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Implementation of resolutions (progress reports)

Report by the Secretariat

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A. REDUCING GLOBAL MEASLES MORTALITY

1. In resolution WHA56.20, the Fifty-sixth World Health Assembly stressed the importance of achieving the global goal to reduce measles deaths to half the levels of 1999 (869 000) by 2005. Approximately 95% of these deaths occurred in only 45 countries (see Figure 1). More than 50% of these deaths occurred in the African Region. The primary reason for high measles mortality is failure to deliver at least one dose of measles vaccine to all infants.

2. Measles deaths can be prevented by using currently available vaccines and strategies. The WHO-UNICEF Strategic Plan for Measles Mortality Reduction, 2001-2005 outlines a comprehensive strategy for the sustainable reduction of measles mortality. This includes strengthening of routine immunization services; provision to all children of a second opportunity for measles immunization, either through routine services or periodic supplementary immunization activities; measles surveillance; and improved case management with vitamin A supplementation. The Strategic Plan targets enhanced activities to reduce measles mortality in 45 priority countries.

3. Coverage rates for measles vaccination vary significantly by region. Although global routine measles vaccination coverage has remained relatively constant from 1999 (71%) to 2002 (73%), substantial progress was made in the South-East Asia Region, where coverage rose from 58% to 70%. In the African Region coverage increased from 52% to 59%.

4. In 2002, 85% of Member States provided children with a second opportunity for measles immunization, compared with 83% in 2001. Member States are providing a second opportunity for measles immunization by implementing a two-dose routine schedule and/or periodically conducting measles supplemental immunization.

5. By the end of 2003, enhanced activities to reduce measles mortality had been initiated in 29 (64%) of the 45 priority countries. Through the support of the Africa Measles Initiative partnership,¹ over 120 million children aged 9 months to 15 years have been provided with a second opportunity for measles immunization since 2001. This partnership mobilized more than US\$ 80 million in support of activities to reduce measles mortality.

6. The integration of efforts to reduce measles mortality with other health activities is being promoted. Vitamin A supplementation, anthelmintic treatment, provision of insecticide-treated bednets, and yellow fever vaccinations are among some of the priority public-health interventions that have been delivered during measles campaigns.

7. These accelerated activities have resulted in a significant reduction in estimated global measles deaths. Overall, global measles mortality decreased by 29% between 1999 and 2002. The largest gains were in the African Region, where measles deaths decreased by 35% and accounted for 67% of the global reduction (see Figure 2).

8. The Cape Town Measles Declaration (October 2003) on the sustainable reduction of measles mortality has reinforced commitment of countries and their partners. The declaration highlighted the

¹ Lead partners in the Initiative are the American Red Cross, Centers for Disease Control and Prevention, UNICEF, WHO and the United Nations Foundation.

importance of strengthening partnerships and assuring financial sustainability of activities to reduce measles mortality.

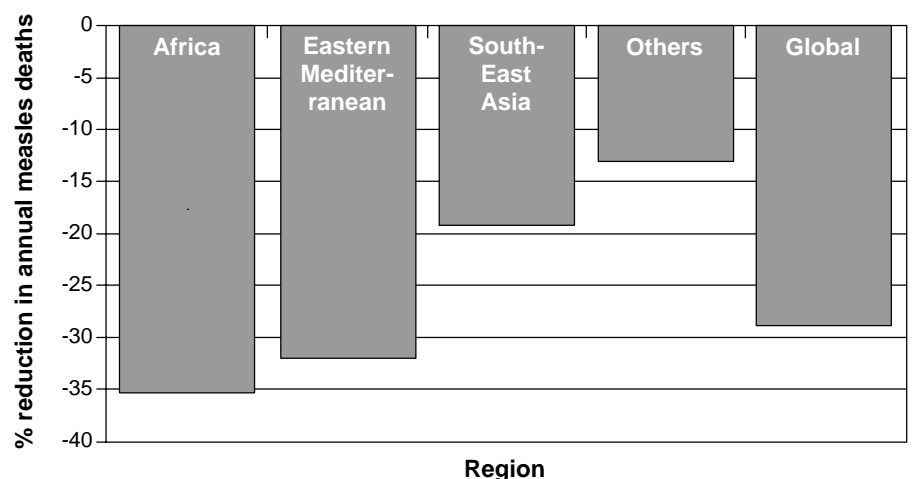
9. Additional financial resources will be required to implement fully the comprehensive strategy for measles mortality reduction over the next three years in the 45 priority countries. Funding needs to be secured for strengthening routine immunization services and conducting planned supplemental immunization in priority countries. The success of the Africa Measles Initiative provides a possible model for other regions.

10. Country ownership of strategies and goals for measles mortality reduction is a prerequisite for achieving a sustained reduction in measles deaths. Partners can contribute to, and complement, country efforts. Efforts are being made to assure coordination between activities to reduce measles mortality and the work of the Global Alliance for Vaccines and Immunization (GAVI).

Figure 1. WHO/UNICEF 45 priority countries for implementation of sustainable activities to reduce measles mortality



Figure 2. Per cent reduction in estimated measles deaths by WHO region 1999-2002



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B. SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

11. Resolution WHA56.29 identified priority activities in response to the outbreak of severe acute respiratory syndrome (SARS) that began in mid-November 2002 in southern China and spread internationally in late February 2003. On 5 July 2003, WHO announced that the last known chain of human-to-human transmission of the SARS coronavirus had been broken, thus bringing the initial outbreak to an end. This report describes subsequent activities aimed at guarding against a re-emergence or recurrence of this disease.

12. In August 2003, WHO posted guidelines for alert, verification and public health management of SARS during the post-outbreak period on its web site. The guidance includes advice on risk assessment, a definition of what constitutes a SARS alert, clinical and laboratory case definitions, and recommended public health measures during a SARS alert. It also includes recommendations for surveillance that are specific to three levels of risk that SARS might occur in a given geographical area, and underscores the need for continued vigilance. New guidance documents, including a global preparedness and response plan, will soon be circulated.

13. To support continued vigilance, WHO issued a consensus document on the epidemiology of SARS in October 2003 and established diagnostic expertise in the form of an international network of laboratories for SARS reference and verification. Post-outbreak biosafety guidelines for the handling of virus specimens and cultures were issued in December 2003.

14. To respond to continuing research needs, WHO established a SARS Scientific Research Advisory Committee. Its first meeting, in October 2003, has been followed by separate workshops and meetings on laboratory issues, clinical research and vaccine development. Participants at the laboratory meeting assessed progress towards satisfying the urgent need for a reliable diagnostic test and discussed laboratory biosafety. The objective of the clinical meeting was to establish standardized

internationally-agreed protocols for clinical trials of SARS treatments. Should a second outbreak of SARS occur, such protocols will allow real-time coordination of ethical and scientifically robust studies, conducted according to a shared protocol, at all outbreak sites. Such procedures are expected to shorten the time needed to obtain conclusive findings for the benefit of all patients and encourage uniform treatment throughout the world. At the third consultation, progress in the development and evaluation of candidate SARS vaccines was reviewed and research priorities were agreed. Work on the development of a SARS vaccine continues. A second meeting of this committee is planned for the first half of 2004.

15. A second outbreak of SARS could arise from two sources. The disease could spread following an accident at one of the many laboratories retaining clinical samples or conducting research on the virus. The disease could also re-emerge following human contact with an animal reservoir or other environmental source. Concern has also been expressed that SARS might show a seasonal pattern similar to that of many respiratory diseases caused by viruses, including other coronaviruses.

16. During the post-outbreak period, including the critical winter season, vigilance for a return of SARS from all possible sources remained high, as evidenced by the reporting and investigation of several suspected cases. Of these suspected cases, six showed laboratory evidence of SARS virus infection. Two cases were linked to laboratory accidents in Singapore and Taiwan, China. From December 2003 through January 2004, four cases of community-acquired SARS were reported in Guangdong Province, China. Rapid detection and proper management of all six cases prevented further transmission, thereby validating the preparedness plans.

C. INTEGRATED PREVENTION OF NONCOMMUNICABLE DISEASES

17. Noncommunicable diseases are the leading cause of death and disability worldwide. Common, preventable biological risk factors (notably high blood pressure, high blood cholesterol and overweight) and related major behavioural risks (unhealthy diet, physical inactivity and tobacco use) underlie four of the most prominent noncommunicable diseases – cardiovascular disease, cancer, chronic obstructive pulmonary disease and type 2 diabetes. Preventive actions should focus on integrated control of these and other major risk factors.

18. The global strategy for prevention and control of noncommunicable diseases, requested in resolution WHA51.18, was submitted to the Fifty-third World Health Assembly.¹ The present document responds to the request in resolution WHA55.23 for a progress report on integrated prevention of noncommunicable diseases to be submitted to the current Health Assembly.

19. Resolution WHA55.23 also requested the Director-General to develop a global strategy on diet, physical activity and health within the framework of the renewed strategy for the prevention and control of noncommunicable diseases, with a multidisciplinary and multisectoral approach governing the global strategy, and strengthened collaboration with other organizations of the United Nations system and other partners.

¹ Documents A53/14 and WHA53/2000/REC/3, summary record of the seventh meeting of Committee A.

Action and progress

20. Support to Member States for prevention has included the adoption of the WHO Framework Convention on Tobacco Control and consultations with the many stakeholders involved in formulating the global strategy on diet, physical activity and health.

21. The global strategy for prevention and control of noncommunicable diseases promotes partnership and networking, and incorporates technical and strategic support for research and development. Progress includes establishing a global forum and regional networks, implementing integrated prevention measures, and promoting capacity building. Emphasis has been placed on surveillance, research into the effectiveness of community-based programmes and country support.

Major components of prevention

22. The networks of national or demonstration programmes for prevention and control are at different stages. The set of actions for the multifactorial reduction of noncommunicable diseases (CARMEN Initiative) in the Americas and the countrywide integrated noncommunicable diseases intervention (CINDI) in Europe are well-established networks of national and community-based prevention programmes. The Network of African Noncommunicable Diseases Interventions and the network for the Eastern Mediterranean approach to noncommunicable diseases were initiated in 2001. A Western Pacific network is operating on an informal basis, and in the South-East Asia Region a network is being set up.

23. The Global Forum on Integrated NCD Prevention and Control, initiated by WHO in 2000, brings together these regional networks, international nongovernmental organizations, development agencies, WHO collaborating centres and organizations of the United Nations system. It provides an important vehicle for setting and maintaining standards through sharing information and guidelines, and has raised the visibility of prevention of noncommunicable diseases.

24. WHO has promoted prevention programmes in Member States through its regional offices, providing technical advice and support in national programme development and evaluation to several Member States through short-term assignments.

25. Attention is being paid to building capabilities in personnel and institutional strengthening for reducing risk factors, drafting policies and strategies, establishing national or demonstration programmes, and monitoring and evaluation. Regional offices, working with WHO collaborating centres, have started training programmes for integrated prevention. A WHO research study was initiated in 2002 to determine the effectiveness of community-based prevention and control programmes.

Tackling major behavioural risk factors

26. **Tobacco use.** The adoption of the WHO Framework Convention on Tobacco Control opens a new era in global and national tobacco-control activities. It provides a tool by which the mortality rate due to tobacco use can be reduced. As resolution WHA56.1 calls upon all States and regional economic integrated organizations to take all appropriate measures to curb tobacco consumption, many government ministries (for instance, those of health, finance, taxation, labour and agriculture) are working closely together for the first time on these complex issues.

27. **Physical inactivity.** Resolution WHA55.23 also urged Member States to celebrate an annual “Move for health” day, following the successful World Health Day 2002 whose initial event had been celebrated in São Paulo, Brazil. The Director-General participated in the event in recognition of the “*Agita São Paulo*” campaign to promote physical activity and healthy behaviours. The Move for Health initiative has triggered considerable interest and commitment by political leaders in many Member States.

28. **Unhealthy diet.** The draft global strategy on diet, physical activity and health will be considered under provisional agenda item 12.6.

D. QUALITY OF CARE: PATIENT SAFETY

29. Resolution WHA55.18 urged Member States to pay the closest possible attention to the problem of patient safety and requested the Director-General, inter alia, to develop relevant global norms, standards and guidelines; to promote framing of evidence-based policies; to encourage research into patient safety; and to support the efforts of Member States to develop mechanisms to recognize excellence in patient safety internationally and to promote a culture of safety within health care organizations.

30. In response, WHO has established a programme tackling systemic issues of patient safety and has created a working group bringing together all the relevant activities throughout WHO into one consolidated action. It is working on a web site on patient safety in order to foster international communication. Progress made in different aspects of patient safety is summarized below.

31. **Estimating hazards.** In order to raise the priority of patient safety and promote the development of strategies to prevent and mitigate the effects of adverse events, better knowledge of the nature and magnitude of the problem is important. WHO has reviewed available methods for estimating hazards in health care, and is now designing a tool for rapid assessment in data-poor environments.

32. **Taxonomy.** WHO is working on the development of a standardized nomenclature and taxonomy of medical errors and failures in health-care systems. This will ensure a common understanding of patient safety concepts and related terms, and facilitate international collaboration and exchange of information.

33. **Reporting and learning systems.** Reporting and learning systems are crucial for improving patient safety because they enable lessons to be learnt from adverse events or “near misses”. WHO is preparing guidelines for such systems, identifying best practices and promoting their adoption in countries.

34. **Health care workers.** Recent reports have shown the effect of staffing conditions of nurses on the quality and safety of patient care. Briefing documents are being prepared which demonstrate the impact of the skill mix of staff on organizational culture and improved patient safety.

35. **Essential clinical care procedures.** WHO has initiated activities to strengthen capacity building in Member States. This includes training of health personnel at first referral health facilities through collaboration with local and international partners, and the use of WHO guidelines on safe emergency and surgical procedures and of safe equipment for trauma, obstetrics and anaesthesia.

36. **Pregnancy safety.** The Making Pregnancy Safer Initiative contributes to strengthening the capacities of countries to establish the continuum of care needed throughout pregnancy, childbirth and the postnatal period. It works to improve access to, and provision, use and quality of care; to develop human resources, and to build up community support.

37. **Injection safety.** In order to provide support to Member States in planning, implementing and assessing the safe and appropriate use of injections, WHO maintains four main activities: raising awareness; broadening the availability of single-use injection devices and safety boxes in health-care facilities; ensuring provision of injection devices with reuse-prevention features and safety boxes by donors and lenders that support the supply of injectable substances; and promoting proper management of waste associated with used syringes and needles.

38. **Immunization safety.** WHO aims to strengthen national capacity to ensure immunization safety and, in particular, to prevent, detect and respond rapidly to adverse events following immunization. Auto-disable syringes have been introduced in nearly half of all non-industrialized countries. Documented surveillance systems exist in nearly half of Member States, and 49 national systems have been assessed. The Global Advisory Committee on Vaccine Safety set up to respond promptly, efficiently and with scientific rigour to issues of vaccine safety, contributes significantly to promoting the above activities.

39. **Blood transfusion safety.** WHO works with Member States to promote national coordination of blood transfusion services with effective quality systems for the collection, testing, processing and use of blood. It promotes haemovigilance as a surveillance system, covering all activities from donation to follow-up of recipients in order to assess any undesirable effects to blood transfusion.

40. **Medical devices.** WHO promotes international standards, performance specifications, prequalification of suppliers, capacity building in the appropriate use and maintenance of equipment, and standardized procedures for alerts and recalls. WHO's guiding principles on the regulation of medical devices aim to provide support to Member States in implementing national regulations.¹

41. **Drug monitoring.** The Programme for International Drug Monitoring consists of activities undertaken by WHO, the WHO Collaborating Centre for International Drug Monitoring (Uppsala, Sweden) and 73 Member States. It ensures exchange of information on medicines, promotes pharmacovigilance in Member States, and supports collaboration between countries.

42. **Poison centres.** WHO provides the central unit of the International Programme on Chemical Safety (IPCS), a joint programme between WHO, UNEP and ILO. The core activities of IPCS include information on poisons and prevention and management of poisonings. Poisons centres in over 80 countries are linked through IPCS and can constitute a point of reference on patient safety issues, including antidotes and other emergency treatments. IPCS is working with the WHO Collaborating Centre for International Drug Monitoring to foster capacity building, harmonized data reporting and improved awareness of safety issues.

43. All **regional offices** are active in implementing activities to improve patient safety. Building on a wide spectrum of current activities, all regions have established initiatives specifically to tackle issues related to patient safety. In addition to working closely with Member States in ensuring the safety of drugs, vaccines, laboratory practices and health care procedures, and improving control of

¹ *Medical device regulations: global overview and guiding principles*. Geneva, World Health Organization, 2003.

hospital infection, regional offices are fully involved in Organization-wide work on systemic factors of patient safety and in fostering international collaboration.

44. An **international alliance** for patient safety will be launched by WHO during 2004. It will bring together countries, interested bodies and experts for the promotion of patient safety in Member States. It aims to accelerate improvements in patient safety through its core functions: to support the framing of policy on patient safety and the use of good practices; to enable Member States to assess progress towards patient safety; and to undertake global reporting, research, and “solution” development.

45. The alliance should encourage concerted action from a range of sectors, with an initial target of adequate representation from all WHO regions and, eventually, the participation of all Member States.

E. INFANT AND YOUNG CHILD NUTRITION: BIENNIAL PROGRESS REPORT

46. Achieving the health-related goals and targets of the United Nations Millennium Declaration depends on reducing malnutrition, which is associated with 54% of the 10.8 million deaths annually among children under five. Recent Health Assemblies have urged Member States to strive for full coverage with known effective interventions.¹

47. Following endorsement of the **global strategy for infant and young child feeding** (resolution WHA55.25), WHO initiated activities in all regions to translate recommendations into action. Regional meetings were held in Harare (November 2002), Casablanca (Morocco, July 2003) and Luxembourg (November 2003), while national meetings were also organized,² by for instance UNICEF and collaborating nongovernmental organizations.³ WHO also convened a global meeting on progress in strategy implementation.⁴ Meanwhile, WHO and its partners⁵ are preparing various practical resources, for example assessment tools⁶ and guidelines.⁷

¹ See especially resolutions WHA54.2 and WHA55.25. This report is submitted in accordance with resolution WHA33.32 and Article 11.7 of the International Code of Marketing of Breast-milk Substitutes.

² In Bolivia, Botswana, Cambodia, China, Egypt, Ethiopia, Ghana and Viet Nam. Since the joint FAO/WHO International Conference on Nutrition (Rome, 1992), 146 Member States and five territories have revised and strengthened intersectoral food and nutrition policies, 100 of them having specifically integrated strategies to promote appropriate infant and young child feeding practices.

³ In Egypt, India, Malaysia, Peru and Viet Nam.

⁴ Implementing the global strategy for infant and young child feeding, Geneva, 3 to 5 February 2003 (http://www.who.int/child-adolescent-health/publications/NUTRITION/ISBN_92_4_159120_X.htm).

⁵ Including UNICEF, FAO, ILO, the LINKAGES Project, International Baby Food Action Network, La Leche League International and World Alliance for Breastfeeding Action.

⁶ *Infant and young child feeding: a tool for assessing national practices, policies and programmes*. Geneva, World Health Organization, 2003.

⁷ *Integrated Management of Childhood Illness: planning, implementing and evaluating pre-service training*. Geneva, World Health Organization, 2003; *Feeding and nutrition of infants and young children: Guidelines for the WHO European Region, with emphasis on the former Soviet countries*. Copenhagen, WHO Regional Office for Europe (European Series No. 87), 2003.

48. Despite overall improvements in exclusive breastfeeding for the first four months¹ of life from 19% in 1990 to 38% in 2002, practices fall far short of WHO's global public health recommendation: **exclusive breastfeeding for six months** followed by safe and appropriate complementary feeding with continued breastfeeding for up to two years of age or beyond (resolution WHA54.2). To support promotion of appropriate **complementary feeding**, WHO has developed guidelines² and tools to promote their use.³

49. Following the **WHO multicentre growth reference study** (1997-2003) in Brazil, Ghana, India, Norway, Oman and the United States of America, scientifically robust tools are being developed for assessing growth and nutritional status that will establish the breastfed infant as the norm. The goal is that, by 2010, most of the 99 countries currently using the National Center for Health Statistics/WHO growth reference will be using the new standards.

50. To guide **feeding in the special circumstances of HIV/AIDS**, WHO and eight other organizations in the United Nations system promote an action framework to create and sustain environments that encourage appropriate feeding for all infants while increasing interventions to reduce HIV transmission.⁴ The framework is complemented by updated guidelines and a technical review.⁵ WHO has also developed a tool for assessing feeding options, and cards to assist health workers in counselling mothers in this regard. Updated recommendations on energy and nutrient requirements of children living with HIV/AIDS are now available,⁶ while guiding principles are being developed for non-breastfed children.

51. The global strategy for infant and young child feeding calls for revitalizing the **Baby-friendly Hospital Initiative**, which is being implemented in more than 19 000 hospitals in 138 countries. WHO is disseminating a reassessment and monitoring tool⁷ and developing recommendations for supporting HIV-positive mothers in baby-friendly hospitals. The course for hospital administrators⁸ is being adapted accordingly.

¹ Although the public health recommendation of six months' exclusive breastfeeding is the preferred variable for analysis, adequate data on this basis are not yet available from national surveys. The competent authorities in more than 60 Member States – including, by end-2003, Australia, Belarus, Bosnia, Bulgaria, Czech Republic, France, Georgia, Ireland, Slovakia and the United Kingdom of Great Britain and Northern Ireland – formally recommended six months of exclusive breastfeeding.

² *Guiding principles for complementary feeding of the breastfed child*. Washington, DC, PAHO/World Health Organization, 2003.

³ *Complementary feeding: family foods for breastfed children*. Geneva, World Health Organization, 2001 (available in Bahasa Indonesia, English, Khmer, Lao and Mongolian); and *Complementary feeding counselling: a training course*. Geneva, World Health Organization, 2003.

⁴ *HIV and infant feeding: framework for priority action*. Geneva, World Health Organization, 2003.

⁵ WHO, UNICEF, UNAIDS. *HIV and infant feeding: Guidelines for decision-makers; A guide for health care managers and supervisors*. Geneva, World Health Organization, 2003; and WHO, UNICEF, UNAIDS. *A review of HIV transmission through breastfeeding* (in press).

⁶ *Nutrient requirements of people living with HIV/AIDS: report of a technical consultation*. Geneva, World Health Organization, 2004.

⁷ WHO, UNICEF and Wellstart International. *The Baby-friendly Hospital Initiative. Monitoring and reassessment tools to sustain progress* (document WHO/NHD/99.2).

⁸ *Promoting breastfeeding in health facilities: a short course for administrators and policy-makers* (document WHO/NHD/96.3).

52. Some 165 (86%) of WHO's 192 Member States have reported at least once on action taken to give effect to the **International Code of Marketing of Breast-milk Substitutes**. Renewed emphasis on the International Code is one of the operational targets of the global strategy for infant and young child feeding¹ and part of the action framework for HIV and infant feeding.² Since the last report to the Health Assembly,³ new information is available from eight Member States: **Azerbaijan** (which prohibits all forms of corporate sponsorship of the medical profession); **Brazil** (which updated and strengthened its legislation); **India** (Amendment Bill 2003, which strengthens the Act of 1993⁴ by prohibiting promotion of products intended for feeding below two years of age); **Malaysia** (amendment of the Food Regulations 1985 prohibiting information promoting another product through any descriptive matter accompanying infant formula); **Micronesia** and **Palau** (which are drafting or awaiting approval of national measures); **Niue** (which has included the Code as part of national health policy); and **Pakistan** (Ordinance on Breastfeeding Protection and Child Nutrition (26 October 2002), which covers all products intended for feeding during the first year of life).⁵ WHO has responded to requests for technical support from Australia, Bahrain, Cambodia, New Zealand and Turkey. In November 2003, WHO, UNICEF and the International Baby Food Action Network jointly organized training on implementation of the Code for Member States of the Region of the Americas. In April 2002, the International Pediatric Association reaffirmed to the Director-General its support for the International Code and subsequent relevant Health Assembly resolutions.

F. INTELLECTUAL PROPERTY RIGHTS, INNOVATION, AND PUBLIC HEALTH

53. In resolution WHA56.27 on intellectual property rights, innovation and public health, the Health Assembly requested the Director-General to take a number of steps in this area, in summary:

- to support Member States in the transfer of technology for relevant medicines
- to set up a time-limited body to produce an analysis of intellectual property rights, innovation and public health and to submit a progress report to the Fifty-seventh World Health Assembly
- to cooperate with Member States, at their request, and with international organizations in analysing the health implications of relevant international agreements
- to encourage biomedical and behavioural research by developed countries including, where possible, developing country partners.

¹ The strategy "includes as a priority for all governments ... to consider what new legislation or other suitable measures may be required, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code ... and to subsequent relevant Health Assembly resolutions" (*Global strategy for infant and young child feeding*. Geneva, World Health Organization, 2003, paragraph 33).

² *HIV and infant feeding: framework for priority action*. Geneva, World Health Organization, 2003.

³ Document A55/14.

⁴ *International Digest of Health Legislation*, 1993: 44:638.

⁵ *International Digest of Health Legislation*, <http://www.who.int/idhl/> (Pak. 02.003).

54. The Executive Board at its 113th session (January 2004) was informed of the terms of reference for the time-limited body and the criteria for selection of members.¹ The terms of reference are set out below:

In the light of resolution WHA56.27 and in its examination of intellectual property rights, innovation and public health, the Commission will:

- *summarize the existing evidence on the prevalence of diseases of public health importance with an emphasis on those that particularly affect poor people and their social and economic impact*
- *review the volume and distribution of existing research, development and innovation efforts directed at these diseases*
- *consider the importance and effectiveness of intellectual property regimes and other incentive and funding mechanisms in stimulating research and the creation of new medicines and other products against these diseases*
- *analyse proposals for improvements to the current incentive and funding regimes, including intellectual property rights, designed to stimulate the creation of new medicines and other products, and facilitate access to them*
- *produce concrete proposals for action by national and international stakeholders.*

55. On 12 February 2004, the Director-General announced the membership of the Commission on Intellectual Property Rights, Innovation and Public Health, which is as follows:

Chairman:	Ms Ruth Dreifuss, President, Swiss Confederation, 1999 (Switzerland)
Vice-Chairman:	Dr Ragunath Anand Mashelkar, Director-General, Council of Scientific and Industrial Research (India)
Members:	Professor Carlos Correa (Argentina) Professor Mahmoud Fathalla (Egypt) Dr Maria Freire (United States of America) Professor Trevor Jones (United Kingdom of Great Britain and Northern Ireland) Mr Tshediso Matona (South Africa) Professor Fabio Pammolli (Italy) Professor Pakdee Pothisiri (Thailand) Professor Hiroko Yamane (Japan).

56. The Commission's first meeting will be held on 5 and 6 April 2004 in Geneva. It will, inter alia, review its mandate, terms of reference and future programme of work.

57. With respect to the other matters referred to in resolution WHA56.27, work is under way on developing the knowledge base on the implications of multilateral trade agreements for public health,

¹ Document EB113/INF.DOC./1.

including agreements on services and intellectual property rights. Training and technical support is being provided to increase capacity in WHO regions and in Member States to understand and act upon the implications of these agreements for public health. Indicators are being developed to assess information on, inter alia, implementation of the Agreement on Trade-Related Aspects of Intellectual Property Rights (including public health safeguards and flexibilities). This assessment will form the basis for framing public policy and providing technical support to countries. WHO is also implementing a research project on priority medicines, which aims to prioritize the need for pharmaceutical research on public health grounds, as the basis for allocating public-sector support to such research.

58. The UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases has undertaken several projects with the private sector geared to the development of innovative medicines for neglected diseases. The Programme is also cooperating with African investigators in drawing up a technical framework to assess natural products as potential antimalarial drugs. It has also established collaboration between public and private sectors in developed countries with those in developing countries to facilitate use and transfer of modern tools (e.g. genomics, proteomics) in order to reduce the knowledge gap in neglected diseases and to facilitate innovation by developing country scientists.

G. WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Overview of the status of the WHO Framework Convention on Tobacco Control

59. Tobacco use is increasing worldwide. In response to the globalization of the epidemic of tobacco-related disease, WHO Member States initiated negotiations on the WHO framework convention on tobacco control in October 2000. The Framework Convention on Tobacco Control – WHO's first treaty – was unanimously adopted by Member States at the Fifty-sixth World Health Assembly in May 2003.¹ In adopting the treaty, WHO and its Member States recognized that the Framework Convention is a powerful global public health tool for combating tobacco use and the ravages it causes.

60. As of 26 March 2004, 100 Member States had signed the WHO Framework Convention on Tobacco Control (see Annex 1).² With the 29 June 2004 deadline for signature approaching, WHO takes this opportunity to remind ministers of health and other Health Assembly delegates of the crucial tobacco control work that remains to be completed; delegates are urged to encourage their respective governments to sign the Framework Convention. Signature indicates a State's intention to be bound by the Convention at a later date (see Annex 2 for a model instrument granting full powers to the signatory). Ratification, acceptance, approval or formal confirmation are international acts by which

¹ Resolution WHA56.1.

² In addition, nine of these Member States had already ratified or approved the Convention.

States or regional economic integration organizations that have already signed the Framework Convention formally agree to be bound by it.¹

61. WHO encourages those Member States and regional economic integration organizations that have signed but not ratified, approved, accepted, or formally confirmed the Framework Convention, to do so as early as possible (see Annex 2 for a model ratification instrument).

62. After 29 June 2004, the WHO Framework Convention on Tobacco Control will be closed for signature. Beyond that date, Member States may still become a party to the Framework Convention by means of accession, a single-stage process equivalent to ratification. The WHO Framework Convention on Tobacco Control will enter into force on the ninetieth day following the date of deposit of the fortieth instrument of ratification, approval, acceptance, formal confirmation, or accession. Although 40 is the minimum number of ratifications for entry into force, the goal is to have the greatest possible number of Member States ratify, accept, approve, formally confirm, or accede to the Framework Convention in order to exploit the treaty's full potential as a global public health tool.

WHO's activities as interim secretariat of the Framework Convention

63. Since the adoption of the Framework Convention, WHO has supported subregional Framework Convention awareness-raising workshops aimed at providing support to Member States in their efforts to sign and ratify the treaty, and prepare for its implementation. Three workshops were held in November and December 2003 in Nairobi (for Member States of the WHO African Region in East Africa);² in Cairo (for Member States of the WHO Eastern Mediterranean Region in the Gulf);³ and in Bishkek (for Member States of the WHO European Region in Central Asia).⁴ More awareness-raising meetings are planned between March and May 2004 in Kathmandu (for Member States of the WHO South-East Asia Region that are members of the South Asian Association for Regional Cooperation and for other Member States in the Region, in Nadi, Fiji (for Member States of the WHO Western Pacific Region from the Pacific island States), and in San José (for Member States of the WHO Region of the Americas from Central America and for other Member States in the Region). National consultations on the Framework Convention with parliamentarians took place in Argentina, Brazil, the Czech Republic and Kenya.

64. WHO's web site has detailed information on the status of the Framework Convention on Tobacco Control.⁵ In addition, WHO has prepared and disseminated background material on the treaty and on national capacity-building processes to prepare countries for treaty implementation. Finally, WHO is available to respond to requests from diplomatic missions in Geneva and other government representatives regarding the Framework Convention and other technical questions related to tobacco.

¹ "Acceptance" and "approval" have the same international legal effects as ratification. Formal confirmation is the equivalent of ratification for regional economic integration organizations such as the European Community.

² The 10 participating countries were: Burundi, Comoros, Ethiopia, Kenya, Madagascar, Malawi, Rwanda, Seychelles, United Republic of Tanzania and Uganda.

³ The seven participating countries were: Bahrain, Egypt, Kuwait, Oman, Saudi Arabia, United Arab Emirates and Yemen.

⁴ The five participating countries were: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

⁵ Internet address: http://www.who.int/tobacco/fctc/signing_ceremony/country/list/en.

The next step

65. Pursuant to paragraph 7 of resolution WHA56.1, the first session of the Open-ended Intergovernmental Working Group on the Framework Convention will be convened from 21 to 25 June 2004. The Working Group is responsible for considering and preparing proposals on those issues identified in the Convention for consideration and adoption, as appropriate, by the first session of the Conference of the Parties.¹

ACTION BY THE HEALTH ASSEMBLY

66. The Health Assembly is invited to note the above progress reports.

¹ See document A/FCTC/IGWG/1/1.

G. ANNEX 1

**MEMBER STATES AND REGIONAL ECONOMIC INTEGRATION
ORGANIZATIONS THAT HAVE SIGNED AND/OR RATIFIED THE
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL
(AS OF 26 MARCH 2004)¹**

WHO African Region (23)	WHO Region of the Americas (18)	WHO Eastern Mediterranean Region (8)	WHO European Region (28 + the European Community)	WHO South- East Asia Region (8)	WHO Western Pacific Region (15)
Algeria	Argentina	Egypt	Austria	Bangladesh	Australia
Botswana	Belize	Iran (Islamic	Belgium	Bhutan	China
Burkina Faso	Bolivia	Republic of)	Bulgaria	Democratic	Fiji
Burundi	Brazil	Kuwait	Czech Republic	People's	Japan
Cape Verde	Canada	Lebanon	Denmark	Republic of	Malaysia
Central African	Chile	Qatar	European	Korea	Marshall
Republic	Costa Rica	Syrian Arab	Community	India	Islands
Comoros	Ecuador	Republic	Finland	Myanmar	Mongolia
Congo	El Salvador	Tunisia	France	Nepal	New Zealand
Côte d'Ivoire	Guatemala	Yemen	Georgia	Sri Lanka	Palau
Ethiopia	Haiti		Germany	Thailand	Philippines
Gabon	Jamaica		Greece		Republic of
Gambia	Mexico		Hungary		Korea
Ghana	Panama		Iceland		Samoa
Madagascar	Paraguay		Ireland		Singapore
Mali	Trinidad and		Israel		Tonga
Mauritius	Tobago		Italy		Viet Nam
Mozambique	Uruguay		Kyrgyzstan		
Namibia	Venezuela		Lithuania		
Senegal			Luxembourg		
Seychelles			Malta		
South Africa			Netherlands		
Uganda			Norway		
United			Portugal		
Republic of			San Marino		
Tanzania			Slovakia		
			Slovenia		
			Spain		
			Sweden		
			United		
			Kingdom of		
			Great Britain		
			and Northern		
			Ireland		

¹ The nine Member States that have already ratified or approved the Convention are highlighted in bold-face type.

G. ANNEX 2

(This instrument is to be signed by the Head of State, Head of Government or
Minister of Foreign Affairs)

LETTER OF AUTHORITY GRANTING FULL POWERS

I, [name and title of the Head of State, Head of Government or Minister of Foreign Affairs],

HEREBY AUTHORIZE [name and title] to sign subject to ratification, acceptance, or approval on behalf of the Government of [name of country], the WHO Framework Convention on Tobacco Control, which was unanimously adopted on 21 May 2003 and deposited with the Secretary-General of the United Nations on 13 June 2003.

Done at [place] on [date].

[Signature]

(To be signed by the Head of State, Head of Government, or Minister of Foreign Affairs)

INSTRUMENT OF RATIFICATION

WHEREAS the WHO Framework Convention on Tobacco Control was adopted on 21 May 2003 in Geneva, Switzerland,

AND WHEREAS the said Framework Convention on Tobacco Control has been signed on behalf of the Government of [name of country] on [date of country's signature of the Framework Convention on Tobacco Control],

NOW THEREFORE I, [name and title of the Head of State, Head of Government, or Minister of Foreign Affairs] declare that the Government of [name of country], having considered the above-mentioned Convention, ratifies the same and undertakes faithfully to perform and carry out the stipulations therein contained.

IN WITNESS THEREOF, I have signed this instrument of ratification at [place] on [date].

[Signature]

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