Egypt, France, Gabon, Guinea-Bissau, Hungary, Lao People's Democratic Republic, Madagascar, Marshall Islands, Mauritius, Mexico, Myanmar, Namibia, Peru, Qatar, Russian Federation, Singapore, Spain, Thailand, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Dr J.F. López Beltrán, El Salvador (President, Fifty-fifth World Health Assembly, *ex officio*).

(First plenary meeting, 19 May 2003)

WHA56(3) Election of officers of the Fifty-sixth World Health Assembly

The Fifty-sixth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers:

President: Dr Khandaker Mosharraf Hossain (Bangladesh)

Vice-Presidents: Mr U. Olanguena Awono (Cameroon)
Dr J. Torres-Goitia C. (Bolivia)
Dr W. Al-Maani (Jordan)
Mr H. Voigtländer (Germany)
Dr C. Otto (Palau)

(First plenary meeting, 19 May 2003)

WHA56(4) Election of officers of the main committees

The Fifty-sixth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers of the main committees:

Committee A:	**Chairman**	Dr J. Larivière (Canada)
Committee B:	**Chairman**	Mr L. Rokovada (Fiji)

(First plenary meeting, 19 May 2003)

The main committees subsequently elected the following officers:

Committee A:	**Vice-Chairmen**	Dr Y.C. Seignon (Benin) Dr J. Mahjour (Morocco)
	Rapporteur	Mrs B. Jankásková (Czech Republic)
Committee B:	**Vice-Chairmen**	Dr R. Constantiniu (Romania) Mr So Se Pyong (Democratic People's Republic of Korea)
	Rapporteur	Mrs C. Velásquez de Visbal (Venezuela)

(First meetings of Committees A and B, 20 and 22 May 2003)

WHA56(5) Establishment of the General Committee

The Fifty-sixth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: Algeria, Bahrain, Burundi, China, Cuba, France, Ghana, Greece, India, Iran (Islamic Republic of), Jamaica, Lesotho, Poland, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, and United States of America.

(First plenary meeting, 19 May 2003)

WHA56(6) Adoption of the agenda

The Fifty-sixth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 111th session with the deletion of one item and one subitem, and the transfer of one item from Committee B to Committee A.

(Second plenary meeting, 19 May 2003)

WHA56(7) Verification of credentials

The Fifty-sixth World Health Assembly recognized the validity of the credentials of the following delegations of Member States: Afghanistan; Albania; Algeria; Andorra; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas;[1] Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei

[1] Credentials provisionally accepted.

Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Micronesia (Federated States of);[1] Mexico; Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia;[1] Saint Vincent and the Grenadines;[1] Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia and Montenegro, Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela; Viet Nam; Yemen; Zambia; Zimbabwe.

The Fifty-sixth World Health Assembly recognized the validity of the credentials of the representatives of the following Associate Member: Puerto Rico.

(Fourth and eighth plenary meetings, 21 and 23 May 2003)

WHA56(8) Election of Members entitled to designate a person to serve on the Executive Board

The Fifty-sixth World Health Assembly, after considering the recommendations of the General Committee,[1] elected the following as Members entitled to designate a person to serve on the Executive Board: Canada, Czech Republic, Ecuador, France, Guinea-Bissau, Iceland, Nepal, Pakistan, Sudan, Viet Nam.

(Eighth plenary meeting, 23 May 2003)

WHA56(9) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Fifty-sixth World Health Assembly reappointed Dr A.J. Mohammad, delegate of Oman, as member of the WHO Staff Pension Committee, and Dr J.K. Gøtrik, delegate of Denmark, as alternate member, each for a three-year period, namely, until May 2006.

[1] Document A56/57.

The Fifty-sixth World Health Assembly also appointed Dr A.A. Yoosuf, delegate of Maldives, as alternate member of the Committee for the remainder of the term of office of Dr S.P. Bhattarai, namely, until May 2004.

(Tenth plenary meeting, 28 May 2003)

WHA56(10) Policy for relations with nongovernmental organizations

The Fifty-sixth World Health Assembly decided to request the Executive Board to review further at its 113th session the policy for relations with nongovernmental organizations, including amendments proposed during consideration of this item, and to report to the Fifty-seventh World Health Assembly with its recommendations.

(Tenth plenary meeting, 28 May 2003)

WHA56(11) Selection of the country in which the Fifty-seventh World Health Assembly would be held

The Fifty-sixth World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Fifty-seventh World Health Assembly would be held in Switzerland.

(Tenth plenary meeting, 28 May 2003)

WHA56(12) Reports of the Executive Board on its 110th and 111th sessions

The Fifty-sixth World Health Assembly, after reviewing the Executive Board's reports on its 110th[1] and 111th[2] sessions, approved the reports; commended the work the Board had performed; and expressed its appreciation of the dedication with which the Board had carried out the tasks entrusted to it.

(Eleventh plenary meeting, 28 May 2003)

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[1] Document EB110/2002/REC/1.

[2] Documents EB111/2003/REC/1 and EB111/2003/REC/2.

ANNEXES

ANNEX 1

Contract of the Director-General[1]

[A56/4, Annex – 16 April 2003]

THIS CONTRACT is made this twenty-first day of May two thousand and three between the World Health Organization (hereinafter called the Organization) of the one part and Dr Jong-Wook Lee (hereinafter called the Director-General) of the other part.

WHEREAS

(1) It is provided by Article 31 of the Constitution of the Organization that the Director-General of the Organization shall be appointed by the World Health Assembly (hereinafter called the Health Assembly) on the nomination of the Executive Board (hereinafter called the Board) on such terms as the Health Assembly may decide; and

(2) The Director-General has been duly nominated by the Board and appointed by the Health Assembly at its meeting held on the twenty-first day of May two thousand and three for a period of five years.

NOW THIS CONTRACT WITNESSETH and it is hereby agreed as follows.

I. (1) The Director-General shall serve from the twenty-first day of July two thousand and three until the twentieth day of July two thousand and eight on which date the appointment and this Contract shall terminate.

(2) Subject to the authority of the Board, the Director-General shall exercise the functions of chief technical and administrative officer of the Organization and shall perform such duties as may be specified in the Constitution and in the rules of the Organization and/or as may be assigned to him or her by the Health Assembly or the Board.

(3) The Director-General shall be subject to the Staff Regulations of the Organization in so far as they may be applicable to him or her. In particular, he or she shall not hold any other administrative post, and shall not receive emoluments from any outside sources in respect of activities relating to the Organization. He or she shall not engage in business or in any employment or activity which would interfere with his or her duties in the Organization.

(4) The Director-General, during the term of this appointment, shall enjoy all the privileges and immunities in keeping with the office by virtue of the Constitution of the Organization and any relevant arrangements already in force or to be concluded in the future.

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[1] See resolution WHA56.3.

(5) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept such resignation on behalf of the Health Assembly; in which case, upon the expiration of the said period of notice, the Director-General shall cease to hold the appointment and this Contract shall terminate.

(6) The Health Assembly shall have the right, on the proposal of the Board and after hearing the Director-General and subject to at least six months' notice in writing, to terminate this Contract for reasons of exceptional gravity likely to prejudice the interests of the Organization.

II. (1) As from the twenty-first day of July two thousand and three the Director-General shall receive from the Organization an annual salary of two hundred and thirteen thousand eight hundred and ninety-two United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and forty-two thousand eight hundred and thirteen United States dollars per annum at the dependency rate (one hundred and twenty-seven thousand United States dollars at the single rate) or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

(2) In addition to the normal adjustments and allowances authorized to staff members under the Staff Rules, the Director-General shall receive an annual representation allowance of twenty thousand United States dollars or its equivalent in such other currency as may be mutually agreed between the parties to this Contract, to be paid monthly commencing on the twenty-first day of July two thousand and three. The representation allowance shall be used at his or her discretion entirely in respect of representation in connection with his or her official duties. He or she shall be entitled to such reimbursable allowances as travel allowances and removal costs on appointment, on subsequent change of official station, on termination of appointment, or on official travel and home-leave travel.

III. The terms of the present Contract relating to rates of salary and representation allowance are subject to review and adjustment by the Health Assembly on the proposal of the Board, and after consultation with the Director-General, to bring them into conformity with any provision regarding the conditions of employment of staff members which the Health Assembly may decide to apply to staff members already in the service.

IV. If any question of interpretation or any dispute arises concerning this Contract, which is not settled by negotiation or agreement, the matter shall be referred for final decision to the competent tribunal provided for in the Staff Rules.

WHEREUNTO we have set our hands the day and year first above written.

(signed) J.-W. LEE
Director-General

(signed) K.M. HOSSAIN
President of the
World Health Assembly

ANNEX 2

Real Estate Fund[1]

Report by the Secretariat

[A56/5 – 29 April 2003]

1. In accordance with resolution WHA23.14 establishing the Real Estate Fund, the Fund may be used to finance the acquisition of land and construction of buildings or building extensions, major repairs of, and alterations to, the Organization's existing office buildings, and housing for staff.

2. Resolution WHA23.14 further provides that specific authorization from the Health Assembly is required, unless otherwise indicated, before contracts are entered into that involve the acquisition of land and construction of buildings or building extensions.

3. The Executive Board at its 111th session was apprised of the proposals of the Regional Office for Africa to construct additional office space, and staff housing in Brazzaville, that had not yet been submitted to the Health Assembly.[2] Consequently, the Board requested the Administration, Budget and Finance Committee to consider the real estate proposals of the Regional Office for Africa and to make a recommendation to the Health Assembly.[3]

4. The Regional Office for Africa recently moved a substantial part of its operations back to Brazzaville from its temporary location in Harare, while maintaining a fairly large presence there, in view of the expansion of operations in the Region. After the return, the office, located in Djoué, some 20 kilometres outside Brazzaville, was refurbished by the Government of Congo. Nonetheless, the office accommodation in Brazzaville is no longer sufficient to meet the present, and even less the future, needs of the Regional Office. The extent and quality of housing available for staff in Djoué is also inadequate to meet present needs. Moreover, a detailed review of security measures at the Djoué compound indicated the need for investment in the office buildings and staff accommodation in order to improve the overall level of security.

5. The requirements are detailed in the Appendix, together with their estimated costs. In summary, these requirements concern the provision of additional office space for some 180 staff members, a conference room with a 600-person capacity and related facilities, and the acquisition and construction of further staff accommodation and facilities within the Djoué compound.

6. The completion of these building projects will enable the Regional Office to operate with its eventual full complement of staff and to provide adequate housing for all international professional

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[1] See resolution WHA56.14.

[2] See document EB111/2003/REC/1, Annex 1.

[3] See document EB111/2003/REC/2, summary record of the fourth meeting, section 1.

staff. A further, important, benefit will be a better security environment at the Djoué compound since WHO will be in control of all the property within the confines of the compound.

ACTION BY THE HEALTH ASSEMBLY

7. [The Health Assembly adopted resolution WHA56.14 at its ninth plenary meeting, 26 May 2003.]

Appendix

REGIONAL OFFICE FOR AFRICA, BRAZZAVILLE: REAL ESTATE PROPOSALS

Extension of office infrastructure

1. The current office space can accommodate adequately only about 250 staff members, compared with an eventual staff complement of some 430.

2. The main conference hall in the Regional Office can accommodate only about 200 persons, taking account of security requirements, which does not reflect the fact that the Region now comprises 46 countries. The design does not allow for easy modification.

3. For safety and security reasons the working environment needs to be improved, which means that office and conference accommodation must be extended and modernized. The work is planned to take place in two phases at a total estimated cost of US$ 2 330 000.

Phase one: 2004, 2005 and 2006: construction of columns on the ground level (temporary parking space) and office accommodation on the upper levels for about 140 staff members. Estimated cost: US$ 1 700 000.

Phase two: 2005 and 2006: conversion of the columned space into a new conference hall with a capacity of 600 seats and ancillary facilities. Conversion also of the existing main conference hall into office space designed to accommodate some 40 persons. Estimated cost for all components: US$ 630 000.

Construction of new housing and sporting facilities in the Djoué compound

4. The return of the Regional Office to Brazzaville and a rise in the number of internationally recruited staff members living with their families requires an increase in the residential capacity at Djoué from 124 to 158 units (apartments and villas) at a total estimated cost of US$ 3 000 000.

5. To meet the increasing need for housing, it is proposed:

(a) to purchase 10 houses in the WHO enclosure from the present private owners; this will secure WHO control of all accommodation within the Djoué compound. Payment to be made over a period of five years. Estimated total cost: US$ 1 000 000;

(b) to renovate the 10 houses. Estimated cost: US$ 300 000;

(c) to convert 26 existing villas with one or two bedrooms into three- or four-bedroomed villas in order to accommodate larger families and to renovate them. Estimated cost: US$ 300 000;

(d) to construct two additional blocks of flats, comprising 24 apartments. Estimated cost: US$ 1 200 000;

(e) to construct sporting facilities, mainly a fitness centre for staff members and their families, as such facilities are virtually nonexistent in Brazzaville. Estimated cost: US$ 200 000.

ANNEX 3

Strategic directions for improving the health and development of children and adolescents: summary[1]

[A56/15, Annex – 27 March 2003]

INTRODUCTION

1. Despite a remarkable reduction in child mortality, 10.8 million children under five years of age died in 2000, over half the deaths caused by just five preventable communicable diseases, compounded by malnutrition. In many countries the progress in reducing deaths has slowed and in some, past gains have been reversed. One reason is failure effectively to address neonatal mortality. Others include the limited progress in tackling determinants of ill-health such as malnutrition, unhealthy environments, and low levels of access to, and use of, good-quality health care services. Knowledge about the management and prevention of childhood disease and injuries has increased, but coverage with essential interventions is still modest.

2. Over the past decade, considerable progress has been made in understanding the factors that affect adolescents and in introducing interventions to address their health needs. Nevertheless, many adolescents still lack the support they need for their development, including access to information, skills and health services. New threats, such as the HIV/AIDS pandemic, and rapidly changing socioeconomic circumstances pose considerable challenges to the safe transition of young people into adulthood.

3. Poverty is an underlying determinant in the health of children and adolescents. Under-five mortality currently averages 6 per 1000 live births in the high-income countries, but is as high as 175 per 1000 in low-income countries. Within countries, poor children also tend to be in worse health.

BASIS FOR ACTION

4. The foundations of health in adulthood and old age are laid during childhood and adolescence. Neonates and young children have basic survival needs for warmth and adequate feeding, but also require social interactions and play to nurture their optimal development. Adolescents have similar needs. In addition, they face the challenge of adopting healthy behaviours as they move toward adulthood. All three age groups need safe and supportive environments and families in which to grow and develop.

5. WHO's strategic directions for improving the health and development of children and adolescents bring together the most critical areas of work for improving the health and development of children and adolescents. They provide a framework for planning, implementing and evaluating

[1] See resolution WHA56.21.

complementary, efficient and effective interventions, whose effect can be amplified by greater coordination.

6. Priority areas for intervention are those that help to protect children and adolescents from age-specific challenges, to grow and to make a successful transition to the next phase of life.[1] WHO's approach aims to unite various efforts at country level and throughout the Organization to promote the healthy growth and development of children and adolescents.

GUIDING PRINCIPLES

7. Three principles guide implementation of the strategic directions: (1) addressing inequities and facilitating respect, protection, and fulfilment of human rights, as stipulated in internationally agreed human-rights instruments, including the Convention on the Rights of the Child; (2) taking a life-course approach that recognizes the continuum from before birth through childhood, adolescence and adulthood; and (3) adopting a public health approach by focusing on major health challenges to the population as a whole, but especially the poor, and applying a systematic development model in order to ensure the availability of effective interventions.

8. Poverty and gender **inequities** are critical determinants of disparities in health outcomes, and attention to them underpins the areas identified for priority action. WHO will cooperate with countries to implement creative and effective approaches that tackle the needs of children and young people hitherto inadequately served or supported.

9. The **life-course** approach recognizes that the quality of life at early ages is important not only for immediate well-being, but also for health and development later in life and, given the crucial links between maternal, neonate, and child health, for the health of future generations. Ensuring that every child can develop to his or her full potential requires a broad, long-term perspective that aims not only at survival, but also at optimal physical and psychosocial development.

10. WHO will apply a systematic model to ensure that **public health** programmes are relevant and effective in addressing major health challenges, and provide support to Member States for their implementation.

11. WHO will aim to reduce the burden of excess mortality and disability among children and adolescents, particularly those who are poor and marginalized, by working to provide safe and supportive environments and by improving services within the health and other sectors that can influence the determinants of child and adolescent health and development.

FUTURE DIRECTIONS

12. Seven areas have been identified as priorities for future action, as set out below.

13. Further reductions in childhood deaths and long-term disabilities require making the **health of mothers and neonates** a higher priority. The health and survival of the child, especially in early infancy, is intricately linked with the health of the mother, her nutritional status, and the reproductive-health care she receives. The reduction of child mortality, as set out in the development goals of the

[1] See document WHO/FCH/CAH/02.21 Rev.1.

United Nations Millennium Declaration,[1] is dependent on the reduction of maternal mortality. A set of essential care practices has been identified to ensure healthy outcomes of pregnancy, and a limited set of low-cost interventions can ensure that both mothers and neonates receive the best possible care.

14. Good **nutrition** is a foundation for healthy development. Furthermore, nutrition and ill-health form a vicious spiral: poor nutrition leads to ill-health and ill-health causes further deterioration of nutritional status. These effects are most dramatically observed in infants and young children, who bear the brunt of malnutrition and the highest risk of death and disability associated with it. WHO is providing technical support to Member States to implement the Global Strategy for Infant and Young Child Feeding[2] in collaboration with partners and concerned parties.

15. Preventable **communicable diseases** account for about half of childhood deaths. Their burden in childhood can be drastically reduced through three strategic activities: the Expanded Programme on Immunization (against vaccine-preventable diseases), including vitamin A supplementation, Integrated Management of Childhood Illness (treatment and prevention of the most common communicable diseases and malnutrition), and school health programmes (provision of essential health services, including deworming). WHO also gives high priority to working with countries both to prevent mother-to-child transmission of HIV and to meet the goals of reducing HIV prevalence among young people.

16. **Injuries**, including those caused by violence, account for a large number of deaths of children and adolescents. Preventive strategies must take account of multiple environmental health risks and the way in which they cluster in specific settings. Community-based interventions have reduced the rates of injuries in many countries; further work is required to broaden the range of effective interventions. WHO will support interventions to address injury risks to children; the results will inform the policy process and ensure that recommendations are based on evidence.

17. Children under five years of age suffer unduly from threats in the **physical environment**. WHO has launched the healthy environments for children initiative, through which principal environmental risk factors to children's health have been identified. It is seeking to create the partnerships that will enable Member States to focus on six priority issues: household water security, hygiene and sanitation, air pollution, disease vectors, chemical hazards, and injuries and accidents.

18. A common set of protective and risk factors underlies a variety of behaviours associated with the health of **adolescents**. Adolescents who have valuable relationships with trusted adults, and who are provided with structure and boundaries around behaviours, are much less likely to engage in early or unsafe sexual activity, to use substances such as tobacco and alcohol, or to engage in violence. Few countries have adopted strategies that deal comprehensively with adolescent health needs, despite their importance. WHO is committed to strengthening the role of the health sector in the promotion of adolescent health and development, including sexual and reproductive health.

19. Major concerns for children and adolescents include their **psychosocial development** and **mental health**. Some 10% to 20% of children have one or more mental or behavioural problems. There is clear recognition of the need to support the psychological development of young infants, children and adolescents for a healthy start in life, and of the view of a continuum of psychological health across the life-course. WHO will promote a wide range of interventions, delivered through communities and health systems, that are effective in assisting children and adolescents with mental health needs.

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[1] See document A56/11, Annex.

[2] Document WHA55/2002/REC/1, Annex 2.

20. Children and adolescents living in especially difficult circumstances or with special needs require particular attention in each of the priority areas described above. They include street children, children at work, children and adolescents subject to commercial exploitation, those affected by natural or manmade disasters, or those living with disabilities. Their specific situations make them more vulnerable to ill-health, violence or exploitation and they are more prone to various forms of discrimination.

IMPLEMENTATION

21. Supporting healthy families is an intersectoral endeavour. The responsibility for setting and implementing healthy public policies involves stakeholders beyond the ministry of health, and embraces multiple other sectors including education, legal and social welfare, transport, agriculture, housing, energy, water, and sanitation. Partnerships are required at local, national and international levels.

22. Growing awareness of the importance of investing in health and human development provides an opportunity for WHO to strengthen its partnerships, focus the attention of the global community on the tasks to be done, and highlight the investments needed to produce results. WHO will work to establish effective partnerships, including with other organizations of the United Nations system, multilateral and bilateral development agencies, nongovernmental organizations and, increasingly, civil society and the private sector, with a view to complementing and building on the strengths and initiatives of its partners.

23. WHO will play several roles with respect to specific areas of work within child and adolescent health and development:

- normative and technical, including formulation of agendas for action, establishment of national and international consensus on health policy, and setting of strategy and standards based on the best available evidence;
- partnership, working closely with others to formulate agendas, plans, and complementary actions with a view to implementing and achieving its goals and objectives;
- supportive, seeking to add value to the impact of health actions undertaken by others, monitoring progress and providing technical inputs as needed.

MONITORING PROGRESS

24. Continuous improvement in meeting the needs of children, adolescents and their families results from information about what is being implemented, at what levels of coverage, and with what outcomes. Documentation and monitoring of processes and outcomes are essential for effective planning and management at all levels. The challenge lies both in developing systems that provide useful information at all levels, and in building capacity to ensure that the resulting data are analysed appropriately and used to inform decision-making. WHO works to support countries in the development and use of effective monitoring systems, and builds on these systems to collect, analyse and disseminate information at regional and global levels that can guide public health decision-making.

ANNEX 4

Joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission[1]

Report by the Director-General

[A56/34 – 3 April 2003]

1. In line with the provisions of resolution WHA53.15 (2000) on food safety and the request made by the FAO Programme Committee at its Eighty-sixth Session in September 2001, a report was prepared on the joint FAO/WHO evaluation of the Codex Alimentarius Commission and other FAO and WHO work on food standards,[2] a summary of which is contained herein, with comments by the Director-General and an analysis of the main policy implications of the report for the work of WHO in the areas of food safety and nutrition.

SUMMARY OF THE REPORT

Purpose and conduct of the evaluation

2. The evaluation was commissioned by FAO and WHO and, although it concentrates on the FAO/WHO Codex Alimentarius Commission, it also covers all aspects of the food-standards work of FAO and WHO, which includes capacity-building and expert scientific advice. The evaluation was undertaken by an independent team advised by an independent expert panel. The evaluation team consisted of five persons, three of whom, including the team leader, were external to the two organizations. The independent expert panel comprised 10 members drawn from various countries and from stakeholder interests. The evaluation also benefited from the advice of the Executive Committee of the Codex Alimentarius Commission.

3. In the conduct of the evaluation, 24 countries were visited, in all parts of the world and at all levels of development. The evaluation team held discussions with a broad range of government and stakeholder representatives relevant to food production, control and consumption and with other international standard-setting organizations. Questionnaires were sent to all members of the Codex Alimentarius Commission and Member States of FAO and WHO that were not members of the Commission and to international nongovernmental organizations and intergovernmental organizations that were observers of the Commission and of WHO. Two general calls for comments were issued on the Internet, the first open, the second targeted to national nongovernmental organizations.

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[1] See resolution WHA56.23.

[2] Report of the evaluation of the Codex Alimentarius and other FAO and WHO food standards work. FAO and WHO, 15 November 2002.

Findings

4. The evaluation found that the food standards set by the Codex Alimentarius Commission were considered to be very important by members. The standards were perceived as vital in promoting food-control systems designed to protect consumer health, including issues related to international trade and the WTO agreements on the Application of Sanitary and Phytosanitary Measures and on Technical Barriers to Trade. Codex standards also provide a basis for standard-setting by smaller and less developed countries. The evaluation also found that the capacity-building activities of FAO, WHO and the Commission continued to make a substantial contribution to enabling individual countries better to protect their citizens and to benefit from an increasingly globalized market in food.

5. The following main areas for improvement were identified:

- greater speed in the Commission's work and provision of expert scientific advice
- increased inclusion of developing Member States in the Commission's process for setting standards, including risk assessment
- more useful standards in terms of relevance to Member States' needs and of timeliness
- more effective capacity-building for development of national food-control systems.

Mandate and priorities

6. A revised, precise mandate for the Commission was suggested, reflecting an increase in activities related to health priorities (to be adopted by the respective FAO and WHO governing bodies in the form of an amendment to the Statutes of the Codex Alimentarius Commission) which reads: "The formulation and revision of international standards for food, in collaboration with other appropriate international organizations, with priority to standards for the protection of consumer health, while taking into full account the needs of developing countries".

7. The health-related demands on the Commission are growing, with greater consumer awareness, new technologies, the emergence of certain pathogens, and nutrition-related issues such as supplements, functional foods and health claims. At the same time, work on food safety increasingly addresses the food chain in a unified way, suggesting increased collaboration at both intersectoral and international levels. Such collaboration should be improved in particular between the Commission and the International Office of Epizootics (OIE) in order to formalize their relationship and thus facilitate their ability to deal with overlapping issues.

8. If the Commission is fully to cover health risks in food, it will be essential to determine priorities for its standard-setting programme. The following order of priorities for the Commission's work is suggested:

(i) standards having an impact on consumer health and safety;

(ii) commodity standards responding to the expressed needs of developing countries;

(iii) commodity standards responding to the expressed needs of developed countries;

(iv) informational labelling relating to nonhealth and nonsafety issues.

Management structure: recommendations

9. Within the overall structure of FAO and WHO, the Commission should have greater independence in the planning and execution of its work programme, as approved by the two parent organizations. Proposals for a revised organizational structure are designed to improve and tighten management of the Commission. The development of standards was regarded as a critical process that needed improved management and mechanisms. A review, followed by consultation on the structure of the Commission's committees, was recommended. The executive role of the Commission's secretariat should be enhanced in order to provide support for greater independence and operational efficiency, by expanding the staff and raising its seniority. The increased financial resources needed for these changes are estimated initially at US$ 1.4 million per biennium.

10. The recommended review should concentrate on greater consistency and on priorities, including emerging issues, and on streamlining and accelerating working procedures of the various committees, while ensuring better participation and consultation, especially with developing countries. Decisions in committees and the Commission should, wherever possible, continue to be taken by consensus. In the case of a vote, the procedure should be handled by the Commission, with decisions made by a two-thirds majority of those present and voting.

11. There should be a clearer distinction between risk assessment and risk management. The Commission's committees should concentrate on risk management, whereas scientific risk assessment should be referred to FAO and WHO expert bodies.

12. Expert advice provided to the Commission needs to have clearer identity and coordination and significantly increased resources. Its independence and transparency need to be further reinforced within FAO and WHO. The Commission needs to be able to establish priorities within an agreed budget for expert advice, in line with its work programme. This budget needs to be adequate not only to cover inputs from existing expert bodies, but also to respond to priorities for more ad hoc advice, including on emerging issues.

13. It is recommended that FAO and WHO should establish a scientific committee of eminent scientists to provide overarching scientific advice, including on emerging challenges, to the Commission and the two organizations, and guidance and quality control to existing and ad hoc committees. The position of joint coordinator of current FAO/WHO activities on food-safety risk assessment should be created, to be housed in WHO, in order to coordinate scientific advice to the Commission and to act as Secretary to the scientific committee. WHO should markedly increase its contribution to health-related risk assessment, while FAO should strengthen its input to good manufacturing and handling practices. A study should immediately be undertaken of expert advice and risk assessment, followed by an expert consultation and discussion in the Commission. In general, the budgetary implications of expansion in the necessary FAO/WHO risk assessment work are estimated at US$ 2.5 million per biennium.

14. Building capacity within health systems for food safety in order both to protect domestic consumers and improve trade prospects is a major priority of developing countries. The evaluation found many examples of successful capacity-building by FAO and WHO, but inadequate interaction between FAO and WHO at country level. The initiative to create the new FAO/WHO trust fund to enable effective participation in the Commission is welcomed, as is the interagency global facility/framework launched by WTO, the World Bank, FAO, WHO and OIE to strengthen capacity in the application of sanitary and phytosanitary measures. The facility has been set up with seed money from the World Bank and is administered by WTO. A major joint FAO/WHO effort is recommended to mobilize extrabudgetary funds and foster coordinated bilateral assistance in capacity-building. Also,

FAO and WHO should urgently analyse ways to improve coordination and distribution of work, drawing on their mutual strengths and synergies, and to share the results with the Commission.

15. Lastly, the report calls for early and continued action to implement agreed recommendations with:

- early decisions on funding requirements and new managerial arrangements by the FAO and WHO governing bodies
- early action by the Commission itself to act on recommendations without loss of momentum, by reference to the Commission's general committees
- establishment of a task force comprising FAO, WHO and the Commission's Chair and Vice-chairs to follow up and monitor implementation of the evaluation's recommendations.

COMMENTS BY THE DIRECTOR-GENERAL

16. The Director-General welcomes the "Report of the evaluation of the Codex Alimentarius and other FAO and WHO food standards work". Within a relatively short time, and thanks to the input of governments and many other stakeholders in the process of setting international standards for food, a thorough and comprehensive analysis has been made. The recommendations made in the report will prove useful in ensuring that the Codex Alimentarius Commission and its subsidiary bodies better achieve their objectives; that scientific advice to the Commission is strengthened; and that participation of Member States, in particular developing countries, is improved.

17. The Director-General considers the Commission to be an important entity that significantly contributes to the objectives of WHO in the areas of food safety and nutrition, and is pleased to note the recommendation that the scope of the Commission should fully cover health-related aspects of food standards. This should translate into increased direct involvement of WHO in the Commission and enhanced capacity within WHO for risk assessment, including a coordination function, for which sufficient resources will be made available.

18. The Director-General supports the recommendation that the Commission should remain a cosponsored programme of its parent organizations. The recommendations to define its mandate and redefine its independence are acceptable within the limits of a budget and programme of work approved by those parent organizations. Such definitions should explicitly reflect the Commission's important role in food safety and nutrition, and in promoting sound regulatory frameworks by establishing guidelines on national food-control systems. This would recognize the activities currently undertaken by the Commission as described in its strategic framework for the period 2003-2007.[1]

19. The Director-General stresses that the activities currently relevant to the Commission should remain joint activities of WHO and FAO, particularly in relation to risk assessment and capacity-building. She will work together with the Director-General of FAO to ensure that coordination and distribution of work between the two organizations are optimized in order to draw on mutual strengths and synergies. Capacity-building in developing countries, which should enable them to represent their interests effectively in the Commission and in WTO negotiations, should benefit from the proposed 12-year FAO/WHO trust fund supported in 2002 by the Executive Committee of the Codex Alimentarius Commission. The integration of considerations on food safety, food standards, food

[1] Codex Alimentarius Commission. Strategic framework 2003-2007. FAO and WHO, 2002.

production and food trade in relation to an agreed focus on sustainable development would represent a significant step forward for developing economies.

20. The Director-General fully supports the recommendation to implement expeditiously the agreed recommendations through the establishment of a joint task force. She will work with FAO to convene a consultation urgently to review the status and procedures of the expert bodies in order to improve the quality, quantity and timeliness of scientific advice, as requested by the Codex Alimentarius Commission at its Twenty-fourth Session in July 2001.

POLICY PERSPECTIVE

21. The results of the evaluation are reviewed below from a policy perspective, focusing on the relevance of the Commission to WHO's strategies for food safety and nutrition. The purpose is to identify areas where WHO may increase its input, in order to improve protection of human health.

22. Resolution WHA53.15 (2000) requested the Director-General, *inter alia*, "to give greater emphasis to food safety". The Executive Board at its 109th session in January 2002 endorsed the draft global WHO food safety strategy, with the primary goal of reducing the health and social burden of foodborne disease.[1] The approaches to achieve this goal include enhancing the scientific and public health role of WHO in the Commission, strengthening surveillance systems for foodborne diseases, improving risk assessment, and building capacity in developing countries.

23. The evaluation has highlighted the need for the Commission to give higher priority to science-based food-safety standards, nutrition-related issues, and health. This work should include the establishment of internationally agreed guidelines for national food-control systems, based on the criteria of protection of consumer health and fair practices in the food trade, and the promotion of optimal nutrition among consumers through appropriate labelling and the use of health claims, to assist them in making the right choices. Promoting healthier diets in this way is one of the modalities indicated in the global strategy on diet, physical activity and health that WHO is currently formulating.

24. WHO already has in place a global strategy on infant and young-child feeding, which should help to combat malnutrition.[2] Food supplements, and in particular food fortification, are among the various tools available. Resolution WHA55.25 (2002) specifically requested the Commission "to continue to give full consideration ... to action it might take to improve the quality standards of processed foods for infants and young children and to promote their safe and proper use at an appropriate age, including through adequate labelling, consistent with the policy of WHO, in particular the International Code of Marketing of Breast-milk Substitutes ...".

25. The timely provision of scientific advice is crucial to enable the Commission to establish health-related standards. The report highlights a clear need to modernize and transform the current process and working arrangements of expert bodies such as the Joint FAO/WHO Expert Committee on Food Additives and the Joint FAO/WHO Meeting on Pesticide Residues, and to create an overarching and uniform approach for assessment of risks associated with food. Such an approach would include consideration of microbiological risks and risks related to foods derived from biotechnology. In order to reflect best practice in this area, peer-review methodology drawing on the work of others should be used in order rapidly to reach science-based conclusions at the international level, without

[1] See document EB109/2002/REC/2, summary record of the fourth meeting.

[2] See resolution WHA55.25.

jeopardizing the quality, independence and transparency of the advice. Through strengthening of systems for surveillance and monitoring of foodborne diseases, WHO will generate data from around the world on health risks from food and the related disease burden, enabling the Commission and governments to define their priorities better.

REVIEW BY THE EXECUTIVE BOARD

26. The Executive Board at its 111th session in January 2003 noted the report of the evaluation of the Commission and its possible implications for the work of WHO. It agreed that, exceptionally, a resolution for consideration by the Fifty-sixth World Health Assembly should be prepared only after the reaction of the Commission to the report was known.

27. The Twenty-fifth (Extraordinary) Session of the Codex Alimentarius Commission in February 2003 adopted a statement on the outcome of the joint FAO/WHO evaluation of the Codex Alimentarius and other FAO and WHO work on food standards, for the attention of the Fifty-sixth World Health Assembly and the governing bodies of FAO (see Annex to resolution WHA56.23).

ACTION BY THE HEALTH ASSEMBLY

28. [The Health Assembly adopted resolution WHA56.23 at its tenth plenary meeting, 28 May 2003.]

ANNEX 5

A global health-sector strategy for HIV/AIDS 2003-2007[1]

Providing a framework for partnership and action

Executive summary[2]

[A56/12, Annex – 31 March 2003]

BACKGROUND

1. The HIV/AIDS pandemic has become a human, social and economic disaster, with far-reaching implications for individuals, communities and countries. No other disease has so dramatically highlighted the current disparities and inequities in access to health care, economic opportunity and the protection of basic human rights. More than 40 million people worldwide are infected with HIV. Each day there are some 14 000 new HIV infections, more than half in people under 24 years of age.

2. HIV incidence and AIDS-related death rates are again rising in some countries where real progress had previously been made in stemming the epidemic. In some settings, HIV prevention and care initiatives and services have been allowed to run down, whereas other countries have not kept a sharp enough focus on prevention after the advent of combination antiretroviral treatment. Developing countries now have a unique opportunity to learn from these experiences by maintaining strong prevention efforts even as access to antiretroviral treatment is expanded.

3. The health sector is facing severe shortages of human and financial resources, especially in the worst affected countries. Health-care workers themselves are directly affected by HIV/AIDS, and organizations and facilities providing care and support are overwhelmed by the demand.

AIMS AND TARGET AUDIENCE

4. The *aim* of the global health-sector strategy is to define and strengthen the response of the health sector to the HIV/AIDS epidemic within the overall multisectoral response.

5. The strategy's specific *objectives* are:

- to advise health ministries on the essential interventions needed for an effective health-sector response to HIV/AIDS;
- to support health ministries in creating the frameworks for policy and for the planning, priority-setting, implementation and monitoring necessary to support such a response;

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[1] See resolution WHA56.30.

[2] The full strategy is contained in document WHO/HIV/2002.25.

- to enhance and promote the strengths, expertise and experience that health ministries can contribute to national strategic planning for HIV/AIDS;

- to help the health sector to attain the goals contained in the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly special session on HIV/AIDS in June 2001.[1]

6. Although the primary *target audience* comprises ministers of health, and policy-makers and other decision-makers in the health sector, the strategy is also intended for other health-sector stakeholders, including international agencies, public and private health services, nongovernmental organizations, community groups, professional associations, and institutions with direct inputs into the health-care system. Many other government departments and agencies, with responsibilities ranging from finance to foreign affairs, can all contribute substantially to a comprehensive response to HIV/AIDS; the strategy will help to identify areas of leadership in the response to HIV/AIDS for the health sector, and for other areas of government with support and technical advice from health ministries. Opportunities for managing diversity and maximizing synergies can be created through partnerships and linkages with the public and private sectors and donors.

GOALS, GUIDING PRINCIPLES AND CORE COMPONENTS

7. In the Declaration of Commitment on HIV/AIDS, the global community committed itself to a range of actions at the local, national, regional and international levels. The global health-sector strategy reflects the aspirations and actions contained in the Declaration, since many of its targets can only be met through a strong, broad contribution of the health sector. The *goals* of current efforts to combat HIV/AIDS can be summarized as follows: (i) to prevent transmission of HIV; (ii) to reduce the morbidity and mortality related to HIV/AIDS; and (iii) to minimize the personal and societal impact of HIV/AIDS.

8. The following *guiding principles* that have emerged from the broad consultative process for formulating the strategy and the various relevant United Nations system documents[2] are prerequisites for effective and sustained prevention, health promotion, treatment and care for HIV/AIDS.

(a) It is the role of government, working with civil society, to provide the leadership, means and coordination for an effective response to HIV/AIDS at national and community levels.

(b) It is a fundamental responsibility of the health sector to provide the highest possible levels of care, even in resource-constrained settings.

(c) Prevention, treatment and care are indivisible elements of effective responses. Although prevention of HIV infection forms the mainstay of the health-sector response, it cannot be separated from the treatment and care of those living with HIV/AIDS.

(d) Health ministries and the health sector have a responsibility to use the best available evidence to inform planning and decision-making for HIV/AIDS.

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[1] United Nations General Assembly twenty-sixth special session, Declaration of Commitment on HIV/AIDS, 27 June 2001, resolution S-26/2.

[2] UNAIDS, Global Strategy Framework on HIV/AIDS, Geneva, UNAIDS, 2001; United Nations system strategic plan for HIV/AIDS for 2001-2005, Geneva, UNAIDS, 2001 (document UNAIDS/PCB(11)/01.3).

(e) People have a right to know their HIV status, and testing and counselling should be widely accessible through ethical, practical and, where appropriate, innovative models of delivery.

(f) Prevention methods, treatment and the applications of results of scientific breakthroughs need to be equitably and affordably available to all, with priority given to vulnerable groups.

(g) A successful response depends on the active engagement of people living with, and affected by, HIV/AIDS.

(h) Programming should take account of the gender inequalities that fuel the pandemic.

(i) Both broad-based and targeted interventions are required: broad-based interventions are essential for generating wide awareness of HIV/AIDS in populations and targeted interventions complement such approaches.

(j) Bringing HIV/AIDS services and programmes into the mainstream of health systems delivers effective, cost-efficient outcomes. Existing reproductive-health programmes in particular offer entry points for HIV/AIDS interventions.

(k) HIV infection in medical settings must be prevented.

9. Even the most resource-limited settings have engendered success stories of slowing the rate of new infections and providing high-quality care for those affected. Based on these experiences and the wealth of knowledge gained globally from two decades of responses to HIV/AIDS, WHO has compiled several *core components* (see Appendix) of a comprehensive health-sector response to HIV/AIDS. Many of these components will depend on, and in turn benefit, other public health programmes. In particular, access to information and services for maternal and child health, sexual and reproductive health, and the control of tuberculosis and sexually transmitted infections together provide an essential foundation upon which to build sound HIV/AIDS programmes.

IMPLEMENTING AN EFFECTIVE HEALTH-SECTOR STRATEGY FOR HIV/AIDS

10. The translation of the core components of a health-sector response into fully operating programmes, services and policies needs: *strong leadership*, to mobilize government and the nongovernmental sector; a *strategic framework*, to support implementation; systems for the identification and allocation of *resources*; means for *setting priorities*; and mechanisms for *evaluation*.

11. To implement an effective health-sector strategy, governments will need to take the following action, provided that it is complemented by the participation of civil society and the business and private sectors:

(a) to provide strong political leadership, within and outside the health sector. Within that sector, health ministries are the major force for leadership and mobilization, with a responsibility to advocate the inclusion of all health-sector stakeholders in national planning and decision-making. Leadership is needed outside the health sector, too. Many countries have broadened leadership and responsibility for responding to HIV/AIDS and have established HIV/AIDS commissions or similar bodies to help to shape and coordinate national efforts, often resulting in major benefits, including the resolve to confront cultural and societal barriers to HIV prevention and care, the commitment of resources, and nationwide action;

(b) to draw up a national HIV/AIDS strategic plan, including the health-sector response, in which all stakeholders fully participate, and which encourages innovation and carefully considers local factors, such as in-country diversity, potential barriers to access, and the availability of resources;

(c) to define and allocate roles and responsibilities in order to avoid uncertainty or conflict. Policy and technical advisory committees on HIV/AIDS – with their membership drawn from health professions, researchers, people living with HIV/AIDS, vulnerable communities, nongovernmental organizations and other areas – provide a forum for obtaining informed advice on the practical implications of policy choices and priorities;

(d) to promote comprehensive responses to HIV/AIDS, bringing in other sectors of government, including departments of finance, justice, education, planning, labour, agriculture, tourism, corrective services, defence and foreign affairs. Health ministries need to be able to assess the impact of policies in nonhealth sectors, including the business sector and donor agencies, on responses to HIV/AIDS;

(e) to mobilize nongovernmental bodies, as it is neither possible nor desirable for health ministries and other areas of government to attempt to provide all HIV/AIDS-related programmes and services;

(f) to optimize use of scarce human and financial resources by including in national strategic plans for HIV/AIDS mechanisms for accountability, monitoring and evaluation;

(g) to formulate a detailed plan for funding with, for many countries, innovative strategies to supplement governmental allocations for HIV/AIDS. Despite the call in the United Nations Declaration of Commitment on HIV/AIDS for substantially increased national and global funding, resources continue to fall far short of the amount needed. Examples of innovative financing include national poverty-reduction strategies; use of the proceeds of debt-relief to reduce the impact of HIV/AIDS, and preferential access to essential commodities through price or trade concessions; engagement of the business and private sectors; health-sector initiatives such as sector-wide approaches; and the Global Fund to Fight AIDS, Tuberculosis and Malaria;

(h) to improve management, accountability and transparency in health ministries and the health sector, and to consider ways to sustain responses to HIV/AIDS over the long term;

(i) given that the demands placed on any HIV/AIDS initiative in most settings are likely far to outstrip the available resources, to provide leadership and technical expertise in prioritizing, with the application of ethical principles and technical criteria, including:

- basing interventions on sound evidence of effectiveness
- applying lessons drawn from national and global experience
- using epidemiological and behavioural information to inform priority-setting
- taking into account the impact on access, vulnerability, equity, human rights and discrimination
- assuring participation of major stakeholders in each step of priority-setting

- fully justifying limitations on access to prevention, treatment and care
- ensuring openness and transparency in priority-setting.

REALIZING OUTCOMES

12. Three further determinants for the successful implementation of a health-sector strategy have been identified: human resources and capabilities; quality assurance; and research. To this end, health ministries and other parts of the health sector will need:

- to ensure a sufficient number of qualified and skilled health-sector personnel through training in not only technical skills in delivering prevention measures, health promotion, treatment and care but also advocacy, leadership, management and strategic planning, as well as fostering interpersonal skills and eliminating prejudice, with the aim of ensuring sensitive, compassionate attitudes towards clients;
- to set clear national quality standards for HIV-related programmes, services and commodities, with allowance for innovation (especially when accompanied by research and evaluation);
- at a minimum, to establish an epidemiological and behavioural surveillance system in order to inform planning and priority-setting. Operational, biomedical, clinical, epidemiological and social research provides invaluable information to help the health sector to respond to HIV/AIDS. Research also contributes to promoting quality standards in clinical care, prevention programmes and other interventions. Even in resource-limited settings, HIV research findings can lead to innovative, cost-effective approaches, and provide data on outcomes of local interventions. Cooperation between countries in research can inform programmatic and policy responses.

CONCLUSION

13. As the first step to putting this global health-sector strategy into practice health ministries, with the active participation of their partners, should examine health-sector planning for HIV/AIDS and consider adjusting it to reflect the principles, framework and interventions proposed. WHO is committed to matching the effort being asked of Member States. It will carefully examine its own capacity for supporting this strategy, and will strengthen that capacity where needed.

Appendix

CORE COMPONENTS OF A HEALTH-SECTOR RESPONSE TO HIV/AIDS

[A56/12 Appendix Rev.1 – 2 May 2003]

Prevention and health promotion

- Providing support for the development of broad-based programmes to educate the general population about HIV/AIDS

- Promoting safer and responsible sexual behaviour including, as appropriate, delaying the onset of sexual activity, practising abstinence, reducing the number of sexual partners, and using condoms
- Targeting interventions where they will yield the most benefit, for example where risk and vulnerability converge through behaviours, locations and group membership
- Promoting harm reduction among injecting drug users, such as wide access to sterile injecting equipment, and drug-dependence treatment and outreach services to help to reduce frequency of injecting drug use
- Providing widely accessible HIV testing and counselling
- Implementing programmes to prevent mother-to-child transmission of HIV

Treatment

- Increasing access to services to diagnose and manage sexually transmitted infections
- Strengthening services to diagnose and treat HIV/AIDS and related opportunistic and concurrent infections such as tuberculosis
- Increasing access to antiretroviral therapy and other advanced HIV-related treatments
- Providing a continuum of care from the home to the health facility, supported by a system of client referral (e.g. to nutritional support, psychosocial support and palliative care)

Health standards and health systems

- Ensuring the safety of blood and blood products
- Promoting universal precautions to reduce the risk of occupational HIV infection in health facilities, community settings and the home, and providing post-exposure prophylaxis to those accidentally exposed to HIV
- Setting and promoting national standards for the public, private and community-based delivery of HIV/AIDS prevention, health promotion, treatment and care
- Building capacity and strengthening health systems, as appropriate, including human resource levels and skills mix

Informed policy and strategy development

- Establishing or strengthening epidemiological and behavioural surveillance for HIV and sexually transmitted infections
- Elaborating plans to generate resources, and strengthening accountability and monitoring systems for both human and financial resources
- Countering discrimination against and stigmatization of vulnerable groups and people living with HIV/AIDS
- Reviewing policies, laws and regulations to ensure that they support programmes on HIV and other sexually transmitted infections
- Mobilizing communities, nongovernmental organizations, people living with HIV/AIDS, vulnerable groups, and the business sector