



Implementation of resolutions and decisions

Report by the Director-General

This document presents progress reports on the implementation of resolutions and decisions of the Executive Board and the Health Assembly. The Board is invited to note the reports and to consider the draft resolutions contained in section XIV.

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I. TASK FORCE ON HEALTH IN DEVELOPMENT

1. The following activities have been carried out in response to resolution WHA50.23.
2. With reference to operative paragraph 4(1), the deliberations of the task force were taken into account in early versions of the health-for-all policy document, particularly the version made available to the Executive Board in January 1997. The recommendations of the task force will provide input for the preparation of the Tenth General Programme of Work.
3. With reference to operative paragraph 4(2), the document "Health: the courage to care; a critical analysis of WHO's leadership role in international health by the Task Force on Health in Development", was made available during regional committee meetings in September and October 1997 as a first step in ensuring wide dissemination of the conclusions of the task force on strengthening WHO in the next century. Every WHO country office has also received copies and task force members are holding national seminars to discuss the ideas in the document with policy- and decision-makers, "partners" in health and development, and academic institutions.
4. The Director-General has advocated the development and use of the potential represented by health promotive and preventive diplomacy, and the task force has recommended that WHO take a strong leadership role in this domain. Follow-up is being undertaken by WHO in collaboration with many "partners" to explore different areas in which to achieve peace through health. This will help to provide fresh experience on using health as a bridge for peace; identify common denominators in conditions that precede conflict; and select health measures at all stages of conflict - before, during and in the entire period of reconstruction and reconciliation. Such measures may usefully form the basis of a plan of action for health as a bridge to peace.
5. A working group of experts in health and in peace initiatives has been established; the first meeting was held in October 1997 under the sponsorship of the Fondation Mérieux, a designated WHO collaborating centre for promotional activities.
6. With reference to operative paragraph 4(3), the ideas of the task force on health in development regarding equity, poverty, and human rights have been adopted by a number of WHO divisions and programmes.
7. As a follow-up to the task force recommendation that WHO should take rapid action to launch a sound programme for the protection of health rights, an informal consultation is being convened on health and human rights on 4 and 5 December 1997 with the involvement of WHO regions, the Office of the High Commissioner for Human Rights, representatives of United Nations human rights treaty bodies and experts in the area of human rights, international law and public health. The objective of the consultation was to agree on the major elements of a WHO programme on health and human rights for the period 1998-2000. This will enable WHO to develop the necessary expertise to take a leadership role in this area as recommended by the task force.

II. WHO COLLABORATING CENTRES

The report on implementation of resolution WHA50.2 will be submitted in an addendum to the present document.

III. IMPROVING TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

1. During the two decades since the Alma-Ata Conference on Primary Health Care and the Buenos Aires Conference on Technical Cooperation among Developing Countries (TCDC), WHO has gained considerable experience in promoting and implementing TCDC in many countries. The combination of WHO's health-for-all goal and the primary health care strategy has had profound implications in these countries, in terms of equity, sustainability and self-reliance. WHO has accordingly recognized TCDC as a natural approach to achieving health for all.
2. In preparation for the twenty-first century, WHO has embarked on an active process with countries for the renewal of their health-for-all policies and strategies. Major challenges to be confronted are the widespread inequities in health status and access to health services and the immense disparities between rich and poor in many countries, including some least developed countries, as well as between countries. Solving these problems will call for increased sharing of experience between countries; TCDC will therefore be an important component of health-for-all renewal.
3. Because of the decentralized structure of WHO, there is a strong regional basis for technical cooperation. For example, in Africa and Asia, joint TCDC initiatives involving many countries in areas such as maternal and child health, essential drugs and reproductive health have given encouraging results. The rapid growth of telecommunications has led to the development of networks linking WHO collaborating centres, national institutions and universities, nongovernmental organizations and professional associations. Networks, predominantly for the South, have been established on subjects such as health economics and financing, schistosomiasis control, and health information (especially in relation to ill-health and poverty), and continue to be used for the exchange of information and experience between countries and institutions. The North's participation has played an important role in these networks. In fact, two of WHO's regions (the Americas and the Western Pacific) officially perceive the concept of technical cooperation among countries as a whole in the spirit of TCDC, since horizontal cooperation should not exclude the participation of any country. Geographically, WHO's support to TCDC is delivered by the six regional offices. The following paragraphs highlight some aspects of its support.
4. In the African Region, there is intercountry collaboration in the area of essential drugs. The regular exchange of expertise between countries in health-sector reform is planned within the framework of the United Nations Special Initiative on Continental Africa.
5. In the Region of the Americas, trade integration and economic restructuring within subregional agreements (the North American Free Trade Agreement (NAFTA), MERCOSUR, and the Central American, Andean and Caribbean common markets), together with healthy border initiatives, are promoting horizontal bilateral/multilateral health cooperation. A successful example is the Chagas disease elimination programme in the Southern Cone subregion.
6. In the South-East Asia Region, cross-border activities have been strengthened by ministerial meetings and visits to promote collaboration, especially for the control of diseases such as poliomyelitis, schistosomiasis, malaria and kala-azar, and for the training of health staff. A comprehensive regional review of the successes and failures in the promotion of TCDC concluded that there should be a more strategic approach, closely linked to sectoral planning and overall health development. This will replace the previous piecemeal approach with a coherent strategy for development planning and health sector reform.
7. In the European Region, broad strategic areas such as poverty alleviation and health sector reform as a component of overall development are being promoted and implemented with a TCDC approach.

8. The Eastern Mediterranean Region supports “horizontal” technical health activities of subregional geopolitical groups such as the Islamic Conference and the League of Arab States. Such activities facilitate exchanges between countries based on spiritual and cultural similarities.

9. The Western Pacific Region treats TCDC as a collaboration strategy fully integrated in all programme areas, with emphasis on human resources development, and boosting capacity-building and national self-reliance.

10. An important new joint initiative with the Non-Aligned Movement is being supported by WHO in health sector reform, emphasizing reduction in health inequities as the principal goal. Following two ministerial meetings of the Movement and a technical consultation on health, the creation of a TCDC network of institutions in the countries concerned was recommended by the Health Assembly in 1997 (resolution WHA50.27). The network will aim to ensure a permanent TCDC mechanism for operational research and the exchange of knowledge and experience between those and other developing countries. The Movement recognizes that many reforms have been spearheaded by multilateral and bilateral institutions giving greater emphasis to economic structural adjustment than to the serious equity challenges faced by the health sector. This is the context for the establishment of the network, with the support of WHO and UNDP. It is being implemented by the Ministry of Health of Colombia, currently chairing the Non-Aligned Movement.

11. WHO will hold a special meeting early in 1998 with representatives of the Non-Aligned Movement to refine the plans for the network and to reconsider TCDC as a “key strategy” to strengthen health-for-all implementation. The recommendations of the meeting will be submitted for discussion at the Fifty-first World Health Assembly in May 1998. The initiative coincides with discussions being held in the United Nations and UNDP on the need to develop a more strategic approach to TCDC, capable of tackling broad issues involving a larger number of countries.

IV. PREVENTION OF VIOLENCE

1. The Forty-ninth World Health Assembly, in resolution WHA49.25, declared the prevention of violence a public health priority and requested the Director-General to prepare a plan of action describing the role and contribution of WHO in violence prevention, for consideration by the Executive Board at its ninety-ninth session. After the Board's review the Fiftieth World Health Assembly endorsed the plan in resolution WHA50.19. To respond effectively to resolutions WHA49.25 and WHA50.19, two types of action were taken immediately following the Fiftieth World Health Assembly:

(1) WHO's capacity to initiate and coordinate violence-related activities was strengthened by expansion of the mandate and professional staff of the unit for Safety Promotion and Injury Control, which will be mainly responsible for coordinating (with other technical programmes) the implementation of the plan of action while continuing to cover activities related to unintentional injuries, with a focus on traffic injuries (owing to the increasing burden of this type of trauma on health, particularly in developing countries); it will also provide regional offices with appropriate support as required - the task force on violence and health, established by the Director-General in June 1996, will assist in monitoring and evaluating the development of the plan of action, ensuring a harmonized and coordinated response to requests for technical cooperation as well as effective coordination with other agencies concerned and potential donors;

(2) an institutional network was established to support implementation of the plan of action; following its endorsement by the Health Assembly, the plan of action was sent to WHO collaborating centres with a request for an analysis of their potential technical contribution; a final plan of cooperation was agreed upon at the Eighth Meeting of Heads of Collaborating Centres on Injury Prevention and Control (Johannesburg, 20 and 21 October 1997) - the task force will assist in coordinating contributions from collaborating centres and the technical programmes concerned.

2. In response to paragraph 3.1 of resolution WHA50.19, preliminary agreements have been established with four collaborating centres to assist in the implementation of the plan concerning "Objective 1: to describe the problem through surveillance", "Objective 3: identification and evaluation of interventions", and "Objective 4: programme implementation and dissemination". The centres will provide technical guidance and contribute to a workshop for programme implementation and national capacity-building. The National Center for Injury Prevention and Control of the United States Centers for Disease Prevention and Control (CDC) and the Consumer Safety Institute in the Netherlands have agreed to play a major role in fulfilling Objective 1 by strengthening the capacity of countries in injury surveillance with a focus on intentional violence and by producing an international classification of external causes as a supplement to the International Statistical Classification of Diseases and Related Health Problems (ICD-10). The plan of action is already being implemented in Africa (Ethiopia, Kenya, Uganda, Zambia, Zimbabwe) and in the Eastern Mediterranean Region (Egypt); a national institute on injury prevention and control is to be established in Uganda with WHO support and with the aim of contributing to the implementation of the plan of action.

3. The Department of Social Medicine (Karolinska Institute, Stockholm), WHO Collaborating Centre on Community Safety Promotion, and the Centre de Santé publique de Québec, WHO Collaborating Centre for the Promotion of Safety and Injury Prevention, have agreed to assist in community-based interventions for violence prevention and to develop methodology for programme evaluation for Objectives 3 and 4 of the plan of action. Close liaison will be maintained for programme implementation with two collaborating centres on violence prevention, the Health Psychology Unit and Centre for Peace Action, University of South Africa, Johannesburg, and the Centro de Investigaciones de Salud y Violencia, Universidad del Valle, San Fernando, Colombia. On the occasion of the Sixth International Conference on Safe Communities, sponsored by WHO (Johannesburg, 15-19 October 1997), a work plan on community-based interventions for violence prevention and mitigation has been initiated with a view to mobilizing WHO's "Safe Communities" network.

4. Considering the crucial role schools play in violence prevention it has been decided jointly with the Division of Health Promotion, Education and Communication to produce a document on this topic in the context of “health-promoting schools” to guide people, both in schools and in the community, in the planning of violence prevention.
5. In September 1997, in response to resolution WHA49.25, the National Observatory of Human Rights in Algeria convened an international colloquium on contemporary forms of violence and the “culture of peace”, sponsored by the Ministry of Health and Population, UNESCO and WHO.
6. To meet Objective 4 of the plan and to disseminate information including new findings from research as a basis for policy and action, experimental steps have been taken to create a “home page” on the WHO website. Proactive teamwork of experts in developed and developing countries will enhance these efforts and technical cooperation will be strengthened.
7. WHO has paid particular attention to the physical and psychological recovery and social reintegration of children and women affected by armed conflict, and has contributed to the United Nations study on the impact of armed conflict on children; in Mozambique it has facilitated interagency coordination on the implementation of the related resolution A/51/77 adopted by the United Nations General Assembly.
8. Violence against women is being considered first in the context of families, rape and sexual assault; in Rwanda and Burundi the needs of women and girls in situations of armed conflict, or during the post-conflict phase, are being assessed and the capacity of health services to meet such needs is being strengthened. A multicountry study on prevalence, risk and protective factors in families will be carried out initially in six to eight countries to obtain estimates of prevalence and incidence of such violence against women; to show the health consequences to determine and compare risk and protective factors in different settings and strategies used by women to cope with violence from family members. WHO also seeks to strengthen local research capacity, to develop and test new instruments for measuring violence and its consequences, including mental and emotional trauma, and to promote research so as to meet the needs of women and involve women’s organizations.
9. An information package on violence against women has been produced.¹ It summarizes recent information on prevalence of various forms of violence against women, certain human rights documents, and action by several bodies collaborating with WHO. With the regional offices, it is being translated into Spanish and French.
10. WHO worked with the International Federation of Gynecology and Obstetrics (FIGO) on several contributions to the XVth FIGO World Congress of Gynecology and Obstetrics: a pre-Congress workshop on “The elimination of violence against women: in search of solutions” (report under preparation); a panel on such violence; and a resolution on the subject, that was adopted by the FIGO General Assembly. A one-day meeting was held with participants at the FIGO pre-Congress workshop to start to review experiences of measures in the health sector against violence against women, with particular attention to their appropriateness and sustainability with limited resources. WHO will follow up its recommendations to develop guidance for policy-makers wishing to start such work, and training materials on care for women who are abused, for use by health workers at various levels.
11. As concern has grown and many more researchers have become interested, a manual on methodology for studying violence against women is being prepared and tested in collaboration with the health and development policy project and the International Network of Researchers on Violence against Women for practical and ethical guidance.
12. A global bibliographical and statistical database has been set up to collect in the first instance information on violence against women in families, rape and sexual assault. The focus is on prevalence and health consequences and it includes unpublished data. More than 600 entries from all regions have already been

¹ Document WHO/FRH/WHD/97.8.

compiled and more than 100 requests for information have been received. The information is being used to support advocacy, research and policy development within and outside WHO. WHO will make the information more widely available through collaboration with the appropriate programme in the United Nations Statistical Division, and eventually through the Internet.

13. Measures for prevention of violence against women and related care and the development and testing of such measures in the health sector are the subject of efforts to mobilize funds for support, since there is little or no reporting on the limited measures being attempted in different parts of the world. The most innovative groups often have the least time, funds or technical expertise to report on their work and benefit others in this field.

V. HEALTH SYSTEMS DEVELOPMENT

BACKGROUND

1. The ninety-eighth session of the Executive Board, concerned at the increasing emphasis being placed on “vertical” disease-oriented programmes, appointed an ad hoc working group on health systems development, which submitted its report to the Board at its 100th session. The Board, after considering the report, adopted resolution EB100.R1 which, *inter alia*, requested the Director-General “to launch a major initiative for research, advocacy, capacity-building and country support for health systems development and ... to submit a plan of action for the initiative to the 101st session of the Board”. Prior to the adoption of this resolution, the Fiftieth World Health Assembly adopted resolution WHA50.27 on strengthening health systems development in developing countries at the proposal of the countries of the Non-aligned Movement, and requested the Director-General “to report on the progress achieved to the Fifty-first World Health Assembly”. This report outlines a plan of action as called for in resolution EB100.R1; the preliminary progress report on resolution WHA50.27 will be updated before being presented to the Health Assembly.

2. The ad hoc working group of the Executive Board concluded that WHO’s support for health systems development was not sufficiently strong and many other entities (like the World Bank and UNICEF) have taken initiatives in the area. However, experiences in health care reform throughout the world show that the need for critical and constructive appraisal of the functioning of health systems is greater than ever.

INITIATIVE ON HEALTH SYSTEMS DEVELOPMENT (RESOLUTION EB100.R1)

3. The objective of the initiative is to increase the attention and priority given to health systems as part of health and human development efforts in countries and in the international arena, and to develop related policies and strategies based on evidence from health sector reform in countries. The initiative should clearly define the roles, functions and levels of the different components of health systems development and increase the capacities where needed. It will put special emphasis on least developed countries and the countries which are lagging behind the targets of health for all, and will give priority to the needs of vulnerable and marginalized groups within countries. It will create links with national institutions to promote and implement cooperative activities. It will establish regional and global reference centres as repositories of information on health systems development to be tapped by all interested countries. It will create and strengthen partnerships with other bilateral and multilateral agencies on the basis of a well established and accepted policy. Finally, it will set in motion mechanisms within the Organization to bring together different elements of health systems development and different technical programmes in order to provide integrated and coherent Organization-wide support to countries and establish a “think-tank” to monitor and assess the policies. Full implementation of the initiative will depend on regular and extrabudgetary funds being available to the programme.

EXTERNAL ADVISORY GROUP

4. The Director-General has established an external advisory group in accordance with resolution EB100.R1. The group, with eight members, met in November 1997 and examined the plan of action for the global initiative. The initiative will be kept under constant review by the governing bodies as well as the advisory group. Periodic progress reports will be submitted to the Executive Board.

PROPOSED PLAN OF ACTION

5. The plan has the following elements:

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|---|----------------|
| (1) prepare a draft outline of the global initiative | November 1997 |
| (2) send draft to selected individuals and past and present members of the Board for comments | December 1997 |
| (3) obtain comments of the Board at its 101st session | January 1998 |
| (4) revise outline in view of comments | February 1998 |
| (5) prepare detailed proposals, including those for funding, and form a network of institutions involved in health system development | March 1998 |
| (6) launch the initiative (see paragraph 3 above) | May 1998 |
| (7) submit the detailed workplan to the external advisory group | September 1998 |
| (8) hold a meeting of potential donors | November 1998 |
| (9) report on progress to the Executive Board at its 103rd session | January 1999 |

PROGRESS IN IMPLEMENTING RESOLUTION WHA50.27

6. The Director-General is strengthening the analytical capacity of the Organization in order to benefit from experiences in health sector reform in countries. However, the major constraint affecting resources remains. At the same time, the Organization is collaborating with the Non-aligned Movement to establish a network of institutions in developing countries to systematize, report and disseminate information on approaches to health sector reform. The network will start with an institution in each of about 10 countries, and will gradually expand to cover a substantial number of developing countries. The first meeting of the network is expected to take place in February 1998, when it will decide on its plan of action. UNDP is closely involved in this effort. Other agencies like the World Bank are also taking steps to intensify their cooperation with the Organization. At the same time, health systems development has been made a key element in the renewal of health-for-all strategy to be presented to the forthcoming Health Assembly.

VI. FELLOWSHIPS PROGRAMME AND POLICY

INTRODUCTION

1. The present review complements and amplifies the statements made in the Director-General's report to the ninety-ninth session of the Executive Board (document EB99/19, pp. 8-10) and is based on the resulting discussion in the Executive Board in January 1997.¹ It represents a thorough analysis of the fellowship programme for the period 1990-1996, i.e., three full bienniums and the first year of the current biennium (1996-1997).

2. A statistical presentation of "key programme features" is given in document EB101/INF.DOC./2. The present text describes the mechanisms for management control, policy planning and evaluation.

MANAGEMENT CONTROL

Selection process

3. When WHO is involved in the selection of fellows, it may contribute to related policies, establish priorities and actually cast votes for candidates. Many countries have established a special selection committee for fellowships, whose membership sometimes includes representatives from other sectors (e.g., in the Region of the Americas). In the South-East Asia Region all countries have national selection committees. In other regions the percentage of countries with such committees ranges from over 90% in Africa to about 8% in Europe. In some instances explicit selection criteria are followed, derived from human resources development plans. Within the regional offices, further screening of fellowship applications is undertaken at three levels: by the Fellowship Officer (administrative appraisal), the Regional Adviser (technical appraisal), and the Director (approval on behalf of the Regional Director). Only in exceptional cases are applications referred to the Regional Director for special approval.

4. The rate of rejection of applications at regional office level varies. In the Eastern Mediterranean Region it has ranged from 10.5% (1996) to 34.7% (1990). Among the common causes for rejections are incompatibility of the study programme with the agreed plan of action, unavailability of funds, inadequate qualification (including linguistic capability) of or age limit exceeded by the candidate.

Monitoring of the implementation and utilization of fellowships

5. WHO systematically monitors performance in the implementation and utilization of fellowships through a reporting system. This includes questionnaires sent to fellows and training institutions during the study period and a questionnaire distributed 12 months after completion of studies to fellows and their national health administration on the utilization of the fellows' services in their countries. The rate of return of the final reports on fellowships ranges from 20% to 50% in most regions (often only after several reminders).

6. In the Region of the Americas some 75% of fellows complete a final report. The utilization reports are received in 10%-20% of cases only. With regard to fellows not returning to their home country, all regions have indicated that these are exceptions. In the European and Eastern Mediterranean Regions there have been no such cases for seven and three years respectively. In the Region of the Americas the return rate is well over 90%. A recent study made in China has revealed a comparatively modest return rate of 75%, but cost recovery from fellows not returning has been mostly successful. In the South-East Asia Region it is felt that post-fellowship evaluation would generally improve if the roles of government authorities and WHO Representatives were

¹ See document EB99/1997/REC/2, pp. 165 and 166.

strengthened. It should be noted that compliance with WHO's reporting rules varies from country to country and region to region as well as over time, so that any indication of averages must be considered with caution. Introduction of the "evaluation tool" throughout the Organization is expected to yield more quantitative data for this aspect of fellowships management.

Assessment of training programmes

7. This is of direct importance for decisions on placement of fellows. WHO adopts a number of complementary approaches: the advice of technical units as well as WHO representatives is regularly sought and data on the quality of training institutions and programmes are kept for internal use in fellowship administration, together with the views of fellows collected from their final reports as well as through special surveys (Western Pacific Region), an essential criterion for programme evaluation being the programmes' relevance to health-for-all strategies and national health priorities in a given region; the cost of training has also become an important consideration.

8. But assessment is only the first step in a larger process, whose ultimate aim is to enhance the relevance and quality of educational activities and institutions. The efforts to reorient medical education are one prominent example of this approach shared by the regional offices and headquarters.

POLICY PLANNING AND EVALUATION

Matching fellowships with national plans and WHO objectives

9. Clear priorities for national health sector development and, in particular, human resource development plans are one of the prerequisites for sound decision-making on fellowships. While in several regions such formal plans are not yet readily available,¹ there are usually other mechanisms for setting priorities for the study of health and health-related sciences. WHO uses a variety of approaches to stimulate such mechanisms. In the African Region countries have been urged to develop human resources development plans for 1998-1999, including fellowships. In the Region of the Americas the country representatives interact regularly with the national authorities through the established annual programme budget process to determine human resources development priorities. In the South-East Asia Region a "Guide to human resources development policy analysis and formulation" was widely distributed in 1996 and the "Fourth regional consultation on fellowship policy and evaluation" was held in August 1996, attended by delegates from all Member States in the Region. New modalities for implementing fellowships were introduced by several countries. Indonesia instituted an in-country fellowship programme, coordinated by the National Board of Fellowships. Bangladesh and Nepal have changed their approaches in the planning and implementation of fellowships in an effort to match awards more closely with their national health priorities. The approach making greater use of regional and in-country training facilities was endorsed by the Regional Committee for South-East Asia in September 1997. In the European Region almost all Newly Independent States and other countries in Eastern Europe have national plans, but fellowships still need to be made an integral part of these plans in most instances. In the Eastern Mediterranean Region fellowships form an integral part of national plans of action negotiated during joint programme review missions. In the Western Pacific Region fellowships are related to the New horizons for health policy framework. In all regions, the internal screening process pays particular attention to the compatibility of fellowship applications with WHO objectives and the agreed plans of action.

¹ WHO's efforts at regional and headquarters level to support countries in such planning are expected to change this situation in due course.

Policy monitoring: implementation of the “evaluation tool” at country level

10. As requested by the Executive Board in January 1997 the tool has been introduced and questionnaires were despatched to Member States in mid-year, after translation from English into Arabic, French, Portuguese, Russian and Spanish. It is expected that its use will improve all aspects of the fellowship programme and stimulate a review of national planning for human resources development. In the Region of the Americas the evaluation results, including those items relating to the performance of WHO and training institutions, will be shared with countries and strategies devised for dealing with shortcomings. As the tool will be used for follow-up at regular intervals, the medium- to long-term outcomes are expected to include the development of national health plans that better reflect training priorities; the strengthening of national fellowship selection committees; and an appropriate advisory role for WHO.

VII. REVISED DRUG STRATEGY

1. Key elements of the revised drug strategy have been implemented in well over 120 countries. Continued efforts are needed to achieve the objectives of the strategy. The Division of Drug Management and Policies (DMP) develops, establishes and promotes international standards for safety, quality, efficacy of biological and pharmaceutical products, and disseminates drug regulatory information. The Action Programme on Essential Drugs (DAP) actively supports countries in implementing policies and programmes which achieve the objectives of the revised drug strategy. In 1997 a new operational plan for programme structure was introduced which emphasizes effectiveness of country programme development. The plan also highlights five areas for policy and technical development: national drug policies, health economics and drug financing, drug management and supply strategies, rational use, and regulation and quality assurance capacity. Collaboration with countries is facilitated by programmes and advisers for essential drugs and pharmaceuticals located in each of the six WHO regions. Elements of the revised drug strategy are also implemented through other WHO health promotion and disease control programmes.

2. More than 70 countries have **national drug policies** based on the essential drug concept within the context of national health policies. It is now widely accepted that national drug policies provide an essential link, meeting real health needs through pharmaceutical sector development. Creation of autonomous central medical stores and other innovative supply arrangements have improved drug availability in some Member States, particularly in Africa. Member States have received increased support for appropriate drug financing strategies. Rational use of drugs has received attention through review of curricula for basic training, continuous education and development of human resources.

3. WHO has worked with Member States to better **coordinate and harmonize their national strategies** in the drug field. To this end, the Organization sponsored in 1996 the International Conference of Drug Regulatory Authorities in Manama, Bahrain, and regional or subregional meetings for regulators, essential drugs managers, and policy-makers were held in each of the WHO regions. In addition, WHO prepared materials such as the WHO guidelines for developing national drug policies, a practical manual on indicators for monitoring such policies, related comparative studies, and publications on related aspects of health sector reform. Guidelines produced by the International Conference on Harmonization have been disseminated to WHO Member States.

4. WHO has actively promoted awareness and implementation of the **WHO Ethical Criteria for Medicinal Drug Promotion**. A "round table" of Member States and interested parties was convened to contribute to a WHO strategy for review and assessment of the effectiveness of the ethical criteria. The resulting WHO strategy draws attention to the continued existence of unethical drug promotion. It sets out strategies to make a greater impact through intersectoral and international collaboration, stronger regulation, self-regulatory codes, and measures to enable consumers and health professionals critically to assess drug promotion.

5. The **WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce**, further endorsed by resolution WHA50.3, continues to be promoted among drug regulatory authorities, public drug supply services and those of nongovernmental organizations, and the pharmaceutical industry. Some 140 Member States are at present signatories to the Scheme.

6. After worldwide consultation, **Guidelines for drug donations** were issued in 1996 as an interagency document endorsed by WHO, UNICEF, UNHCR, and five other international organizations. The guidelines have been widely distributed in English, French and Spanish. Australia, Italy, Norway, Zimbabwe, and other Member States now have national guidelines for drug donations based on the interagency guidelines.

7. Access depends greatly on reasonable **prices** for essential drugs and raw materials of good quality. WHO, in consultation with interested parties, has initiated a study on prices and sources of information on prices of essential drugs. The African Region has already initiated a pilot service for regional price exchange. WHO continues to ensure that price information is regularly made available on raw materials for essential drugs. It has

also completed reviews of pricing policies in the Americas and in Europe, and is preparing a global summary analysis.

8. **Drug regulation and quality assurance** are receiving increased attention through greater emphasis on effective drug regulation and through continued work on pharmaceutical norms. Regulatory networks, information exchange, computer-assisted drug registration, meetings for harmonization of measures, and other intercountry and/or country initiatives have been supported in each of the six WHO regions. In the 1996-1997 biennium alone, support for regulation and quality assurance was provided to about 40 Member States. Quality control specifications for substances and drug products in the WHO Model List of Essential Drugs continue to be developed and published in the International Pharmacopoeia (in English, French and Spanish) and “Basic tests for pharmaceuticals” are issued (in English, French, Spanish, Arabic and Chinese). The WHO Guidelines for Good Manufacturing Practices have been supplemented with recommendations for inspection of manufacturing locations, distribution channels and guidance for the establishment of a quality control laboratory. WHO continues to assign and publish listings of International Nonproprietary Names for newly developed pharmaceutical substances; it has a project for combating counterfeit drugs, and guidelines for combating counterfeit drugs are in their final stage of development. The number of countries participating in the international system for drug safety monitoring has increased to 47. Several developing countries, in particular in Latin America, South-East Asia, and the Eastern Mediterranean, have received assistance in establishing drug safety monitoring systems.

9. WHO continues to develop and disseminate **information on pharmaceutical products**. The ninth WHO Model List of Essential Drugs was published in 1997. Model Prescribing Information has been issued for HIV and associated infections and for drugs used in skin diseases. Work is in progress for the WHO Model Formulary for Essential Drugs. Quarterly WHO Drug Information and the monthly WHO Pharmaceuticals Newsletter provide current information on drug development, drug regulation, and drug regulatory decisions.

10. Collection of information from Member States on policies for development **of drugs for rare and tropical diseases** is continuing. A working group of all major WHO programmes concerned with new drugs has been determining strategies whereby WHO can promote development of and access to new drugs.

11. WHO has initiated work to identify issues in **WTO agreements** relevant to drug policies and access to essential drugs; to further collaboration with WTO; to compare WTO agreements and WHO technical requirements and guidelines for pharmaceutical and biological products; to assess the effect of “globalization” on national drug policy objectives; to advise Member States on measures to protect public health in the implementation of the new trade agreements; and to make countries aware of the significance of international trade agreements for public health.

VIII. CROSS-BORDER ADVERTISING, PROMOTION, AND SALE OF MEDICAL PRODUCTS THROUGH THE INTERNET

1. An ad hoc working group was convened by the Director-General in Geneva from 3 to 5 September 1997,¹ in accordance with resolution WHA50.4.

2. The ad hoc working group reviewed the implications of resolution WHA50.4 and formulated the following recommendations:

(1) Member States should:

- review existing legislation, regulations, and guidelines to ensure that they are adequate and applicable to cover issues concerning cross-border advertising, promotion and sale of medical products using the Internet;
- develop, evaluate and implement strategies for monitoring, surveillance and enforcement activities regarding cross-border advertising, promotion and sale of medical products using the Internet. When appropriate, measures for enforcement should be taken and, except in exceptional circumstances, widely published;
- collaborate with other Member States on the issues raised by the Internet, and designate appropriate contact points, and disseminate this information also through WHO to all Member States;
- disseminate information on problem cases and aspects of cross-border advertising, promotion and sale of medical products using the Internet to WHO, other Member States, and the public, when appropriate;
- establish web-sites, where feasible, for dissemination of information about medical products, and regulatory information;
- maintain and/or establish mechanism(s) for responding to inquiries from the public;
- inform the public that the Internet is a powerful new medium for the provision of health information and educate health professionals and consumers on using the Internet; such education should include the ability to assess, to the extent possible, the benefits and risks of the products in order to prevent harm to people from false or misleading information about medical products;
- in the case of information, promotion and advertising of medical products on the Internet, Member States should encourage the development and implementation of a voluntary code of conduct applicable to all organizations posting information on the Internet; this includes, for example, identification of the information source and its status (e.g., advertisement, Data Sheet, Patient Information Leaflet), and operate within the context of a self-regulatory system, if necessary, backed up by legislation; adherence to the principles of the WHO Ethical Criteria for Medicinal Drug Promotion should be encouraged; and

¹ The members were Dr G. Thiers, Director, Louis Pasteur Institute of Public Health, Brussels, Belgium (Chairman), Dr Mariatou Tala Jallow, National Pharmaceutical Services, Banjul, Gambia (Vice-Chairman), Dr S. Nightingale, Associate Commissioner, United States Food and Drug Administration, Washington, D.C., USA (Rapporteur) and Dr J.E. Idänpään-Heikkilä, Director, Division of Drug Management and Policies, and Dr M. Ten Ham, Drug Safety, were co-secretaries.

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- collaborate with other Member States in order to establish appropriate measures to prevent cross-border advertising, promotion and sale of medical products using the Internet to countries in which it is illegal; where possible, an organized system of licensing of all entities engaged in the sale of medical products should be developed.

(2) The pharmaceutical industry, health professionals and consumer organizations and other interested parties should:

- educate their members to use the Internet effectively;
- encourage their members, where appropriate, to promote the formulation and use of good information practice guidelines; where applicable consistent with the principles embodied in WHO Ethical Criteria for Medicinal Drug Promotion; and
- monitor and report problem cases and aspects relating to the cross-border advertising, promotion and sale of medical products using the Internet.

(3) The Director-General should:

- encourage the international community to formulate self-regulatory guidelines for good informational practices, consistent with the principles of the WHO Ethical Criteria for Medicinal Drug Promotion;
- develop a model guide for Member States to educate people using the Internet on how best to obtain information on medical products through the Internet;
- collaborate with other relevant international organizations and institutions on Internet issues relating to medical products;
- urge Member States to set up or strengthen mechanisms to monitor and survey, where appropriate, cross-border advertising, promotion and sale of medical products using the Internet, and provide technical assistance as required;
- urge Member States to take regulatory action, where appropriate, for violations of their national laws regarding advertising, promotion and sale of medical products using the Internet;
- encourage Member States and concerned nongovernmental organizations to report to WHO problem cases and aspects of the cross-border advertising, promotion and sale of medical products using the Internet; and
- report problem cases and concerns, as appropriate, to the Member States.

3. The ad hoc working group further recommended that the Board should adopt the draft resolution in section XIV of the present document.

IX. ETHICAL, SCIENTIFIC AND SOCIAL IMPLICATIONS OF CLONING IN HUMAN HEALTH

1. Following the debate on cloning that took place during the Fiftieth World Health Assembly in May 1997 and in conformity with resolution WHA50.37, the Director-General has set up an internal group to strengthen the coordination of activities and exchange of information on all issues related to ethics and health, including “the ethical, scientific and social implications of cloning in the area of human health”. The Steering Group on Ethics and Health brings together members of WHO’s various technical programmes, and focal points have been designated in the six regional offices, at headquarters, and at the International Agency for Research on Cancer in Lyons.

2. During its debate on cloning in May 1997, the Health Assembly expressed the wish that the Director-General should set up a committee of experts at global level to deal with issues related to cloning. WHO planned meetings in different programme areas to take place before the end of 1997 in order to prepare the work of such a global committee. The purpose of these meetings is to specify the areas of human health concerned, and the ethical and social issues involved in each of these areas. Particular attention is being given to ensuring the participation of experts from various disciplines and cultural settings, as well as national research institutes and international organizations concerned. Steps are being taken to ensure that WHO’s regions have the opportunity to participate fully in the global committee of experts and in the preparatory process.

3. A report on the outcome of the following activities will be provided during the 101st session of the Board (document EB101/INF.DOC./3):

(1) **Reproductive health.** The Special Programme of Research, Development and Research Training in Human Reproduction held a meeting of its Scientific and Ethical Review Group from 22 to 24 October 1997 in Geneva, the last day being an extraordinary session entirely devoted to cloning, with the support of the Director-General’s Development Fund. There was strong participation of developing countries and major attention was given to ensuring cultural and religious diversity. The purpose was to review and analyse worldwide reactions and attitudes to the potential use of cloning in reproductive health, and to clarify areas of consensus on the ethical and public policy issues involved, as well as to consider whether international guidelines, regulation or legislation are needed.

(2) **Xenotransplantation.** Another meeting was organized by the Division of Emerging and Other Communicable Diseases with the support of the Director-General’s Development Fund. It was held in Geneva from 28 to 30 October 1997, and focused on the current status of research and technology development in the area of xenotransplantation, with particular regard to infectious disease prevention and related ethical concerns. The meeting reviewed issues such as the development and management of “source animals” and the use and implications of genetic engineering procedures including cloning, societal and recipient attitudes, human rights, public policy framework and regulatory requirements. The meeting followed the second session of the task force on organ transplantation (Annecy, France, 9-10 October 1997) held at the initiative of the Office of Research Policy and Strategy Coordination, with the support of the WHO Mérieux Collaborating Centre. At its first session, in October 1996, the task force had recommended further research on and monitoring of xenotransplantation, which was also part of the agenda of its second session.

(3) **Biologicals.** The WHO Expert Committee on Biological Standardization met in Geneva from 27 to 31 October 1997 to consider, *inter alia*, the use of transgenic mice for the quality control of oral polio-vaccine.

(4) **Genetic and hereditary disorders.** WHO is convening a meeting to review its guidelines on ethical issues in medical genetics in Geneva from 15 to 16 December 1997, with support from the Director-General’s Development Fund. It is also cosponsoring an international symposium on current trends in

medical genetics and bioethics in different cultural, legal and institutional settings, in Fukui, Japan, on 8 November 1997, in association with and following the UNESCO Asian Bioethics Conference (Kobe, Japan, 4-8 November 1997).

(5) **Research and regional participation in the ethical debate.** The session of the global ACHR was held in Geneva from 21 to 24 October 1997. In accordance with the Director-General's report to the Health Assembly,¹ the ACHR considered ways in which it could help to gather and circulate information and foster a public debate on the ethical, scientific and social implications of cloning, particularly at regional and subregional levels.

4. The Director-General has requested the regional offices to participate in the collection of information on initiatives taken by Member States to assess potential uses and implications of cloning. The information received to date includes position papers from national ethics committees, international agencies and religious bodies. The responses forwarded by PAHO and the Regional Offices for South-East Asia and the Eastern Mediterranean emphasize the need to proceed carefully and rationally in assessing the potential benefits of cloning for medical purposes. They stress the importance of cultural, religious and social values and the potential implications for civil law. All three offices stress the need to develop ethics committees and promote education on ethics in countries. Concern has also been expressed about the need to protect developing countries from the risk of unregulated expatriate research involving human subjects.

¹ Document WHA50/30, paragraphs 7 and 17.

X. HEALTH PROMOTION

1. The Fourth International Conference on Health Promotion, Jakarta, Indonesia, 21-25 July 1997, on the theme “New players for a new era - leading health promotion into the twenty-first century”, was the first to be held in a developing country, and more than half of the participants came from developing countries. It followed the First International Conference on Health Promotion held in Ottawa (1986), which produced the Ottawa Charter on Health Promotion providing guidance nationally and internationally. The Second and Third International Conferences on Health Promotion, held in Australia (Adelaide, 1988) and Sweden (Sundsvall, 1991) resulted in the adoption of the Adelaide Recommendations on Healthy Public Policy and the Sundsvall Statement on Supportive Environments. The Fourth International Conference has taken place 20 years after WHO commitment to health for all and the principles of primary health care at Alma-Ata. It has contributed to the follow-up of resolution WHA42.44 on health promotion, public information and education for health, which recognized that “the spirit of Alma-Ata was carried forward in the Ottawa Charter for Health Promotion ...” and that “education concerning prevailing health problems and the methods of preventing and controlling them” is the first of the eight basic elements of primary health care.
2. The Conference was held against the background of the major global changes since the Ottawa Conference in 1986. It had three objectives:
 - to review and evaluate the impact of health promotion;
 - to determine innovative strategies to achieve success in health promotion;
 - to facilitate the development of “partnerships” in health promotion to meet the global health challenges.
3. The Conference, formerly opened by the President of Indonesia, not only endorsed the Ottawa Charter for Health Promotion but also confirmed the relevance of health promotion for both developing and developed countries, placing it firmly “at the centre of health development”.
4. The Jakarta Declaration on “Leading Health Promotion into the Twenty-first Century” confirms the findings of the review and evaluation of the effectiveness of health promotion. It states that health promotion is a practical approach to achieving greater equity in health. The five strategies set out in the Ottawa Charter are essential for success. There is now clear evidence that comprehensive approaches to health development are the most effective and that particular settings offer practical opportunities for the implementation of such comprehensive strategies.
5. The Declaration reflects the firm commitment of the conference participants to build partnership, and describes the wide range of resources needed to tackle global health problems in the twenty-first century. It stresses the need for more partnerships with universities, the private sector and entertainment industries to increase health promotion. It calls for increased investments in health, “empowerment” of individuals and the public, increased social responsibility for health and consolidation of infrastructure for health promotion.
6. The Declaration calls on WHO to take the lead in building a global health promotion alliance and enabling its Member States to apply the findings of the Conference, engaging governments, organizations of the United Nations system, interregional bodies, development banks, bilateral agencies, nongovernmental organizations, the labour movement and cooperatives, as well as the private sector, in advancing the priorities for action in health promotion.
7. In addition to the Jakarta Declaration, the symposia on partnerships in action held during the Conference produced statements on school health, ageing and health, “healthy cities” and “healthy workplaces”. A statement was also read at the final plenary session on behalf of participants from private-sector companies and groups stating their commitment to work with WHO. The Jakarta Declaration was unanimously adopted by acclamation;

the Conference has provided global direction and impetus for follow-up to “lead health promotion into the twenty-first century”.

XI. INFANT AND YOUNG CHILD NUTRITION

1. This report is presented in accordance with resolution WHA33.32, Article 11, paragraph 7, of the International Code of Marketing of Breast-milk Substitutes, and resolutions EB97.R13 and WHA49.15 concerning reporting on infant and young child nutrition, appropriate feeding practices and related issues.

PROTEIN-ENERGY MALNUTRITION

2. Notwithstanding the end-of-decade goal of reducing protein-energy malnutrition (PEM) among under-five children by half of 1990 levels, the worldwide prevalence of PEM has fallen only from 28.5% (177.6 million) in 1990 to 27.4% (167.9 million) in 1995, while in some African countries it has actually increased. Maternal malnutrition remains a major factor for the estimated 30 million (23.8%) malnourished babies born each year with intrauterine growth retardation (IUGR).¹ Poverty-linked factors predominate in causing PEM, e.g., poor or unreliable food supplies, infection and infestation, lack of health care, inappropriate feeding practices and care, illiteracy, and nutritional emergencies.

3. Intensified technical and financial support to Member States, particularly those with high malnutrition rates, as well as production and wide dissemination of scientifically sound guidelines, norms, criteria and methodology for nutrition constitute WHO's two main approaches. Thus far 132 (69%) Member States have strengthened their national nutrition plans and programmes as a direct response to the decade goals and guiding strategies established under the World Declaration and Plan of Action² and have reaffirmed the commitments they made to it.

4. Given the importance of growth monitoring for infants and young children, and of assessing malnutrition at community and national levels, WHO is also undertaking a four-year growth reference study involving several centres to establish new, internationally representative growth reference curves that are based on healthy breast-fed infants and young children. The currently used United States National Center for Health Statistics/WHO growth curves, which reflect predominantly artificially fed middle-class Caucasian infants in the 1960s, are sufficiently flawed to warrant their urgent replacement. Many countries are seeking participation in the study, and funds are being sought for developing-country participation. Data collection has already begun in Brazil.

CHILDHOOD OBESITY

5. While millions remain undernourished, there is a growing epidemic of obesity in children and adults, especially in industrialized countries, but also in developing countries with fast-growing economies. An estimated 22 million children under five years of age are significantly overweight (>2 standard deviation above reference median weight for height). Obesity in children is a major risk factor for obesity in adults, which in turn affects an estimated 286 million people. It is a significant risk factor in the huge burden of morbidity and mortality, owing to cardiovascular disease, hypertension, stroke, diabetes (type 2), some cancers, liver disease, gall-bladder disease, and accidents. WHO organized a major consultation on obesity³ and, in view of the magnitude of the problem, both regular global reporting and effective national public health nutrition strategies are urgently needed.

¹ de Onis M, Blössner M, Villar J. Levels and patterns of intrauterine growth retardation in developing countries. *European Journal of Clinical Nutrition*, November 1997. In this context, IUGR is defined as weight below the 10th percentile of birth-weight-for-gestational-age reference curve).

² See *Joint FAO/WHO Progress Report on the Implementation of the ICN World Declaration and Plan of Action for Nutrition*. Food and Agriculture Organization, Rome, World Health Organization, Geneva, 1996.

³ *Obesity: preventing and managing the global epidemic*. Report of the WHO Consultation on Obesity, Geneva, 3-5 June 1997 (unpublished document WHO/NUT/NCD/97.2).

MICRONUTRIENT MALNUTRITION

6. Many countries have made significant progress in establishing salt iodization programmes and in reducing **iodine deficiency disorders** (IDD), although lack of iodine remains the greatest single global cause of preventable brain damage to fetus, infant and young child. Over 911 million people (all ages) are still estimated to have goitre. Nevertheless, of the 118 countries with IDD as a public health problem in 1990, 83 now have salt iodization programmes well under way. A comprehensive progress report on this subject will be presented to the Health Assembly in 1999.

7. **Vitamin A deficiency**, though decreasing, still affects some 256 million children, with 2.8 million children exhibiting eye damage (xerophthalmia), and the remainder at increased risk of infection and death. Similarly, **iron deficiency and anaemia** affect some 340 million children, and an estimated 58% of pregnant women and 31% of children under five in developing countries are anaemic. WHO, UNICEF, FAO, USAID, CIDA and other international and bilateral development agencies are supporting micronutrient activities in many of the 76 countries where vitamin A deficiency remains a public health problem. Most efforts are aimed at developing effective national and community programmes based on breast-feeding promotion, control of infections, dietary diversification and food fortification and supplementation.¹

BREAST-FEEDING PROMOTION

8. Longstanding disregard in some environments of the right to breast-feed combines with commercial influences, whether in the marketplace or in health systems and among health professionals, to discourage breast-feeding. Only 35% of infants in the world are exclusively breast-fed at some point between birth and four months of age, according to WHO's Global Data Bank on Breast-feeding, which covers 94 countries and 65% of the world's infant population. Although breast-feeding prevalence has increased in a few countries, in others faulty feeding practices remain widespread, with breast-feeding declining and complementary foods, often contaminated, introduced too early (in developed and developing countries) or too late (in developing countries). The result is high rates of malnutrition, morbidity and mortality.

9. Monitoring progress towards the four operational targets of the Innocenti Declaration² indicates that 122 Member States have now established breast-feeding committees (though not all are seen to be authoritative or multisectoral); 118 Member States have maternity leave of at least 12 weeks for at least some mothers; and the Baby-friendly Hospital Initiative, launched in 1992, is now operating in 171 countries, the number of hospitals designated "baby-friendly" according to WHO/UNICEF criteria having risen from about 4300 in 1995 to 8000 in 1996 and nearly 11 000 by the end of 1997.

PROGRESS IN IMPLEMENTING THE INTERNATIONAL CODE

10. Since the adoption of the International Code of Marketing of Breast-milk Substitutes (1981), 158 Member States (i.e. 83%) have reported to WHO on steps they have taken to give effect to the Code. Since the last report by the Director-General (1996), WHO has received new information from 30 Member States on predominantly legislative action to give effect to all or part of the Code. Of these, seven (in italics) are reporting for the first

¹ See in this connection *Vitamin A supplements: a guide to their use in the treatment and prevention of vitamin A deficiency and xerophthalmia*. Second edition. Geneva, World Health Organization, 1997; *Safe vitamin A dosage during pregnancy and lactation*. Unpublished document NUT/96.14; and *Iron deficiency: indicators for assessment and strategies for prevention* (in press).

² The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (1990) has four operational targets for all countries: an authoritative national breast-feeding coordinator and multisectoral committee; all maternity facilities "baby-friendly"; action to give effect to the principles and aim of the International Code; and legislation to protect breast-feeding rights of working women.

time: **Africa:** Botswana, Madagascar, *Mauritania*, Mozambique, *Namibia*, *Seychelles*, Togo, and Zimbabwe; **the Americas:** Belize, Honduras, Nicaragua, and Trinidad and Tobago; **South-East Asia:** Bangladesh and India; **Europe:** Austria, Poland, and Sweden; **Eastern Mediterranean:** Cyprus, Djibouti, Iran (Islamic Republic of), and Saudi Arabia; **Western Pacific:** Australia, *Cambodia*, China, *Marshall Islands*, New Zealand, *Niue*, *Palau*, Singapore, and Tonga.

11. Government bodies are taking a more active role in implementing and monitoring national action to give effect to the International Code. Moreover, they are investigating the allegations of non-compliance with this action by manufacturers and distributors of products within the scope of the Code that have been brought to their attention, in accordance with Articles 11.2 and 11.4 of the Code, by nongovernmental organizations and others. WHO has produced a framework¹ to facilitate Member States' review and evaluation of their action to give effect to the International Code.

NUTRITION IN EMERGENCIES

12. Every year for the last quarter century, at least 150 million people have been affected by some sort of emergency, and this currently includes an estimated 26 million refugees and displaced persons. High malnutrition rates, e.g., for PEM, vitamin A and iron deficiencies, and at times beriberi, scurvy and pellagra, occur in these populations, contributing to high death rates and disability. WHO has continued its active technical collaboration with UNHCR and WFP to assess, reduce and prevent malnutrition. A review version of guiding principles² to ensure optimal feeding of infants and young children during emergencies has been completed, and manuals on the management of nutrition in major emergencies³ and on treatment and management of severe malnutrition⁴ are both about to be published. Reviews of the management of scurvy, beriberi and pellagra are also in preparation. Following an intercountry workshop on managing nutrition in emergency situations held in Eritrea in 1996, a joint WHO/UNHCR consultation on caring for the nutritionally vulnerable during emergencies was planned (Rome, December 1997).

¹ *The International Code of Marketing of Breast-milk Substitutes: a common review and evaluation framework*. Priced document WHO/NUT/96.2. Available in English; Arabic, French, and Russian in preparation. Geneva, World Health Organization, 1997.

² *Guiding principles for feeding infants and young children during emergencies*. Review version. Unpublished document NUT/97.3.

³ *Management of Nutrition in Major Emergencies*. Geneva, World Health Organization (in press).

⁴ *Treatment and Management of Severe Malnutrition*. Geneva, World Health Organization (in press).

XII. TUBERCULOSIS

1. Tuberculosis killed more adults than any other infection in 1995. Ineffective treatment is fuelling the global epidemic and creating multidrug-resistant tuberculosis. In some countries the number of cases is rapidly increasing as a result of the spread of infection with the human immunodeficiency virus (HIV). However, a cost-effective primary health care strategy for the control of tuberculosis - the "directly observed treatment, short-course" (DOTS) strategy - is available. DOTS is a strategy for managing and documenting the cure of tuberculosis cases, thus stopping the transmission of infection and preventing the emergence of multidrug-resistant strains of the disease. In fact, DOTS is one of the most important health breakthroughs of the 1990s in terms of the number of lives already saved and the potential to save more. WHO is actively promoting DOTS to achieve the global tuberculosis control goals (successfully treat 85% of new sputum-positive cases and detect 70% of such cases by the year 2000) set by resolutions WHA44.8 and WHA46.36.

PROGRESS

2. In 1990, only 10 countries, with less than 1% of the estimated global tuberculosis cases, were implementing the DOTS strategy. By 1997, nearly 100 countries had accepted the DOTS strategy and about 60 had implemented it widely. Where DOTS is used, treatment success rates are much higher (77%) than where it is not (45%). Over 15% of all infectious tuberculosis cases are now being treated with this strategy.

3. In the parts of China where DOTS is used, treatment success rates are now 96%. In Peru, the successful treatment rate is 91% and the overall number of new cases has begun to decline.

4. External assistance for tuberculosis control has increased from US\$ 16 million (1990 commitments) to US\$ 60 million (1995). Some national tuberculosis budgets have increased and countries using DOTS are spending their budgets more efficiently. The cost of drugs for the treatment of tuberculosis has decreased from US\$ 40-50 (per six-month regimen) in 1990 to US\$ 15-25 in 1996.

5. Despite this, the global treatment success rate has reached at most 58%, and the global case detection rate could be as low as 38%.

6. WHO's global targets will not be met by the year 2000. Actions need to be intensified and accelerated. How quickly the DOTS strategy can be expanded depends on political commitment rather than on the technical content of the DOTS package, which clearly works. In some countries lack of political commitment is holding back expansion of DOTS coverage. In other countries, the utility of DOTS is still contested.

FUTURE OUTLOOK

7. Achievement of WHO targets would reduce both disease incidence and deaths due to tuberculosis by about 5% per year and eventually bring the epidemic under control. WHO now estimates that if the present control effort remains unchanged, the tuberculosis burden in the world will be higher by 2020 than it is now. Intensified action now will save more lives and result in fewer cases. What remains in doubt is the world's willingness to take the necessary action.

PROSPECTIVE GLOBAL TUBERCULOSIS INCIDENCE

Lines represent, top to bottom: situation with no change in control effort, and the situations if WHO targets (70% case detection, 85% treatment success) are met by 2020, 2010, and 2000.

8. According to country-specific assessment of feasible progress, if current adoption of DOTS can be further improved and sustained, about 130 countries could meet the specified goals by the year 2000.
9. Of the 22 countries currently accounting for more than 80% of the global disease burden, about 17¹ may not be able, even with maximum effort, to meet the targets for the year 2000. The 130 countries that can meet the targets with extra effort must be encouraged to maintain their efforts thereafter in order to begin to reduce disease incidence, which will lead to eventual elimination of tuberculosis. Those not meeting the targets for the year 2000 should be encouraged to implement and/or expand their DOTS programmes to achieve the targets as soon as possible thereafter.
10. Maintaining the current global targets after the year 2000 without a new action plan would discredit WHO. Conversely, postponing the target date is likely to check the current momentum and serve as a disincentive to countries that might otherwise meet the targets. WHO must decide on an appropriate course of action, seek endorsement of it and pursue it. The work of WHO now shows that the control of tuberculosis today primarily hinges on political commitment and decision-making rather than on technical or health intervention issues. The challenge therefore is for Member States, WHO and other international partners to find a way to place a higher priority on tuberculosis control and allocate and maintain resources accordingly.
11. The issue of the global targets will be presented to the Global Tuberculosis Programme's management advisory body in November 1997 for its advice to WHO. Its recommendations will be conveyed to the Executive Board, during its 101st session.

¹ Afghanistan, Bangladesh, Brazil, China, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Mexico, Myanmar, Nigeria, Pakistan, Philippines, Russia, South Africa, Thailand and Uganda.

XIII. GLOBAL ELIMINATION OF BLINDING TRACHOMA

1. Trachoma was one of the first diseases tackled by WHO. In the 1950s, three expert committees were convened and field research was undertaken in several countries. In the 1960s and 1970s, national trachoma control campaigns were mounted in many of the endemic countries. The results of those campaigns were often good in the short term, but long-term trachoma control proved difficult to achieve, particularly in remote rural areas with few prospects for improving living standards. Therefore, despite the progress made over more than two decades in a number of countries, trachoma remains a very significant public health problem. It is the most common cause of preventable blindness, typically found amongst the poorest people.

GLOBAL SITUATION

2. The disease in its active form is estimated to affect some 146 million people, mainly children and women. In addition, there are approximately 5.6 million people blinded or visually disabled by trachoma. The blinding disease is endemic in 46 countries, mainly in Africa, the Eastern Mediterranean Region, Asia, and Latin America.

3. Recurrence of trachoma infections during childhood lead to blinding complications later in life, and women are particularly exposed to infection among the children they care for. Transmission of *Chlamydia trachomatis* is favoured by crowding, poor personal and environmental hygiene and abundant eye-seeking houseflies. Epidemics of conjunctivitis, often seasonal, aggravate trachoma.

ACTION BY WHO

4. During the 1980s, field research for easier assessment of trachoma and its complications was undertaken to facilitate intervention by primary health care personnel. This, together with a standardized surgical procedure for the correction of intumed eyelids (trichiasis) and the elaboration of community-based approaches to control the disease, resulted in new emphasis on trachoma control using the SAFE formula (surgery for trichiasis, antibiotics, facial cleanliness, and environmental improvements), as follows:

(1) **Surgery:** Easy access to eyelid surgery is essential to correct intumed eyelids resulting from intense scarring. Such surgery must be provided promptly to avoid blindness. A tarsal rotation procedure has proved to be the most effective of the various surgical procedures. It is a technique easily taught and nonmedical staff can perform it safely and successfully. Standardized surgical kits can be purchased at low cost.

(2) **Antibiotics:** In order to rapidly control the disease and its spread, certain antibiotics can be applied on a large scale, either as topical or systemic preventive treatment. Tetracycline 1% eye ointment has been in use for three decades, and is effective. However, it has proved very difficult to maintain regular prolonged use of ointment. Amongst the systemic treatment options, the new generation of longer-acting macrolides, in particular azithromycin, large-scale clinical trials of which are under way, offers hope for better global control of trachoma.

(3) **Facial cleanliness:** Maintaining facial cleanliness in children is an effective way of reducing trachomatous inflammation; this can be achieved, even with minimal available water.

(4) **Environmental betterment:** This implies measures for water supply and basic sanitation, and when possible, improved housing. Measures against the breeding of flies are of particular importance.

5. Following a global scientific meeting convened in June 1996, the WHO Alliance for the Global Elimination of Trachoma (GET), comprising collaborating nongovernmental development organizations, the Edna McConnell

Clark Foundation and other interested parties was established. The Alliance is preparing a uniform reporting system, rapid assessment procedures, a data bank, a newsletter, and support to selected endemic countries. The long-term goal of eliminating trachoma by the year 2020 has been set, but this presupposes adequate preparedness for the global control of the active disease in the target populations (children and women).

XIV. ACTION BY THE EXECUTIVE BOARD

The Board is invited to note the reports and consider the following resolutions and decision:

HEALTH SYSTEMS DEVELOPMENT

The Board may wish to request that a progress report on the proposed initiative for health systems development be submitted to its 103rd session.

CROSS-BORDER ADVERTISING, PROMOTION AND SALE OF MEDICAL PRODUCTS THROUGH THE INTERNET

The Executive Board

RECOMMENDS to the Fifty-first World Health Assembly that it should adopt the following resolution:

The Fifty-first World Health Assembly,

Recalling resolution WHA50.4, “Cross-border advertising, promotion and sale of medical products using the Internet”, requesting that the Director-General convene a WHO ad hoc working group to formulate recommendations on cross-border advertising, promotion, and sale of medical products using the Internet;

Recalling resolutions WHA41.17, WHA45.30 and WHA47.16 on ethical criteria for medicinal drug promotion;

Recognizing the value and great potential of electronic communications means, including the Internet, for disseminating and obtaining information regarding medical products;

Recognizing the differences among Member States in their regulatory capacities, and in their approaches to advertising, promotion, and sale of medical products;

Recognizing the importance of collaboration between Member States and WHO, as well as between consumers, health professionals, and industry, on issues involving cross-border advertising, promotion, and sale of medical products using the Internet;

Recognizing the importance of national legislation, regulations, guidelines, and policies to control advertising, promotion, and sale of medical products, and the importance of ensuring adherence to national regulations;

Recognizing the importance of the development and implementation of self-regulatory mechanisms for guidelines on good information practices, where applicable consistent with the principles embodied in the WHO Ethical Criteria for Medicinal Drug Promotion;

Bearing in mind the importance of educating and training the public about the value and quality of information on medical products obtained using the Internet, and of the rational use of medical products;

Recognizing the report and recommendations of the ad hoc working group on cross-border advertising, promotion, and sale of medical products using the Internet as reflected in the Director-General’s report,

1. URGES all Member States:
 - (1) to review existing legislation, regulations, and guidelines to ensure that they are applicable and adequate to cover issues concerning cross-border advertising, promotion, and sale of medical products using the Internet and to develop, evaluate, and implement strategies for monitoring, surveillance, and enforcement activities;
 - (2) to collaborate with other Member States on the issues raised by the Internet, especially on the dissemination of information on problem cases and aspects, establishing appropriate measures to prevent cross-border advertising, promotion, and sale of medical products using the Internet to countries where it is illegal, and on specific measures for enforcement, and to designate appropriate contact points and disseminate this information through WHO to all Member States;
 - (3) to educate the public concerning the value and use of the Internet for obtaining medical product information, as well as about the quality of some information;
2. APPEALS to industry, health professional and consumer organizations and other interested parties:
 - (1) to encourage their members, where appropriate, to promote the formulation and use of good information practices, where applicable consistent with the principles embodied in the WHO Ethical Criteria for Medicinal Drug Promotion;
 - (2) to monitor and report problem cases and aspects of cross-border advertising, promotion, and sale of medical products using the Internet;
3. REQUESTS the Director-General:
 - (1) to encourage the international community to formulate self-regulatory guidelines for good informational practices, consistent with the principles of the WHO Ethical Criteria for Medicinal Drug Promotion;
 - (2) to develop a model guide for Member States to educate people using the Internet about how best to obtain reliable, independent and compatible information on medical products using the Internet;
 - (3) to collaborate with other appropriate international organizations and institutions on Internet issues relating to medical products;
 - (4) to urge Member States to set up or strengthen mechanisms to monitor and survey cross-border advertising, promotion, and sale of medical products using the Internet, and provide technical assistance as required;
 - (5) to urge Member States to take regulatory action, where appropriate, for violations of their national laws regarding advertising, promotion, and sale of medical products using the Internet;
 - (6) to encourage Member States and concerned nongovernmental organizations to report to WHO problem cases and aspects of cross-border advertising, promotion, and sale of medical products using the Internet and report problem cases and other aspects, as appropriate, to Member States.

GLOBAL ELIMINATION OF BLINDING TRACHOMA

The Executive Board,

Noting the report of the Director-General on the global elimination of blinding trachoma,

RECOMMENDS to the Fifty-first World Health Assembly the adoption of the following resolution:

The Fifty-first World Health Assembly,

Recalling resolutions WHA22.29, WHA25.55 and WHA28.54 on the prevention of blindness, and WHA45.10 on disability prevention and rehabilitation;

Aware of previous efforts and progress made in the global fight against infectious eye diseases, in particular trachoma;

Noting that blinding trachoma still constitutes a serious public health problem amongst the poorest populations in 46 endemic countries;

Concerned that there are at present some 146 million active cases of the disease, mainly among children and women, and that in addition, almost six million people are blind or visually disabled by trachoma;

Recognizing the need for sustainable community-based action - including surgery for intumed eyelids, antibiotics, facial cleanliness and environmental improvement (the SAFE strategy) - for the elimination of blinding trachoma in the remaining endemic countries;

Encouraged by recent progress towards simplified assessment and enhanced management of the disease, including large-scale preventive measures, particularly for vulnerable groups;

Noting with satisfaction the recent establishment of the WHO Alliance for the Global Elimination of Trachoma, comprising certain collaborating nongovernmental organizations and foundations and other interested parties,

1. CALLS ON Member States:

- (1) to apply the new methods for the rapid assessment and mapping of blinding trachoma in the remaining endemic areas;
- (2) to implement, as required, the SAFE strategy for the elimination of blinding trachoma;
- (3) to collaborate in the Alliance for the Global Elimination of Trachoma and its network of interested parties for the global coordination of action and specific support;
- (4) to consider all possible intersectoral approaches for community development in endemic areas, particularly for greater access to water and basic sanitation for the populations concerned;

2. REQUESTS the Director-General:

- (1) to intensify the cooperation needed with Member States in which the disease is endemic for the elimination of blinding trachoma;
- (2) further to refine the components of the SAFE strategy for trachoma elimination, particularly through operational research, and by considering potential antibiotic or other treatment schemes for safe large-scale application;

- (3) to strengthen interagency collaboration, particularly with UNICEF and the World Bank, for the mobilization of the necessary global support;
- (4) to facilitate the mobilization of extrabudgetary funds;
- (5) to report, as appropriate, to the Executive Board and the Health Assembly on progress made.

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