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FIFTY-FIRST WORLD HEALTH ASSEMBLY

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Implementation of resolutions and decisions

Report by the Director-General

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

CONTENTS

I. TASK FORCE ON HEALTH IN DEVELOPMENT

1. The Fiftieth World Health Assembly reviewed the report of the task force on health in development and adopted resolution WHA50.23, requesting the Director-General to report to the 101st session of the Executive Board and the Fifty-first World Health Assembly.

2. Activities of the task force, particularly in promoting "health as a bridge for peace" and as a central element in development and advocating WHO's leadership in health, continued. A full meeting of the task force is planned and a plan of action for its future work is being drawn up.

3. An informal consultation on health and human rights was held from 4 to 5 December 1997; public health and human rights experts from all regions sought to advise WHO on (1) the components of a proactive programme aimed at incorporating a health and human rights approach and concomitant obligations in all parts of WHO; and (2) the development and strengthening of partnerships with entities concerned with human rights within the United Nations system, and with intergovernmental and nongovernmental organizations, as well as academic and other centres of expertise concerned with health and human rights.

4. A number of specific suggestions were made on how to accelerate and strengthen the links between human rights and health activities, showing awareness of the impact of steps taken in one field on the other, and making conscious efforts to maximize that impact. Further details of the deliberations and recommendations of the consultation are contained in document WHO/HPD/98.1, which is available on request.

5. The Executive Board was informed that the report of the task force included recommendations which had been taken into account in the development of the health-for-all policy for the twenty-first century (document A51/5). The fundamental policy objective of making health central to the process of development at international, regional, national and local levels is an outcome of some of the earliest work of the task force in this area, as is the idea that health and human rights should be one of the values guiding the health-for-all vision in the next millennium.

6. As called for in resolution WHA50.23, the task force's work will continue for assistance to WHO as the leader in global health as the Organization continues to adapt to and meet changing health needs in a rapidly changing world. As part of this, the task force will concentrate on health advocacy at the global level; using the influence and expertise of its broad membership to uphold WHO's image, disseminate WHO's vision and mission and act as a powerful catalyst for change.

7. A plan of action for the future work of the task force will be finalized by mid-1998, and includes streamlined terms of reference to maximize its resources and expertise. It also reflects a rotating membership to allow the group to evolve with the best minds and most influential people from all regions and a broad range of disciplines while maintaining the institutional memory of the task force and building upon work already undertaken.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

II. 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 strategic 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 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 formulate health-for-all policies and accelerate implementation through intensified technical cooperation with the support of collaborating institutions. The recommendations of the meeting will be available at the time of 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.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

III. PREVENTION OF VIOLENCE

IMPLEMENTATION OF RESOLUTION WHA50.19

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 prevention of violence, 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 after 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; the task force on violence and health, established by the Director-General in June 1996, will assist in monitoring and evaluating implementation of the plan of action;

(2) an institutional network was established to support implementation of the plan of action, which 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).

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 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 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 to 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. WHO is producing a document on prevention of violence in the context of "health-promoting schools" which included violence in initiatives for life-skills education and child friendly schools. Violence was included in several mental health projects, particularly with regard to refugees, and as part of the "nations for mental health" initiative.

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. As a follow-up, it has been proposed to set up an international centre for the study of contemporary forms of violence, and a meeting between WHO, the Ministry of Health and other interested parties (Algiers, March 1998) established the terms of reference of such a centre.

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.

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. In Rwanda this project has implemented several activities on the basis of the detailed plan of work elaborated in conjunction with the relevant ministries. A variety of training workshops have been carried out and activities related to community health, social mobilization and drug supply are under way. In Burundi this project has implemented surveillance activities countrywide to explore the dimensions and health consequences of violence against women and better to determine the capacity of services to deal with the problem.

9. 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 domestic violence, to demonstrate the health consequences, and 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.

10. 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.

11. WHO, on the occasion of the XVth FIGO World Congress of Gynecology and Obstetrics, held a pre-Congress workshop on "The elimination of violence against women: in search of solutions". A resolution on the subject was adopted by the General Assembly of the International Federation of Gynecology and Obstetrics. Experiences of measures in the health sector to counter violence against women, with particular attention to their appropriateness and sustainability with limited resources, were reviewed. WHO will follow up recommendations to develop guidance for policy-makers and training materials for use by health workers.

12. 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.

13. A database has been set up to collect information on violence against women in families, rape and sexual assault. More than 600 entries from all regions have already been compiled and more than 100 requests for information have been received. The information is being used to support advocacy, research and policy

[1] Document WHO/FRH/WHD/97.8.

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.

14. 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.

CONCERTED PUBLIC HEALTH ACTION ON ANTI-PERSONNEL MINES

15. Although anti-personnel mines left behind after conflicts continue to terrorize and decimate families and communities long after being planted, reliable information is not readily available on the number of anti-personnel mines scattered around the globe and the number of casualties. Moreover, the figures that have been used until now do not tell much about the psychosocial and economic burden on communities of disabilities caused by mines, the impact on various community needs, such as access to health services or safety of health care workers, and the capacity of affected countries to assess the size of the problem and subsequent needs and the means to manage and control the problem. They do not indicate how long a mine remains active after being planted, thus how long the risk of being killed or maimed persists.

16. The strong need to collect and analyse data on the burden of anti-personnel mines and on their effects on public health in a systematic, coherent and collaborative way for the sake of matching needs and resources for humanitarian assistance to mine victims, has to be considered as priority. Hence the Executive Board at its 101st session adopted resolution EB101.R23 which *inter alia* requested the Director-General to submit to the Fifty-first World Health Assembly a plan of action for a concerted public health response to anti-personnel mines.

17. Subsequent to United Nations General Assembly resolution 52/173 of 18 December 1997, calling for a coordinating role of the United Nations in mine action, the Department of Peacekeeping Operations was entrusted with this responsibility and established a United Nations mine action service, in order to draw up a concerted, coherent and transparent policy and a work plan. Two groups have been formed, the Inter-Agency Working Group on Mine Action, responsible for preparing policy documents and agenda for action, which are validated and endorsed by the Inter-Agency Coordination Group. As the lead agency for coordination of international work in public health, WHO is a member of both groups and is particularly involved in raising awareness of mine injury and assistance to victims. The first meeting of the subgroup on mine awareness and assistance to victims of the Inter-Agency Working Group, took place in February 1998 with WHO participation and initiated its work on the basis of the draft plan of action for a "concerted public health response on anti-personnel mines" drawn up by WHO. WHO also contributed to the subgroup on information management and databases in relation to the proposal to establish a WHO clearing-house on public health aspects of mines.

18. The proposed plan of action, which will cover an initial period of two years, is the result of several steps WHO took towards defining its role concerning anti-personnel mines, after the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and their Destruction was opened for signature in Ottawa in December 1997. The goal of the WHO plan is to strengthen the capacity of affected States for the planning and execution of programmes for:

- better assessment of the effects of anti-personnel mine injuries on health through the establishment or reinforcement of a surveillance system
- promotion of programmes to raise awareness of mines and prevent injuries through health education, in close cooperation with interested parties

- strengthening of emergency and post-emergency management of anti-personnel mine injuries within the context of integrated health service delivery

- strengthening of rehabilitation services, with special attention to psychosocial rehabilitation.

19. The five objectives of the WHO plan of action and expected output are detailed below.

Objective 1. Surveillance and information: To strengthen both the surveillance capability of national health systems in order to assess the severity of the problem of mine injury through collection of data on mortality, morbidity and disability, and their response capability by collecting data on health care facilities, capacity, organization, equipment, staff, etc.

Product: WHO will work closely with organizations of the United Nations system, the International Committee of the Red Cross (ICRC) and nongovernmental organizations involved in data collection at field level, and WHO collaborating centres, to establish a database of accurate and reliable information from countries on mine injury, linked to the WHO clearing-house. At country level, data will be distributed to users for setting priorities in health resources allocation, demining, and prevention activities. At global level, the data will be shared and used for advocacy.

Objective 2. Prevention and awareness: To ensure that a mine avoidance element for the community and a safety promotion component for health care workers is included in awareness programmes. WHO will work in close collaboration with other bodies of the United Nations system, particularly UNICEF, to draw up norms and standards for programmes to raise awareness of mine injury as part of national health education programmes, in order to prevent the occurrence and reduce the number of mine injuries.

Product: Country information kits for programmes to raise awareness of mine injury will be produced and disseminated.

Objective 3. Emergency and post-emergency care management: To cooperate with ministries of health of affected States and, jointly with ICRC, to disseminate and/or determine standards for strengthening the capacity of health care services in emergency and post-emergency care management, with due attention to the needs of laboratory and blood bank services.

Product: National guidelines will be adapted and disseminated for use by hospital and paramedical personnel. Training modules will be prepared and disseminated to identified trainers.

Objective 4. Rehabilitation: To draw up national standards and comprehensive programmes for physical and psychosocial rehabilitation of victims of anti-personnel mines within the frame of community-based rehabilitation programmes in order to ensure complete integration of persons with disabilities into the community. To assure the provision of prosthetic and other assistive devices, including maintenance and repair. To promote decentralization of rehabilitation services through primary health care, supported by an appropriate referral system.

Product: WHO will draw up guidelines for integrated community-based rehabilitation in collaboration with health authorities and other partners.

Objective 5. Coordination within the United Nations system: To ensure development of a coherent and concerted approach to the assistance of anti-personnel mine survivors, through the Inter-Agency Coordination Group on Mine Action, under the chairmanship of the United Nations Department for Peace Keeping Operations. To establish a clearing-house for information on public health aspects of the use of mines in order to improve information management.

Product: Coordinated programme delivery in countries will be assured, and an information clearing-house will be established.

20. The plan of action will be implemented through an integrated approach at country level, involving local health authorities and relevant partners. It will focus on joint efforts and will ensure effective coordination for programme delivery. In order to maximize efforts and to provide concerted and coherent assistance to victims of anti-personnel mines, WHO will provide technical support to the Inter-Agency Coordination Group on Mine Action. Collaboration at global and country levels with the bodies indicated under Objective 1 will be a priority in project implementation.

21. Evaluation of the impact of activities under the proposed plan of action to support affected countries will be carried out at the end of the first two years on the basis of data collected, norms and standards drawn up, and effective collaboration with the partners involved. WHO will ensure that a continuing evaluation process is established from the beginning, particularly with regard to appropriate reporting to donors, when requested.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

22. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R23.

IV. HEALTH SYSTEMS DEVELOPMENT

BACKGROUND

1. At its ninety-eighth session, the Executive Board, concerned by the increasing emphasis 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.[1] 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 ...". Prior to the adoption of this resolution, the Fiftieth World Health Assembly had 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".

2. The initiative on health systems development is intended to raise the profile of, and give priority to, health systems development in countries. This requires greater awareness in international forums and research communities of the important contribution of health systems development to improving the health of populations. Roles and functions of the many actors and components of the health systems must be clarified and capacities should be strengthened where needed. Methods to accomplish this include:

- creating mechanisms in WHO that ensure organization-wide coordination of different elements of the health systems development with other technical programmes
- providing support to countries and establishing a "think tank" to monitor and assess policies
- placing emphasis on least developed countries and others that are furthest behind in meeting the targets of health for all, and on vulnerable and marginalized groups within countries
- creating links with national institutions in order to promote and implement joint country activities
- establishing regional and global reference centres for interested countries
- strengthening partnerships with other bilateral and multilateral organizations on the basis of a well-established and accepted policy.

PROPOSALS OF THE EXTERNAL ADVISORY GROUP

3. An external advisory group, set up as requested by resolution EB100.R1, met on 26 and 27 November 1997; it clarified some of the terms, distinguishing between health care systems, health systems and health systems development. It concluded that health care systems refer to the provision of health care to individuals and to communities; health systems deal with broader issues, including interaction with other sectors influencing health; health systems development covers the options available for the strengthening of health systems in countries, with the ultimate aim of improving health status of the population.

4. The group proposed that the initiative should proceed with the examination of certain themes relevant to all systems, including: policy development, planning, health information, regulation and legislation, and the role of the private sector; financing, expenditure and resource allocation; organizational and institutional

[1] Document EB100/1997/REC/1, Annex 2.

development, including management, "governance" and decentralization; service delivery and quality assurance; essential drugs and health technology; health workforce development; and "partnership" and "empowerment" within the health sector and with other sectors. It emphasized that this list was not exhaustive and should not necessarily form the basis of WHO's action, or the organization of health systems at country level.

KEY AREAS

5. The Organization has been providing support to countries on demand, especially the developing countries, to pursue their health systems development and reform effort. For example, in the area of *research*, WHO has been assessing health systems issues, determining best practices, designing frameworks and tools or analysing options, and elaborating methods for monitoring and evaluating, both within the health sector and with appropriate government and nongovernment agencies. It has concentrated on decentralization and change, approaches involving local institutions and non-State entities, health financing policies, human resources development, and the organization and management of disease-specific programmes in the context of health sector reform.

6. The Organization has been strengthening its analytical capability in the area to assess the success of health sector reform. *The world health report 1999* will be devoted to the subject of health systems development. The Regional Office for Europe has been using a "template" for drawing up health systems profiles of "countries in transition", and this template is being modified according to each region's perception of its special needs in order to prepare a set of country health systems profiles which highlight recent changes and reform in health systems in the light of global changes. It will also constitute the foundation for improved regional and global information on countries' health systems and their processes for change.

PARTNERSHIPS IN HEALTH SYSTEMS DEVELOPMENT

7. WHO has been working actively with other partners in areas of concern. For example, UNICEF and WHO have developed new approaches to strengthening district health systems. Links are being strengthened with other organizations, such as UNDP, ILO and the World Bank, in order to frame integrated policies for support to human resources development and to define options for global partnership for health systems development at local or district levels. WHO is also collaborating with countries of the Non-Aligned Movement to establish a network of institutions in developing countries which will, among other tasks, gather, assess and disseminate information on approaches to health sector reform.[1] UNDP is closely involved in this effort. Furthermore, WHO has contributed to the initial conceptual work on sector-wide approaches with other development agencies, national policy-makers and experts, and an international technical working group has recently been established.

CONCLUSIONS

8. Health systems development is not the task of only a few programmes within WHO. It permeates the whole Organization, as sustainability of health action depends largely on the capacity of countries to strengthen their health systems. Consequently, an organization-wide effort is needed to support countries in the development of their health systems. Additionally, close collaboration with other external agencies and nongovernmental organizations is imperative if the envisaged goals of the initiative are to be achieved. Major

[1] See also section II.

regional and global conferences are needed to obtain consensus of views and consider further the role that WHO should be playing.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

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

V. REVISED DRUG STRATEGY

1. Resolution WHA39.27 of the Thirty-ninth World Health Assembly endorsed the WHO revised drug strategy. The strategy called for support to governments to implement national drug policies and programmes which promote equity of access to essential drugs, rational use of drugs, and drug quality.

2. Resolution WHA49.14 reaffirmed the intent and content of the revised drug strategy and contained 11 operative paragraphs, each of which has received specific attention during the current biennium.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. **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.

11. 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.

12. 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.

13. 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.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

14. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R24.

VI. CROSS-BORDER ADVERTISING, PROMOTION AND SALE OF MEDICAL PRODUCTS USING THE INTERNET

1. An ad hoc working group was convened by the Director-General in Geneva from 3 to 5 September 1997, 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]

(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, designate appropriate contact points, and disseminate this information also through WHO to all Member States;

- disseminate information on problems 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 websites, 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 in the use of 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, 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

- 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

[1] The report of the ad hoc working group is available from the Secretariat.

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 using the Internet;

- collaborate with other international organizations and institutions concerned 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, against 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.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

3. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R3.

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

The report on implementation of resolution WHA50.37 will be submitted in an addendum to the present document.

VIII. 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 took place 20 years after WHO's 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 devise innovative strategies for health promotion;
- to facilitate the development of "partnerships" in health promotion to meet the global health challenges.

3. The Conference 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 settings for health, such as "healthy cities", "healthy islands" and health promoting schools, workplaces and communities, offer practical opportunities for the implementation of health promotion.

5. The Declaration reflects the firm commitment of the Conference participants to build partnerships, 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. 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.

7. Since the Jakarta Declaration, there has been active follow-up. The WHO five-year plan of action on health promotion and health education has been revised. The Declaration, which has been translated into more than 10 languages, is widely used and has already been the subject of discussion at the sessions of at least two

regional committees. The results of the Conference include the network of most populous countries, a "mega-country initiative" (10 countries representing approximately 60% of the world's population); publications including the health promotion glossary; the preparation of an international handbook on health promotion; a WHO information series on school health; and a health promotion website. Other aspects demonstrating the "horizontal" nature of health promotion include healthy ageing, the "active living" initiative, partnerships with sports associations and tourist associations. In addition, the development of a network of private-sector nongovernmental organizations with a commitment to the promotion of health is being explored.

8. The 101st session of the Executive Board commended the Fourth International Conference on Health Promotion and the Jakarta Declaration as an important step in the further development of health promotion.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

9. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R8.

IX. INFANT AND YOUNG CHILD NUTRITION[1]

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; 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.[2] 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, and 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 Action for Nutrition, and have reaffirmed the commitments they made to it.[3]

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 growth curves of the United States National Center for Health Statistics/WHO, 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

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[1] See also document A51/INF.DOC./3, which complements this section, providing a more comprehensive evaluation of the most serious forms of child malnutrition, the progress made in reducing them, and action taken by Member States and WHO.

[2] 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, retardation is defined as weight below the 10th percentile of birth-weight-for-gestational-age reference curve.

[3] 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.

mortality, caused by cardiovascular disease, hypertension, stroke, diabetes (type 2), some cancers, liver disease, gall-bladder disease, and accidents. WHO organized a major consultation on obesity[1] and, in view of the magnitude of the problem, both regular global reporting and effective national public health nutrition strategies are urgently needed.

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.[2]

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.[3] 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 Declaration[4] 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

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[1] Obesity: preventing and managing the global epidemic. Report of the WHO Consultation on Obesity, Geneva, 3-5 June 1997 (unpublished document WHO/NUT/NCD/98.1).

[2] 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 WHO/NUT/98.4; and *Iron deficiency: indicators for assessment and strategies for prevention* (in press).

[3] WHO global data bank on breast-feeding. Unpublished document WHO/NUT/96.1 (English only).

[4] 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. See The Innocenti Declaration: progress and achievements (Part I). *Weekly Epidemiological Record*, **73**(5): 25-30 (1998).

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 to more than 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 time: **Africa:** Botswana, Madagascar, *Mauritania*, Mozambique, *Namibia*, *Seychelles*, Togo, Zimbabwe; **the Americas:** Belize, Honduras, Nicaragua. Trinidad and Tobago; **South-East Asia:** Bangladesh, India; **Europe:** Austria, Poland, Sweden; **Eastern Mediterranean:** Cyprus, Djibouti, Iran (Islamic Republic of), Saudi Arabia; **Western Pacific:** Australia, *Cambodia*, China, *Marshall Islands*, New Zealand, *Niue*, *Palau*, Singapore, 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 noncompliance 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 framework[1] 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 principles[2] to ensure optimal feeding of infants and young children during emergencies has been completed, and manuals on the management of nutrition in major emergencies[3] and on treatment and management of severe malnutrition[4] 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 (Eritrea, 1996), a joint WHO/UNHCR consultation on caring for the nutritionally vulnerable during emergencies was planned (Rome, December 1997).

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

13. The Health Assembly is invited to note the Director-General's report.

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[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, 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).

X. 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.

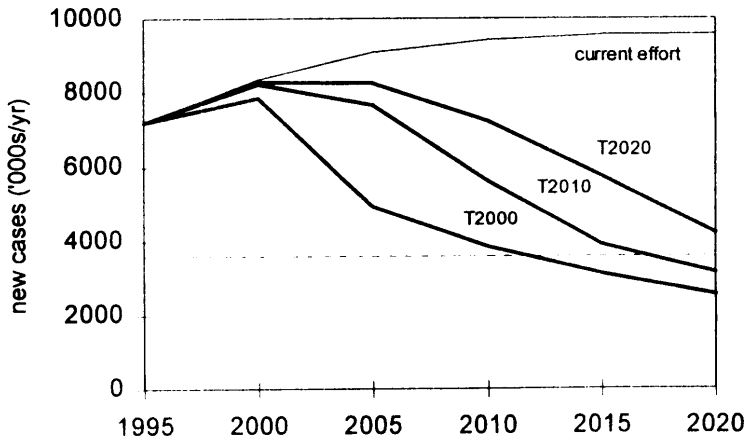
5. Despite this, the global treatment success rate has reached at most 58%, and the global case detection rate could be as low as 38%.

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 17[1] 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. In January 1998 the Executive Board was informed of four main recommendations made to the Director-General by the global tuberculosis programme's management and advisory body following its meeting in November 1997.[2]

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

[2] See summary record of the eleventh meeting of the Executive Board at its 101st session (document EB101/1998/REC/2).

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

12. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R4.

XI. 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 inturned eyelids (trichiasis) and the elaboration of community-based approaches to control the disease, resulted in new emphasis on trachoma control using the SAFE strategy (surgery for trichiasis, use of antibiotics, facial cleanliness, and environmental improvements), as follows:

(1) Surgery: Easy access to eyelid surgery is essential to correct inturned 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).

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

6. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R5.

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