WHA57/2004/REC/1

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY

GENEVA, 17-22 MAY 2004

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
2004

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

PREFACE

The Fifty-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 22 May 2004, in accordance with the decision of the Executive Board at its 112th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA57/2004/REC/1

Verbatim records of plenary meetings, list of participants – document WHA57/2004/REC/2

Summary records of committees; reports of committees – document WHA57/2004/REC/3

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A57/INF.DOC./2	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report of the Ministry of Health of Israel)

A57/INF.DOC./3	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report submitted by the Permanent Observer of Palestine to the United Nations Office at Geneva)
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Mr Muhammad Nasir KHAN (Pakistan)

Vice-Presidents

Dr M.E. TSHABALALA-MSIMANG (South Africa)
Mrs A. DAVID-ANTOINE (Grenada)
Mr S. BOGOEV (Bulgaria)
Dr R. MARIA DE ARAUJO (Timor-Leste)
Dr CHUA SOI LEK (Malaysia)

Secretary

Dr LEE Jong-wook, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Austria, Belize, Canada, Djibouti, Gambia, India, Italy, Kenya, Mali, Myanmar, Papua New Guinea, and Uzbekistan.

Chairman: Dr J. LARIVIÈRE (Canada)
Vice-Chairman: Dr A. MISORE (Kenya)
Rapporteur: Dr F. CICOGNA (Italy)
Secretary: Mr T.S.R. TOPPING, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, China, Democratic Republic of the Congo, Eritrea, Estonia, France, Guyana, Israel, Mexico, Micronesia (Federated States of), Monaco, Mozambique, Nicaragua, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Dr Khandaker Mosharraf Hossain, Bangladesh (President, Fifty-sixth World Health Assembly, ex officio).

Chairman: Dr Khandaker Mosharraf HOSSAIN (Bangladesh)
Secretary: Dr LEE Jong-wook, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Botswana, Chad, Chile, China, Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America, and Yemen.

Chairman: Mr Muhammad Nasir KHAN (Pakistan)
Secretary: Dr LEE Jong-wook, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)
V**ice-Chairmen:** Dr D. SLATER (Saint Vincent and the Grenadines) and Mrs A. VAN BOLHUIS (Netherlands)
Rapporteur: Professor M. MIZANUR RAHMAN (Bangladesh)
Secretary: Dr S. HOLCK, Office of the Director-General

Committee B

Chairman: Dr Jigmi SINGAY (Bhutan)
Vice-Chairmen: Professor N.M. NALI (Central African Republic) and Dr S. AL KHARABSEH (Jordan)

Rapporteur: Mrs Z. JAKAB (Hungary)
Secretary: Dr M. KARAM, Scientist, Communicable Disease Control, Prevention and Eradication

RESOLUTIONS

WHA57.1 Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer)

The Fifty-seventh World Health Assembly,

Having considered the report on surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer);[1]

Deeply concerned about the spread of Buruli ulcer, especially among children, and its health and socioeconomic impact in poor rural communities;

Aware that early detection and treatment minimize the adverse consequences of the disease;

Noting with satisfaction the progress made by the Global Buruli Ulcer Initiative since its inception in 1998, in coordinating control and research activities among partners;

Concerned that several factors, including late detection of cases and lack of effective tools for diagnosis, treatment and prevention, impede further progress;

Mindful that achievement of two of the United Nations Millennium Development Goals, namely, to eradicate extreme poverty and hunger and to achieve universal primary education, may be hampered by the negative impact of neglected diseases of the poor, including Buruli ulcer,

1. URGES Member States in which Buruli ulcer is or threatens to become endemic:

   (1) to assess the burden of Buruli ulcer and, where necessary, establish a control programme;

   (2) to accelerate efforts to detect and treat cases at an early stage;

   (3) where feasible, to build up effective collaboration with other relevant disease-control activities;

   (4) within the context of health-system development, to establish and sustain partnerships at country level for control of Buruli ulcer;

   (5) to ensure that sufficient national resources are available to meet control needs, including access to treatment and rehabilitation services;

[1] Document A57/5.

(6) to provide training to general doctors to improve surgical skills;

(7) to provide training to all health workers in the prevention of disability;

2. ENCOURAGES all Member States:

(1) to participate in the Global Buruli Ulcer Initiative;

(2) to intensify research to develop tools to diagnose, treat and prevent the disease, and to integrate Buruli ulcer into the national disease-surveillance system;

(3) to intensify community participation in the recognition of disease symptoms;

3. CALLS UPON the international community, organizations and bodies of the United Nations system, donors, nongovernmental organizations, foundations and research institutions:

(1) to cooperate directly with countries in which the disease is endemic in order to strengthen control and research activities;

(2) to develop partnerships and to foster collaboration with organizations and programmes involved in health-system development in order to ensure that effective interventions can reach all those in need;

(3) to provide support to the Global Buruli Ulcer Initiative;

4. REQUESTS the Director-General:

(1) to continue to provide technical support to the Global Buruli Ulcer Initiative, in order particularly to advance understanding of the disease burden and to improve early access to diagnosis and treatment by general strengthening of health infrastructure;

(2) to foster technical cooperation among countries as a means of strengthening surveillance, control and rehabilitation services;

(3) to promote research on better diagnostic, treatment and preventive tools through coordination by, and support from, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.

(Seventh plenary meeting, 21 May 2004 –
Committee A, first report)

WHA57.2 Control of human African trypanosomiasis

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA50.36 and WHA56.7;

Having considered the report on human African trypanosomiasis;[1]

Deeply concerned by the resurgence of African trypanosomiasis and its devastating effect on human and livestock populations on the African continent;

Recognizing that the human form of this disease constitutes a major public health problem because of its invariably fatal outcome in untreated cases, the frequency of permanent neurological impairments in treated cases including, especially, permanent mental and psychomotor impairments in children, and its propensity to occur in epidemics;

Further concerned by the growing problems of drug resistance and treatment failure;

Welcoming the high level of political commitment to combat human African trypanosomiasis expressed by government leaders of countries in which the disease is endemic;

Further welcoming the renewed commitment to control this disease expressed in recent initiatives and public-private partnerships, which have greatly relieved the problem of inadequate access to existing drugs;

Noting that, although great strides are being made in controlling this disease, better control tools, including safer and more effective drugs and simplified diagnostic tests, are badly needed,

1. URGES Member States:

(1) to continue to give high priority to the control of human African trypanosomiasis;

(2) in endemic areas, to increase human resources and dedicated financing, drawing as appropriate on funds previously used for the purchase of drugs; and to strengthen case detection, diagnosis and treatment, and the infrastructure for doing so;

2. REQUESTS the Director-General:

(1) to continue to refine control strategies so as to make maximum use of national and international resources and to prevent further epidemic spread;

(2) to promote among the various sectors and agencies concerned an integrated approach that takes into account the importance of vector control and of control of disease in livestock;

(3) to continue to collaborate closely with all partners concerned, notably through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases on research to develop safer and more effective drugs and simplified tests for trypanosomal detection;

(4) to keep the Health Assembly informed of progress in the first year of each biennium.

(Seventh plenary meeting, 21 May 2004 –
Committee A, first report)

[1] Document A57/6.

WHA57.3 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

The Fifty-seventh World Health Assembly,

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

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

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

Expressing its concern at the deterioration of health conditions and the humanitarian crises resulting from military activities which caused severe restrictions on the movement of Palestinian people and goods, including restrictions on the movement to and from Palestinian territories, particularly of ambulances, health workers, the wounded and sick;

Expressing its concern at the continued use of excessive force by the Israeli military forces which resulted in the killing and injuring of thousands of Palestinians, including children;

Expressing its concern at the serious deterioration of the economic and health situation resulting from closures and curfews imposed on the Palestinians by the Israeli occupying forces, which together with the withholding of Palestinian tax revenues, has resulted in unprecedented levels of unemployment, with implications for poverty, food insecurity and nutritional vulnerability; and at reports of malnutrition among children, and evidence of endemic anaemia among nursing mothers;

Expressing its concern at the widespread destruction of civilian infrastructure during Israeli military incursions, and particularly at the continued construction by Israel of a “security fence”, which is not being built on or near the 1967 borders, and which produces humanitarian and economic hardship for the Palestinians, and prevents access to hospitals and to health care;

Expressing its concern at the grave violations of international humanitarian law by the Israeli occupation authorities in the occupied Arab territories, including the unlawful arrest of thousands of Palestinian civilians, among whom hundreds of children locked up in Israeli jails, some of whom detained without charge and others sick, without receiving medical care;

Affirming that the targeting of civilian populations by any party, in particular extrajudicial executions, is another violation of international humanitarian law;

Affirming that the ongoing violence, closures and curfews and the continuing occupation of the Palestinian territories are among the main causes of acute psychological distress and emotional problems among Palestinian children and adults, including psychosomatic problems, rejection of authority, risk-taking behaviour, decreasing hope in the future, and those stemming from the general atmosphere of hopelessness and frustration;

Affirming the right of Palestinian patients and medical staff to be able to benefit from the health facilities available in the Palestinian health institutions in occupied east Jerusalem,

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[1] Document A57/30.

1. CALLS upon Israel, the occupying power, to halt immediately all its practices, policies and plans which seriously affect the health conditions of civilians under occupation, particularly its excessive use of force and military actions against Palestinian civilians;

2. EXPRESSES gratitude to all Member States, and intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people;

3. EXTENDS its thanks and appreciation to the Director-General for his efforts to provide necessary assistance to the Palestinian people, the rest of the Arab population in the occupied Arab territories, and other peoples of the region;

4. REQUESTS the Director-General:

(1) to dispatch as soon as possible to the occupied Arab territories, including Palestine, a fact-finding committee on the deterioration of the health and economic situation resulting from both the current crises and erection of the "security fence" in the occupied Palestinian territories;

(2) to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health and other medical service-providers in their efforts to overcome the current difficulties, in particular so as to guarantee the free movement of all health personnel and patients and the normal provision of medical supplies to Palestinian medical premises;

(3) to take steps, in cooperation with Member States, to ensure the free movement of goods, workers and people in order to allow trading, farming and other forms of economic activity inside the occupied Palestinian territories and the access by the population in general to basic services;

(4) to continue providing necessary technical assistance to meet needs arising from the current crises, including health problems resulting from erection of the "security fence";

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

(6) to take urgent action to implement the joint Ministry of Health/WHO strategy for mental health;

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

(Seventh plenary meeting, 21 May 2004 –
Committee B, first report)

WHA57.4 Financial report on the accounts of WHO for 2002-2003; report of the External Auditor and comments thereon made on behalf of the Executive Board

The Fifty-seventh World Health Assembly,

Having examined the Financial report and audited financial statements for the period 1 January 2002 – 31 December 2003 and the Report of the External Auditor to the World Health Assembly;[1]

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

ACCEPTS the Director-General's Financial report and audited financial statements for the period 1 January 2002 – 31 December 2003 and the Report of the External Auditor to the World Health Assembly.

(Eighth plenary meeting, 22 May 2004 –
Committee B, second report)

WHA57.5 Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Fifty-seventh World Health Assembly,

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

Noting that, at the time of opening of the Fifty-seventh World Health Assembly, the voting rights of Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Chad, Comoros, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kyrgyzstan, Liberia, Nauru, Niger, Republic of Moldova, Somalia, Suriname, Tajikistan and Turkmenistan remained suspended, such suspension to continue until the arrears of the Member State concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Solomon Islands and Uruguay were in arrears at the time of the opening of the Fifty-seventh World Health Assembly to such an extent that it is necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of these countries should be suspended at the opening of the Fifty-eighth World Health Assembly;

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

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[1] Documents A57/20 and A57/20 Add.1.

[2] Document A57/21.

[3] Document A57/22.

DECIDES:

(1) that, in accordance with the statement of principles in resolution WHA41.7, if, by the time of the opening of the Fifty-eighth World Health Assembly, Solomon Islands is still in arrears in the payment of its contributions to an extent that would justify invoking Article 7 of the Constitution, its voting privileges shall be suspended as from the said opening;

(2) that any suspension which takes effect as aforesaid shall continue at the Fifty-eighth and subsequent Health Assemblies until the arrears of Solomon Islands have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

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

(Eighth plenary meeting, 22 May 2004 –
Committee B, third report)

WHA57.6 Arrears in payment of contributions: Ukraine

The Fifty-seventh World Health Assembly,

Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, with respect to the request of Ukraine for the settlement of its outstanding contributions,[1]

1. DECIDES to restore the voting privileges of Ukraine at the Fifty-seventh World Health Assembly on the following conditions:

(1) Ukraine shall pay its outstanding arrears of assessed contributions, totalling US$ 36 163 544, over 15 years, subject to payment of at least half the total amount of arrears, i.e. US$ 18 081 772, by the end of 2011;

(2) Ukraine shall make a minimum payment of US$ 1 500 000 per annum, which shall be applied first, against its current-year assessment, second, against the eight annual instalments of US$ 342 848 each, due under resolution WHA45.23, and third, against the balance of its arrears;

2. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if Ukraine does not meet the requirements stipulated in paragraph 1 above;

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

[1] Document A57/22.

4. REQUESTS the Director-General to communicate this resolution to the Government of Ukraine.

(Eighth plenary meeting, 22 May 2004 –
Committee B, third report)

WHA57.7 Agreement with the *Office International des Epizooties*

The Fifty-seventh World Health Assembly,

Having considered the report on the agreement between WHO and the *Office International des Epizooties*;[1]

Considering Article 70 of the Constitution of WHO,

APPROVES the agreement between the World Health Organization and the *Office International des Epizooties*, subject to the replacement of "Member Countries" by "Members" whenever this term appears.

(Eighth plenary meeting, 22 May 2004 –
Committee B, fourth report)

WHA57.8 Rules of Procedure of the World Health Assembly: amendment to Rule 72

The Fifty-seventh World Health Assembly,

Recalling resolution WHA33.17 on the study of WHO's structure in the light of its functions and resolution WHA54.22 on the reform of the Executive Board;

Having considered resolution EB112.R1,

1. DECIDES to replace the existing text of Rule 72 of its Rules of Procedure with the following text:

Rule 72

> Decisions by the Health Assembly on important questions shall be made by a two thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and with intergovernmental organizations and agencies in accordance with Articles 69, 70 and 72 of the Constitution; amendments to the Constitution; appointment of the Director-General; decisions on the amount of the effective working budget; and decisions to suspend the voting privileges and services of a Member under Article 7 of the Constitution.

[1] See Annex 1.

2. RESOLVES that in the *Basic documents*, in accordance with the generally accepted rules of interpretation, the use of one gender shall be considered as including a reference to the other unless the context otherwise requires.

(Eighth plenary meeting, 22 May 2004 –
Committee B, fourth report)

WHA57.9 Eradication of dracunculiasis

The Fifty-seventh World Health Assembly,

Having considered the report on eradication of dracunculiasis;[1]

Noting with satisfaction the excellent results achieved by the endemic countries in decreasing the number of dracunculiasis cases from an estimated 3.5 million in 1986 to 32 000 reported cases in 2003;

Noting also that only 12 countries are endemic, all in sub-Saharan Africa,

1. CONGRATULATES Member States, the Organization and partner bodies, particularly UNICEF and The Carter Center, for increasing the availability of safe and potable water, improving surveillance for case detection, strengthening interventions and expanding public awareness of the disease;

2. CONGRATULATES the 168 countries and territories that have been certified free of dracunculiasis transmission since the International Commission for the Certification of Dracunculiasis Eradication was established in 1995;

3. RECALLS that ministers of health from the remaining endemic countries signed, at the time of the Fifty-seventh World Health Assembly, the Geneva Declaration for the Eradication of Dracunculiasis by 2009;

4. URGES the remaining endemic countries to intensify their eradication efforts, including active surveillance and prevention measures;

5. URGES Member States, the Organization, UNICEF, The Carter Center and other appropriate entities to capitalize on current successes and opportunities by continuing their commitment, collaboration and cooperation, to ensure political support at the highest level and to assure that the much-needed resources are mobilized for the completion of eradication by 2009;

6. RECOMMENDS the Director-General to provide support for mobilization of adequate resources required for the eradication of dracunculiasis through the last steps of the programme and for its verification and certification activities for a world free of dracunculiasis.

(Eighth plenary meeting, 22 May 2004 –
Committee B, fourth report)

[1] Document A57/33.

WHA57.10 Road safety and health

The Fifty-seventh World Health Assembly,

Recalling resolution WHA27.59 (1974), which noted that road traffic accidents caused extensive and serious public health problems, that coordinated international efforts were required, and that WHO should provide leadership to Member States;

Having considered the report on road safety and health;[1]

Welcoming United Nations General Assembly resolution 58/9 on the global road-safety crisis;

Noting with appreciation the adoption of resolution 58/289 by the United Nations General Assembly inviting WHO to act as a coordinator on road safety issues within the United Nations system, working in close cooperation with the United Nations regional commissions;

Recognizing the tremendous global burden of mortality resulting from road traffic crashes, 90% of which occur in low- and middle-income countries;

Acknowledging that every road user must take the responsibility to travel safely and respect traffic laws and regulations;

Recognizing that road traffic injuries constitute a major but neglected public health problem that has significant consequences in terms of mortality and morbidity and considerable social and economic costs, and that in the absence of urgent action this problem is expected to worsen;

Further recognizing that a multisectoral approach is required successfully to address this problem, and that evidence-based interventions exist for reducing the impact of road traffic injuries;

Noting the large number of activities on the occasion of World Health Day 2004, in particular, the launch of the first world report on traffic injury prevention,[2]

1. CONSIDERS that the public health sector and other sectors – government and civil society alike – should actively participate in programmes for the prevention of road traffic injury through injury surveillance and data collection, research on risk factors of road traffic injuries, implementation and evaluation of interventions for reducing road traffic injuries, provision of prehospital and trauma care and mental-health support for traffic-injury victims, and advocacy for prevention of road traffic injuries;

2. URGES Member States, particularly those which bear a large proportion of the burden of road traffic injuries, to mobilize their public-health sector by appointing focal points for prevention and mitigation of the adverse consequences of road crashes, who would coordinate the public-health response in terms of epidemiology, prevention and advocacy, and liaise with other sectors;

3. ACCEPTS the invitation of the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close cooperation with the United Nations regional commissions;

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[1] Document A57/10.

[2] *World report on road traffic injury prevention.* Geneva, World Health Organization, 2004.

4. RECOMMENDS Member States:

(1) to integrate prevention of traffic injuries into public health programmes;

(2) to assess the national situation concerning the burden of road traffic injury, and to assure that the resources available are commensurate with the extent of the problem;

(3) if they have not yet done so, to prepare and implement a national strategy on prevention of road traffic injury and appropriate action plans;

(4) to establish government leadership in road safety, including by designating a single agency or focal point for road safety or through another effective mechanism according to the national context;

(5) to facilitate multisectoral collaboration between different ministries and sectors, including private transportation companies, communities and civil society;

(6) to strengthen emergency and rehabilitation services;

(7) to raise awareness about risk factors, in particular the effects of alcohol abuse, psychoactive drugs and the use of mobile phones while driving;

(8) to take specific measures to prevent and control mortality and morbidity due to road traffic crashes, and to evaluate the impact of such measures;

(9) to enforce existing traffic laws and regulations, and to work with schools, employers and other organizations to promote road-safety education to drivers and pedestrians alike;

(10) to use the forthcoming world report on prevention of road traffic injuries as a tool to plan and implement appropriate prevention strategies;

(11) to ensure that ministries of health are involved in the framing of policy on the prevention of road traffic injuries;

(12) especially developing countries, to legislate and strictly enforce wearing of crash helmets by motorcyclists and pillion riders, and to make mandatory both provision of seat belts by automobile manufacturers and wearing of seat belts by drivers;

(13) explore the possibilities to increase financing for road safety, including through the creation of a fund;

5. REQUESTS the Director-General:

(1) to collaborate with Member States in establishing science-based public health policies and programmes for implementation of measures to prevent road traffic injuries and mitigate their consequences;

(2) to encourage research to support evidence-based approaches for prevention of road traffic injuries and mitigation of their consequences;

(3) to facilitate the adaptation of effective measures to prevent traffic injury that can be applied in local communities;

(4) to provide technical support for strengthening systems of prehospital and trauma care for victims of road traffic crashes;

(5) to collaborate with Member States, organizations of the United Nations system, and nongovernmental organizations in order to develop capacity for injury prevention;

(6) to maintain and strengthen efforts to raise awareness of the magnitude and prevention of road traffic injuries;

(7) to organize regular meetings of experts to exchange information and build capacity;

(8) to report on progress made in promotion of road safety and traffic-injury prevention in Member States to the Sixtieth World Health Assembly.

(Eighth plenary meeting, 22 May 2004 –
Committee A, second report)

WHA57.11 Family and health in the context of the tenth anniversary of the International Year of the Family

The Fifty-seventh World Health Assembly,

Having considered the report on family health in the context of the tenth anniversary of the International Year of the Family;[1]

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

Recognizing and promoting the equal rights of men and women and emphasizing that equality between women and men and respect for the rights of all family members are essential to family well-being and to society at large;

Recalling also the commitments, goals, and outcomes of United Nations conferences and summits that address health issues related to family members, individuals, and communities;

Recalling further that relevant United Nations instruments on human rights and relevant global plans and programmes of action call for the widest possible protection and assistance to be accorded to the family, bearing in mind that, in different cultural, political and social systems, various forms of the family exist;

Also recognizing that parents, families, legal guardians and other caregivers have the primary role and responsibility for the well-being of children, and must be supported in the performance of their child-rearing responsibilities; and that in all actions related to children, the best interests of the child shall be a primary consideration;

Further recognizing that cultural norms, socioeconomic conditions, gender equality and education are significant determinants of health;

[1] Document A57/12.

Acknowledging that strong and supportive families and social networks have a positive impact on the health of all family members, whereas inadequate access to health care, child abuse, neglect, and violence in all its forms, especially spousal and domestic violence, alcohol and substance abuse, neglect of older persons and persons with disabilities and the potential effects of prolonged periods of separation, such as those resulting from migration, are a significant concern;

Noting with concern the devastating effects of the HIV/AIDS pandemic on families, family members, individuals and communities, especially in families headed by children and older persons;

Noting that the tenth anniversary of the International Year of the Family is being observed in 2004,

1. URGES Member States:

(1) to assess government policies with a view to assisting families to provide a supportive environment for all their members;

(2) to ensure the availability of appropriate legal, social and physical infrastructures to support mothers and fathers, families, legal guardians and other caregivers, particularly older women and men, to strengthen their capability to provide care, nurturing and protection in the best interest of every child in their care, the views of the child being given due weight in accordance with the age and maturity of the child;

(3) to take measures to ensure that gender-sensitive health policies, plans and programmes recognize and address the rights and comprehensive health and development needs of each family member, with special attention to families at risk of being unable to meet the basic needs of their members, such as those families in which child abuse, violence in general, domestic violence or neglect, including members with disability and older persons, occur;

(4) to develop, use, and maintain systems to provide data, disaggregated by sex, age and other determinants of health, to underpin the planning, implementation, monitoring and evaluation of evidence-based health interventions relevant to all family members;

(5) to develop or strengthen alliances and partnerships with all relevant governmental and nongovernmental partners to assist families to meet the health and development needs of all their members;

(6) to strengthen national actions to ensure sufficient resources to fulfil the international commitments, goals and outcomes of relevant United Nations conferences and summits related to the health of family members;

(7) to fulfil their obligations under international instruments relevant to family and health development, such as the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, as specified in resolution WHA46.27 on the International Year of the Family;

2. REQUESTS the Director-General:

(1) to raise awareness of health issues relevant to families, family members, individuals and the community and to support Member States in increasing their efforts to strengthen health policies on these issues;

(2) to support Member States, upon request, in developing, using, and maintaining systems to provide data, disaggregated by sex, age and other determinants of health, that underpin the planning, implementation, monitoring and evaluation of evidence-based health interventions relevant to families and their members;

(3) to support Member States in their efforts to establish or strengthen programmes on parenting through relevant research and international forums for sharing country experiences;

(4) to support Member States in their efforts to fulfil their commitments to the goals and outcomes of relevant United Nations conferences and summits related to the health of family members, in collaboration with relevant partners;

(5) to pay due attention to the care and support issues related to the health of family members, including men and the elderly, in relevant policies and programmes of the Organization, and to ensure that initiatives focusing on family and health take into account the role of schools in educating children, especially girls;

(6) to work closely with the United Nations Department of Economic and Social Affairs and other relevant organizations of the United Nations system, such as UNICEF and UNFPA, on issues related to families and their members by sharing experiences and findings;

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

(Eighth plenary meeting, 22 May 2004 –
Committee A, second report)

WHA57.12 Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets

The Fifty-seventh World Health Assembly,

Having considered the draft strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;[1]

Recalling and recognizing the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and key actions for the further implementation of the Programme of Action of the International Conference on Population and Development adopted by the twenty-first special session of the United Nations General Assembly in July 1999;

Recalling and recognizing further the Beijing Platform for Action (Beijing, 1995) and the further actions and initiatives to implement the Beijing Declaration and the Platform for Action adopted at the twenty-third special session of the United Nations General Assembly in June 2000;

Reaffirming the development goals as contained in the Millennium Declaration adopted by the United Nations General Assembly at its fifty-fifth session in September 2000,[2] and in the Road Map

[1] See Annex 2.

[2] United Nations General Assembly resolution 55/2.

towards the implementation of the United Nations Millennium Declaration,[1] and other international development goals and targets;

Recognizing that attainment of the development goals of the United Nations Millennium Declaration and other international goals and targets require, as a priority, strong investment and political commitment in reproductive and sexual health;

Recalling that resolution WHA55.19 requested the Director-General, inter alia, to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health,

1. ENDORSES the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;

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

(1) to adopt and implement the strategy as part of national efforts to achieve the development goals of the United Nations Millennium Declaration and other international development goals and targets, and to mobilize political will and financial resources for that purpose;

(2) to make reproductive and sexual health an integral part of national planning and budgeting;

(3) to strengthen the capacity of health systems with the participation of community and nongovernmental groups in order to achieve universal access to sexual and reproductive health care, with particular attention to maternal and neonatal health in all countries;

(4) to monitor implementation of the strategy to ensure that it benefits the poor and other marginalized groups, including adolescents and men, and that it strengthens reproductive and sexual health care and programmes at all levels;

(5) to ensure that all aspects of reproductive and sexual health including, inter alia, adolescent reproductive health and maternal and neonatal health, are included within national monitoring and reporting of progress towards attainment of the development goals of the United Nations Millennium Declaration;

3. REQUESTS the Director-General:

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

(2) to devote sufficient organizational priority, commitment and resources to supporting effective promotion and implementation of the strategy and the “necessary actions” that it highlights;

(3) to provide support to Member States in ensuring security in reproductive-health commodities;

[1] Document A/56/326.

(4) to give particular attention to maternal and neonatal health in WHO's first progress report on reproductive and sexual health in 2005, as part of its contribution to the Secretary-General's report to the United Nations General Assembly on progress towards attainment of the development goals of the United Nations Millennium Declaration;

(5) to provide regular (at least biennial) progress reports on implementation of the strategy to the Health Assembly, through the Executive Board.

(Eighth plenary meeting, 22 May 2004 –
Committee A, second report)

WHA57.13 Genomics and world health

The Fifty-seventh World Health Assembly,

Having considered the report on genomics and world health;[1]

Acknowledging the remarkable progress in genomics research and the fact that many Member States are not well prepared for this new approach to medical research and practice;

Wishing to promote the potential benefits of the genomics revolution for the health of populations in developed and developing countries alike;

Aware that genomics raises concerns about safety and has complicated and new ethical, legal, social and economic implications;

Reaffirming that advances in genomics must be considered in the context of their value added in the practice and delivery of health care;

Recognizing the urgent need for research into, and applications of, genomics in order to promote benefits that accrue to human beings;

Recognizing that genomics has a significant contribution to make in the area of public health;

Convinced that it is time for governments, the scientific community, civil society, the private sector and the international community to pledge their commitment to ensuring that the advances of genomics are equitably shared by all,

1. TAKES NOTE of the recommendations contained in the report of the Advisory Committee on Health Research on genomics and world health;[2]

2. ADOPTS, for the purposes of the present resolution and all subsequent activities of WHO, the following definition of genomics: genomics is the study of genes and their functions, and related techniques;

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[1] Document A57/16.

[2] *Genomics and world health: report of the Advisory Committee on Health Research.* Geneva, World Health Organization, 2002.

3. URGES Member States to consider adopting the said recommendations and to mobilize all concerned scientific, social, political and economic parties in order:

(1) to frame national genomic policies and strategies, and to set up mechanisms for assessing relevant technologies, cost-effectiveness, ethical review structures, legal, social and economic implications, regulatory systems particularly with regard to safety, and the need for public awareness;

(2) to strengthen existing, or establish new, centres and institutions engaged in genomics research with a view to strengthening national capacity and accelerating the ethical application of the advances in genomics relevant to countries' health problems;

4. CALLS UPON Member States to facilitate greater collaboration among the private sector, the scientific community, civil society, and other relevant stakeholders in particular within the United Nations system, and engagement in dialogue in order to find creative and equitable ways of mobilizing more resources for genomics research targeted at the health needs of developing countries and building capacity in such areas as bioethics and bioinformatics;

5. REQUESTS the Director-General:

(1) to provide support to Member States for framing national policies and strategies and strengthening capacity so that they can benefit from the advances in genomics relevant to their health problems and regulatory systems, particularly with regard to safety and the need for public awareness;

(2) to promote WHO's role in collaboration with relevant United Nations bodies in convening regional and international forums and fostering partnerships among the main stakeholders in order to mobilize resources, contribute to building capacity, and find innovative solutions to issues associated with advances in genomics research;

(3) to facilitate exchange between developed and developing countries in the use and application of genomic technologies in order to tackle both local and region-specific problems through, for example, training and technical support activities.

(Eighth plenary meeting, 22 May 2004 –
Committee A, second report)

WHA57.14 Scaling up treatment and care within a coordinated and comprehensive reponse to HIV/AIDS

The Fifty-seventh World Health Assembly,

Having considered the report on HIV/AIDS;[1]

Noting with great concern that by the end of 2003 about 40 million people were living with HIV/AIDS, the pandemic had claimed an estimated three million lives in 2003, and that HIV/AIDS affects women and children with particular severity;

[1] Document A57/4.

Also concerned that, although about six million people in developing countries need antiretroviral treatment, only 440 000 currently receive it;

Noting with concern that other health conditions also cause high morbidity and mortality in developing countries;

Acknowledging that antiretroviral therapy has reduced mortality and prolonged healthy lives and that the feasibility of delivering antiretroviral treatment has been demonstrated in several resource-constrained settings;

Recognizing that treatment and access to medication for those infected and affected by HIV/AIDS, as well as prevention, care and support are inseparable elements of a comprehensive health-sector response at national level, and require adequate financial support from States and other donors;

Recognizing that social stigmatization, discrimination, lack of affordability of antiretroviral medicines, economic constraints, limitations in health-care capacity and human resources are some of the major impediments to access to treatment and care and social support for people living with HIV/AIDS;

Also recognizing the need to further reduce the costs of antiretroviral medicines;

Recalling the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly special session on HIV/AIDS (27 June 2001), which acknowledges that prevention of HIV infection must be the mainstay of national, regional and international responses to the epidemic and calls for significant progress, by 2005, in implementing comprehensive care strategies, including for access to antiretroviral drugs;

Recalling also resolution WHA55.12 on the contribution of WHO to the follow-up of the United Nations General Assembly special session on HIV/AIDS, resolution WHA55.14 on ensuring accessibility of essential medicines, resolution WHA56.27 on intellectual property rights, innovation and public health, and resolution WHA56.30 on the global health-sector strategy for HIV/AIDS;

Recalling and recognizing the Programme of Action adopted at the International Conference on Population and Development (Cairo, 1994), commitments made at the World Summit for Social Development (Copenhagen, 1995) and the World Summit for Children (New York, 1990), the Beijing Declaration and Platform for Action (1995), the Declaration on the Elimination of Violence against Women (1993), and the Millennium Declaration (2000), their recommendations and respective follow-ups and reports;

Noting with satisfaction the agreement of 25 April 2004 among development partners to improve coordination and harmonization in the response to HIV/AIDS at country level, through the "Three Ones" principle, namely, one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system;

Recognizing the central role of the health sector in the response to HIV/AIDS and the need to strengthen health systems and development of human capacity so that countries and communities may contribute fully to realization of the global targets set out in the Declaration of Commitment on HIV/AIDS, and to develop public health systems with a view to minimizing the emergence of drug resistance;

Underlining the importance of WHO's work, including through the WHO-initiated procurement, quality and sourcing project, to facilitate access of developing countries to safe, effective and affordable antiretroviral drugs and diagnostics at the best price;

Recalling the Declaration on the TRIPS Agreement and Public Health adopted at the WTO Ministerial Conference (Doha, 2001), and welcoming the decision taken by the General Council of WTO on 30 August 2003 on implementation of paragraph 6 of that Declaration;[1]

Acknowledging WHO's special role within the United Nations system to combat and mitigate the effects of HIV/AIDS, its responsibility in the follow-up of the Declaration of Commitment on HIV/AIDS and, as a cosponsor of UNAIDS, in leading United Nations efforts in relation to treatment and care for HIV/AIDS and playing a strong role in prevention;

Welcoming the progress made by many Member States in beginning to scale up treatment for HIV/AIDS in their countries;

Welcoming also the increased support of Member States for programmes to combat HIV/AIDS,

1. WELCOMES the Director-General's "3 by 5" strategy to support developing countries, as part of WHO's follow-up to the comprehensive global health-sector strategy for HIV/AIDS, in securing access to antiretroviral treatment for three million people living with HIV/AIDS by the end of 2005, and notes the importance of mobilizing financial resources from States and other donors including for WHO to achieve this target;

2. URGES Member States, as a matter of priority:

(1) to establish or strengthen national health and social infrastructure and health systems, with the assistance of the international community as necessary, in order to assure their capacity to deliver effectively HIV/AIDS prevention, treatment, care and support services;

(2) to strengthen national planning, monitoring and evaluation systems in order to deliver HIV/AIDS prevention, treatment, care and support services within the context of the overall national health strategy, ensuring an appropriate balance between services for HIV/AIDS and all other essential health services;

(3) to pursue policies and practices that promote:

(a) sufficient and adequately trained human resources with the appropriate mix of skills to trigger a scaled-up response;

(b) human rights, equity, and gender equality in access to treatment and care;

(c) affordability and availability, in sufficient quantities, of pharmaceutical products of good quality, including antiretroviral medicines and medical technologies used to treat, diagnose and manage HIV/AIDS;

(d) accessible and affordable treatment, testing and counselling with informed consent, prevention and care services for all, without discrimination, including the most vulnerable or socially disadvantaged groups of the population;

[1] Document WT/L/540, available at http://docsonline.wto.org.

(e) good quality and scientific and medical appropriateness of pharmaceutical products or medical technologies for treatment and management of HIV/AIDS, irrespective of their sources and countries of origin, inter alia by making the best use of WHO's list of prequalified drugs that meet international quality standards;

(f) further investments in medicines, including microbicides, diagnostics and vaccine research, in social science and health systems research, and in traditional medicines and possible interactions with other medicines, in order to improve effectiveness of interventions;

(g) development of health systems designed to promote access to antiretroviral medicines and to facilitate adherence to treatment regimens with a view to minimizing drug resistance and protecting patients against counterfeit medicines;

(h) integration of nutrition into a comprehensive response to HIV/AIDS;

(i) promotion of breastfeeding in the light of the United Nations system's Framework for Priority Action on HIV and Infant Feeding and WHO/UNICEF's guidelines for policy-makers and health-care managers;

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

(5) to apply the "Three Ones" principle with a view to improving coordination and harmonization in the response to HIV/AIDS;

(6) to take into account in bilateral trade agreements the flexibilities contained in the Agreement on Trade-related Aspects of Intellectual Property Rights and recognized by the Declaration on the TRIPS Agreement and Public Health adopted by the WTO Ministerial Conference (Doha, 2001);

3. REQUESTS the Director-General:

(1) to strengthen the key role of WHO in providing technical leadership, direction and support to health systems' response to HIV/AIDS, within the United Nations system-wide response, as a cosponsor of UNAIDS;

(2) to take action within the framework of the "Three Ones" principle:

(a) to provide support to countries in order to maximize opportunities for the delivery of all relevant interventions for prevention, care, support and treatment of HIV/AIDS and related conditions, including tuberculosis;

(b) to support, mobilize and facilitate efforts of developing countries to scale up antiretroviral treatment in a manner that focuses on poverty, gender equality, and the most vulnerable groups, within the context of strengthening national health systems while maintaining a proper balance of investment between prevention, care and treatment;

(c) to provide guidance on accelerating prevention in the context of scaled-up treatment, in line with the global health-sector strategy for HIV/AIDS;

(3) to take measures to improve access of developing countries to pharmaceutical and diagnostic products to diagnose, treat and manage HIV/AIDS, including by strengthening WHO's prequalification project;

(4) to ensure that the prequalification review process and the results of inspection and assessment reports of the listed products, aside from proprietary and confidential information, are made publicly available;

(5) to provide support to developing countries in improving management of the supply chain and procurement of good-quality AIDS medicines and diagnostics;

(6) to provide support to countries for embedding the scaling-up of the response to HIV/AIDS into a broad effort to strengthen national health systems, with special reference to human-resources development, health infrastructure, health-system financing and health information;

(7) to report on progress in implementation of this resolution to the Fifty-eighth World Health Assembly, through the Executive Board.

(Eighth plenary meeting, 22 May 2004 –
Committee A, second report)

WHA57.15 Scale of assessments for 2005

The Fifty-seventh World Health Assembly,

Having considered the report of the Director-General,[1]

1. DECIDES to adopt a revised scale of assessments for 2005, reflecting the latest available United Nations scale as shown below:

Members and Associate Members	Revised WHO scale for 2005
	%
Afghanistan	0.00200
Albania	0.00500
Algeria	0.07600
Andorra	0.00500
Angola	0.00100
Antigua and Barbuda	0.00300
Argentina	0.95600
Armenia	0.00200
Australia	1.59200
Austria	0.85900
Azerbaijan	0.00500
Bahamas	0.01300
Bahrain	0.03000

[1] Document A57/23.

Members and Associate Members	Revised WHO scale for 2005 %
Bangladesh	0.01000
Barbados	0.01000
Belarus	0.01800
Belgium	1.06900
Belize	0.00100
Benin	0.00200
Bhutan	0.00100
Bolivia	0.00900
Bosnia and Herzegovina	0.00300
Botswana	0.01200
Brazil	1.52300
Brunei Darussalam	0.03400
Bulgaria	0.01700
Burkina Faso	0.00200
Burundi	0.00100
Cambodia	0.00200
Cameroon	0.00800
Canada	2.81300
Cape Verde	0.00100
Central African Republic	0.00100
Chad	0.00100
Chile	0.22300
China	2.05300
Colombia	0.15500
Comoros	0.00100
Congo	0.00100
Cook Islands	0.00100
Costa Rica	0.03000
Côte d'Ivoire	0.01000
Croatia	0.03700
Cuba	0.04300
Cyprus	0.03900
Czech Republic	0.18300
Democratic People's Republic of Korea	0.01000
Democratic Republic of the Congo	0.00300
Denmark	0.71800
Djibouti	0.00100
Dominica	0.00100
Dominican Republic	0.03500
Ecuador	0.01900
Egypt	0.12000
El Salvador	0.02200
Equatorial Guinea	0.00200
Eritrea	0.00100
Estonia	0.01200
Ethiopia	0.00400
Fiji	0.00400
Finland	0.53300

Members and Associate Members	Revised WHO scale for 2005
	%
France	6.03010
Gabon	0.00900
Gambia	0.00100
Georgia	0.00300
Germany	8.66230
Ghana	0.00400
Greece	0.53000
Grenada	0.00100
Guatemala	0.03000
Guinea	0.00300
Guinea-Bissau	0.00100
Guyana	0.00100
Haiti	0.00300
Honduras	0.00500
Hungary	0.12600
Iceland	0.03400
India	0.42100
Indonesia	0.14200
Iran (Islamic Republic of)	0.15700
Iraq	0.01600
Ireland	0.35000
Israel	0.46700
Italy	4.88510
Jamaica	0.00800
Japan	19.46830
Jordan	0.01100
Kazakhstan	0.02500
Kenya	0.00900
Kiribati	0.00100
Kuwait	0.16200
Kyrgyzstan	0.00100
Lao People’s Democratic Republic	0.00100
Latvia	0.01500
Lebanon	0.02400
Lesotho	0.00100
Liberia	0.00100
Libyan Arab Jamahiriya	0.13200
Lithuania	0.02400
Luxembourg	0.07700
Madagascar	0.00300
Malawi	0.00100
Malaysia	0.20300
Maldives	0.00100
Mali	0.00200
Malta	0.01400
Marshall Islands	0.00100
Mauritania	0.00100
Mauritius	0.01100

Members and Associate Members	Revised WHO scale for 2005 %
Mexico	1.88300
Micronesia (Federated States of)	0.00100
Monaco	0.00300
Mongolia	0.00100
Morocco	0.04700
Mozambique	0.00100
Myanmar	0.01000
Namibia	0.00600
Nauru	0.00100
Nepal	0.00400
Netherlands	1.69000
New Zealand	0.22100
Nicaragua	0.00100
Niger	0.00100
Nigeria	0.04200
Niue	0.00100
Norway	0.67900
Oman	0.07000
Pakistan	0.05500
Palau	0.00100
Panama	0.01900
Papua New Guinea	0.00300
Paraguay	0.01200
Peru	0.09200
Philippines	0.09500
Poland	0.46100
Portugal	0.47000
Puerto Rico	0.00100
Qatar	0.06400
Republic of Korea	1.79600
Republic of Moldova	0.00100
Romania	0.06000
Russian Federation	1.10000
Rwanda	0.00100
Saint Kitts and Nevis	0.00100
Saint Lucia	0.00200
Saint Vincent and the Grenadines	0.00100
Samoa	0.00100
San Marino	0.00300
Sao Tome and Principe	0.00100
Saudi Arabia	0.71300
Senegal	0.00500
Serbia and Montenegro	0.01900
Seychelles	0.00200
Sierra Leone	0.00100
Singapore	0.38800
Slovakia	0.05100
Slovenia	0.08200

Members and Associate Members	Revised WHO scale for 2005
	%
Solomon Islands	0.00100
Somalia	0.00100
South Africa	0.29200
Spain	2.52000
Sri Lanka	0.01700
Sudan	0.00800
Suriname	0.00100
Swaziland	0.00200
Sweden	0.99800
Switzerland	1.19700
Syrian Arab Republic	0.03800
Tajikistan	0.00100
Thailand	0.20900
The former Yugoslav Republic of Macedonia	0.00600
Timor-Leste	0.00100
Togo	0.00100
Tokelau	0.00100
Tonga	0.00100
Trinidad and Tobago	0.02200
Tunisia	0.03200
Turkey	0.37200
Turkmenistan	0.00500
Tuvalu	0.00100
Uganda	0.00600
Ukraine	0.03900
United Arab Emirates	0.23500
United Kingdom of Great Britain and Northern Ireland	6.12720
United Republic of Tanzania	0.00600
United States of America	22.00000
Uruguay	0.04800
Uzbekistan	0.01400
Vanuatu	0.00100
Venezuela	0.17100
Viet Nam	0.02100
Yemen	0.00600
Zambia	0.00200
Zimbabwe	0.00700
Total	100.00000

2. DECIDES to implement the amounts available under the adjustment mechanism for 2005, shown below, modified to reflect the revised assessments for 2005, and in accordance with the method of calculation established in resolution WHA56.34, the amounts to be proportionally reduced, if necessary, to ensure that the total claimed, on the basis of notifications received by 31 October 2004, is fully covered by the amount appropriated for the adjustment mechanism in 2004-2005.

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Afghanistan	-
Albania	3 435
Algeria	-
Andorra	1 715
Angola	-
Antigua and Barbuda	1 715
Argentina	-
Armenia	-
Australia	228 355
Austria	-
Azerbaijan	-
Bahamas	-
Bahrain	22 320
Bangladesh	-
Barbados	3 435
Belarus	-
Belgium	-
Belize	-
Benin	-
Bhutan	-
Bolivia	3 435
Bosnia and Herzegovina	-
Botswana	3 435
Brazil	130 490
Brunei Darussalam	24 035
Bulgaria	10 300
Burkina Faso	-
Burundi	-
Cambodia	1 715
Cameroon	-
Canada	214 620
Cape Verde	-
Central African Republic	-
Chad	-
Chile	152 810
China	1 844 005
Colombia	82 415
Comoros	-
Congo	-
Cook Islands	-
Costa Rica	24 035
Côte d'Ivoire	1 715
Croatia	13 735
Cuba	32 620
Cyprus	10 300
Czech Republic	66 960
Democratic People's Republic of Korea	-
Democratic Republic of the Congo	-
Denmark	63 525
Djibouti	-
Dominica	-
Dominican Republic	34 340

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Ecuador	-
Egypt	96 150
El Salvador	17 170
Equatorial Guinea	1 715
Eritrea	-
Estonia	-
Ethiopia	-
Fiji	-
Finland	-
France	-
Gabon	-
Gambia	-
Georgia	-
Germany	-
Ghana	-
Greece	317 635
Grenada	-
Guatemala	20 605
Guinea	-
Guinea-Bissau	-
Guyana	-
Haiti	1 715
Honduras	3 435
Hungary	13 735
Iceland	5 150
India	218 055
Indonesia	-
Iran (Islamic Republic of)	-
Iraq	
Ireland	223 205
Israel	211 185
Italy	-
Jamaica	3 435
Japan	-
Jordan	8 585
Kazakhstan	-
Kenya	3 435
Kiribati	-
Kuwait	61 810
Kyrgyzstan	-
Lao People’s Democratic Republic	-
Latvia	-
Lebanon	13 735
Lesotho	-
Liberia	-
Libyan Arab Jamahiriya	17 170
Lithuania	15 455
Luxembourg	17 170
Madagascar	-
Malawi	-
Malaysia	39 490
Maldives	-

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Mali	-
Malta	-
Marshall Islands	-
Mauritania	-
Mauritius	3 435
Mexico	1 552 125
Micronesia (Federated States of)	-
Monaco	-
Mongolia	-
Morocco	12 020
Mozambique	-
Myanmar	3 435
Namibia	-
Nauru	-
Nepal	-
Netherlands	144 225
New Zealand	6 870
Nicaragua	-
Niger	-
Nigeria	18 885
Niue	-
Norway	135 640
Oman	34 340
Pakistan	-
Palau	-
Panama	10 300
Papua New Guinea	-
Paraguay	-
Peru	-
Philippines	25 755
Poland	460 145
Portugal	78 980
Puerto Rico	-
Qatar	54 940
Republic of Korea	1 383 860
Republic of Moldova	-
Romania	8 585
Russian Federation	68 680
Rwanda	-
Saint Kitts and Nevis	-
Saint Lucia	1 715
Saint Vincent and the Grenadines	-
Samoa	-
San Marino	1 715
Sao Tome and Principe	-
Saudi Arabia	274 710
Senegal	-
Serbia and Montenegro	-
Seychelles	-
Sierra Leone	-
Singapore	363 995
Slovakia	29 190

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Slovenia	37 775
Solomon Islands	-
Somalia	-
South Africa	-
Spain	
Sri Lanka	8 585
Sudan	1 715
Suriname	-
Swaziland	-
Sweden	-
Switzerland	1 715
Syrian Arab Republic	-
Tajikistan	-
Thailand	72 110
The former Yugoslav Republic of Macedonia	3 435
Timor-Leste	1 715
Togo	-
Tokelau	-
Tonga	-
Trinidad and Tobago	10 300
Tunisia	8 585
Turkey	-
Turkmenistan	-
Tuvalu	-
Uganda	3 435
Ukraine	-
United Arab Emirates	103 015
United Kingdom of Great Britain and Northern Ireland	1 916 460
United Republic of Tanzania	5 150
United States of America	-
Uruguay	1 715
Uzbekistan	-
Vanuatu	-
Venezuela	24 035
Viet Nam	24 035
Yemen	-
Zambia	-
Zimbabwe	-
Total	11 182 830

(Eighth plenary meeting, 22 May 2004 –
Committee B, fifth report)

WHA57.16 Health promotion and healthy lifestyles

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA42.44 and WHA51.12 on health promotion, public information and education for health, and the outcome of five global conferences on health promotion, from Ottawa

(1986), Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta (1997), to Mexico City (2000), the Ministerial Statement for the promotion of health (2000), and the adoption of the WHO Framework Convention on Tobacco Control (2003);

Having considered the report on health promotion and healthy lifestyles;[1]

Noting that *The world health report 2002*[2] addresses major risks to global health, and highlights the role of behavioural factors, notably unhealthy diet, physical inactivity, tobacco consumption and the harmful use of alcohol as key risk factors for noncommunicable diseases which constitute a rapidly growing burden;

Noting that promotion of mental health constitutes an important component of overall health promotion;

Recognizing that the need for health promotion strategies, models and methods is limited neither to a specific health issue nor to a specific set of behaviours, but applies to a variety of population groups, risk factors and diseases, and in various cultures and settings;

Recognizing that, in general, the overriding efforts in health promotion should be geared to reducing health inequalities by comprehensively tackling the determinant chain, including societal structures, environmental factors and lifestyles;

Recognizing the need for Member States to strengthen the policies, human and financial resources, and institutional capability for sustainable and effective health promotion that addresses the major determinants of health and their related risk factors, with a view to building national capacity, strengthening evidence-based approaches, developing innovative means of financing, and drawing up guidelines for implementation and evaluation;

Recalling the importance of primary health care and the five areas of action set out in the Ottawa Charter for Health Promotion,

1. URGES Member States:

(1) to strengthen existing capability at national and local levels for the planning and implementation of gender-sensitive and culturally appropriate, comprehensive and multisectoral health-promotion policies and programmes, with particular attention to poor and marginalized groups;

(2) to set up appropriate mechanisms to collect, monitor and analyse national experiences in order to strengthen the evidence base for the effectiveness of health promotion interventions as an integral part of health systems with a view to achieving effective societal and lifestyle changes;

(3) to give high priority to promoting healthy lifestyles among children and young people – boys and girls both in and out of school or other educational institution – including healthy and safe recreational opportunities and creation of supportive environments for such lifestyles;

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[1] Document A57/11.

[2] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

(4) to include harmful use of alcohol in the list of lifestyle-related risk factors as stated in *The world health report 2002*, and to give attention to the prevention of alcohol-related harm and promotion of strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;

(5) to set up tobacco-cessation programmes;

(6) to consider actively, where necessary and appropriate, the establishment of innovative, adequate and sustainable financing mechanisms for health promotion with a firm institutional base for the management of health promotion;

2. REQUESTS the Director-General:

(1) to give health promotion highest priority in order to support its development within the Organization as requested in resolution WHA51.12, with a view to supporting Member States, in consultation with involved stakeholders, more effectively to address the major risk factors to health, including harmful use of alcohol and other major lifestyle-related factors;

(2) to continue to advocate an evidence-based approach to health promotion and to provide technical and other support to Member States in building their capacity for the implementation, monitoring, evaluation and dissemination of effective health promotion programmes at all levels;

(3) to provide support and guidance to Member States in relation to the challenges and opportunities stemming from the promotion of healthy lifestyles and the management of related risk factors, as outlined in *The world health report 2002*;

(4) to provide support to all Member States for development and implementation of tobacco-cessation programmes;

(5) to provide support to Member States, where necessary and appropriate, in their attempt to establish an innovative, adequate and sustainable financing mechanism with a firm institutional base in order to coordinate effectively and monitor systematically their health promotion efforts;

(6) to report on progress made in the promotion of healthy lifestyles to the Executive Board at its 115th session and to the Fifty-eighth World Health Assembly, including a report on the Organization's future work on alcohol consumption.

(Eighth plenary meeting, 22 May 2004 –
Committee A, third report)

WHA57.17 Global strategy on diet, physical activity and health

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA55.23 on diet, physical activity and health;

Recalling *The world health report 2002*,[1] which indicates that mortality, morbidity and disability attributed to the major noncommunicable diseases currently account for about 60% of all deaths and 47% of the global burden of disease, which figures are expected to rise to 73% and 60%, respectively, by 2020;

Noting that 66% of the deaths attributed to noncommunicable diseases occur in developing countries where those affected are on average younger than in developed countries;

Alarmed by these rising figures that are a consequence of evolving trends in demography and lifestyles, including those related to diet and physical activity;

Recognizing the existing, vast body of knowledge and public health potential, the need to reduce the level of exposure to the major risks resulting from unhealthy diet and physical inactivity, and the largely preventable nature of the consequent diseases;

Mindful also that these major behavioural and environmental risk factors are amenable to modification through implementation of concerted essential public-health action, as has been demonstrated in several Member States;

Acknowledging that malnutrition, including undernutrition and nutritional deficiencies, is still a major cause of death and disease in many parts of the world, especially in developing countries, and that this strategy complements the important work of WHO and its Member States in the overall area of nutrition;

Recognizing the interdependence of nations, communities and individuals, and that governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages individuals, families and communities to make positive, life-enhancing decisions on healthy diet and physical activity;

Recognizing the importance of a global strategy for diet, physical activity and health within the integrated prevention and control of noncommunicable diseases, including support of healthy lifestyles, facilitation of healthier environments, provision of public information and health services, and the major involvement in improving the lifestyles and health of individuals and communities of the health and relevant professions and of all concerned stakeholders and sectors committed to reducing the risks of noncommunicable diseases;

Recognizing that for the implementation of this global strategy, capacity building and financial and technical support should be promoted through international cooperation in support of national efforts in developing countries;

Recognizing the socioeconomic importance and the potential health benefits of traditional dietary and physical-activity practices, including those of indigenous peoples;

Reaffirming that nothing in this strategy shall be construed as a justification for adoption of trade-restrictive measures or trade-distorting practices;

Reaffirming that appropriate intake levels for energy, nutrients and foods, including free sugars, salt, fats, fruits, vegetables, legumes, whole grains, and nuts shall be determined in accordance with national dietary and physical-activity guidelines based on the best available scientific evidence and as

[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

part of Member States' policies and programmes taking into account cultural traditions and national dietary habits and practices;

Convinced that it is time for governments, civil society and the international community, including the private sector, to renew their commitment to encouraging healthy patterns of diet and physical activity;

Noting that resolution WHA56.23 urged Member States to make full use of Codex Alimentarius Commission standards for the protection of human health throughout the food chain, including assistance with making healthy choices regarding nutrition and diet,

1. ENDORSES the Global Strategy on Diet, Physical Activity and Health annexed hereto;

2. URGES Member States:

(1) to develop, implement and evaluate actions recommended in the Strategy, as appropriate to national circumstances and as part of their overall policies and programmes, that promote individual and community health through healthy diet and physical activity and reduce the risks and incidence of noncommunicable diseases;

(2) to promote lifestyles that include a healthy diet and physical activity and foster energy balance;

(3) to strengthen existing, or establish new, structures for implementing the Strategy through the health and other concerned sectors, for monitoring and evaluating its effectiveness and for guiding resource investment and management to reduce the prevalence of noncommunicable diseases and the risks related to unhealthy diet and physical inactivity;

(4) to define for this purpose, consistent with national circumstances:

(a) national goals and objectives,

(b) a realistic timetable for their achievement,

(c) national dietary and physical-activity guidelines,

(d) measurable process and output indicators that will permit accurate monitoring and evaluation of action taken and a rapid response to identified needs,

(e) measures to preserve and promote traditional foods and physical activity;

(5) to encourage mobilization of all concerned social and economic groups, including scientific, professional, nongovernmental, voluntary, private-sector, civil society, and industry associations, and to engage them actively and appropriately in implementing the Strategy and achieving its aims and objectives;

(6) to encourage and foster a favourable environment for the exercise of individual responsibility for health through the adoption of lifestyles that include a healthy diet and physical activity;

(7) to ensure that public policies adopted in the context of implementation of this Strategy are in accordance with their individual commitments in international and multilateral agreements,

including trade and other related agreements, so as to avoid a trade-restrictive or trade-distorting impact;

(8) to consider, when implementing the Strategy, the risk of unintentional effects on vulnerable populations and specific products;

3. CALLS UPON other international organizations and bodies to give high priority within their respective mandates and programmes to, and invites public and private stakeholders including the donor community to cooperate with governments in, the promotion of healthy diets and physical activity to improve health outcomes;

4. REQUESTS the Codex Alimentarius Commission to continue to give full consideration, within the framework of its operational mandate, to evidence-based action it might take to improve the health standards of foods, consistent with the aims and objectives of the Strategy;

5. REQUESTS the Director-General:

(1) to continue and strengthen work devoted to undernutrition and micronutrient deficiencies, in cooperation with Member States, and to continue to report to Member States on developments in the field of nutrition (resolutions WHA46.7, WHA52.24, WHA54.2 and WHA55.25);

(2) to provide technical advice and to mobilize support at both global and regional levels for Member States, when requested, in implementing the Strategy and in monitoring and evaluating implementation;

(3) to monitor on an ongoing basis international scientific developments and research relative to diet, physical activity and health, including claims on the dietary benefits of agricultural products which constitute a significant or important part of the diet of individual countries, so as to enable Member States to adapt their programmes to the most up-to-date knowledge;

(4) to continue to prepare and disseminate technical information, guidelines, studies, evaluations, and advocacy and training materials so that Member States are better aware of the cost/benefits and contributions of healthy diet and physical activity as they address the growing global burden of noncommunicable diseases;

(5) to strengthen international cooperation with other organizations of the United Nations system and bilateral agencies in promoting healthy diet and physical activity throughout life;

(6) to cooperate with civil society and with public and private stakeholders committed to reducing the risks of noncommunicable diseases in implementing the Strategy and promoting healthy diet and physical activity, while ensuring avoidance of potential conflicts of interest;

(7) to work with other specialized bodies of the United Nations system and intergovernmental agencies on assessing and monitoring the health aspects, socioeconomic impact and gender aspects of the Strategy and its implementation, and to brief the Fifty-ninth World Health Assembly on progress;

(8) to report on implementation of the Strategy to the Fifty-ninth World Health Assembly.

ANNEX

GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH

1. Recognizing the heavy and growing burden of noncommunicable diseases, Member States requested the Director-General to develop a global strategy on diet, physical activity and health through a broad consultation process.[1] To establish the content of the draft global strategy, six regional consultations were held with Member States, and organizations of the United Nations system, other intergovernmental bodies, and representatives of civil society and the private sector were consulted. A reference group of independent international experts on diet and physical activity from WHO's six regions also provided advice.

2. The Strategy addresses two of the main risk factors for noncommunicable diseases, namely, diet and physical activity, while complementing the long-established and ongoing work carried out by WHO and nationally on other nutrition-related areas, including undernutrition, micronutrient deficiencies and infant- and young-child feeding.

THE CHALLENGE

3. A profound shift in the balance of the major causes of death and disease has already occurred in developed countries and is under way in many developing countries. Globally, the burden of noncommunicable diseases has rapidly increased. In 2001 noncommunicable diseases accounted for almost 60% of the 56 million deaths annually and 47% of the global burden of disease. In view of these figures and the predicted future growth in this disease burden, the prevention of noncommunicable diseases presents a major challenge to global public health.

4. *The world health report 2002*[2] describes in detail how, in most countries, a few major risk factors account for much of the morbidity and mortality. For noncommunicable diseases, the most important risks included high blood pressure, high concentrations of cholesterol in the blood, inadequate intake of fruit and vegetables, overweight or obesity, physical inactivity and tobacco use. Five of these risk factors are closely related to diet and physical activity.

5. Unhealthy diets and physical inactivity are thus among the leading causes of the major noncommunicable diseases, including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the global burden of disease, death and disability. Other diseases related to diet and physical inactivity, such as dental caries and osteoporosis, are widespread causes of morbidity.

6. The burden of mortality, morbidity and disability attributable to noncommunicable diseases is currently greatest and continuing to grow in the developing countries, where those affected are on average younger than in developed countries, and where 66% of these deaths occur. Rapid changes in diets and patterns of physical activity are further causing rates to rise. Smoking also increases the risk for these diseases, although largely through independent mechanisms.

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[1] Resolution WHA55.23.

[2] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

7. In some developed countries where noncommunicable diseases have dominated the national burden of disease, age-specific death and disease rates have been slowly declining. Progress is being made in reducing premature death rates from coronary artery disease, cerebrovascular disease and some tobacco-related cancers. However, the overall burden and number of patients remain high, and the numbers of overweight and obese adults and children, and of cases, closely linked, of type 2 diabetes are growing in many developed countries.

8. Noncommunicable diseases and their risk factors are initially mostly limited to economically successful groups in low- and middle-income countries. However, recent evidence shows that, over time, patterns of unhealthy behaviour and the noncommunicable diseases associated with them cluster among poor communities and contribute to social and economic inequalities.

9. In the poorest countries, even though infectious diseases and undernutrition dominate their current disease burden, the major risk factors for chronic diseases are spreading. The prevalence of overweight and obesity is increasing in developing countries, and even in low-income groups in richer countries. An integrated approach to the causes of unhealthy diet and decreasing levels of physical activity would contribute to reducing the future burden of noncommunicable diseases.

10. For all countries for which data are available, the underlying determinants of noncommunicable diseases are largely the same. Factors that increase the risks of noncommunicable disease include elevated consumption of energy-dense, nutrient-poor foods that are high in fat, sugar and salt; reduced levels of physical activity at home, at school, at work and for recreation and transport; and use of tobacco. Variations in risk levels and related health outcomes among the population are attributed, in part, to the variability in timing and intensity of economic, demographic and social changes at national and global levels. Of particular concern are unhealthy diets, inadequate physical activity and energy imbalances in children and adolescents.

11. Maternal health and nutrition before and during pregnancy, and early infant nutrition may be important in the prevention of noncommunicable diseases throughout the life course. Exclusive breastfeeding for six months and appropriate complementary feeding contribute to optimal physical growth and mental development. Infants who suffer prenatal, and possibly postnatal, growth restrictions appear to be at higher risk for noncommunicable diseases in adulthood.

12. Most elderly people live in developing countries, and the ageing of populations has a strong impact on morbidity and mortality patterns. Many developing countries will therefore be faced with an increased burden of noncommunicable diseases at the same time as a persisting burden of infectious diseases. In addition to the human dimension, maintaining the health and functional capacity of the increasing elderly population will be a crucial factor in reducing the demand for, and cost of, health services.

13. Diet and physical activity influence health both together and separately. Although the effects of diet and physical activity on health often interact, particularly in relation to obesity, there are additional health benefits to be gained from physical activity that are independent of nutrition and diet, and there are significant nutritional risks that are unrelated to obesity. Physical activity is a fundamental means of improving the physical and mental health of individuals.

14. Governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages behaviour changes by individuals, families and communities, to make positive, life-enhancing decisions on healthy diets and patterns of physical activity.

15. Noncommunicable diseases impose a significant economic burden on already strained health systems, and inflict great costs on society. Health is a key determinant of development and a precursor

of economic growth. The WHO Commission on Macroeconomics and Health has demonstrated the disruptive effect of disease on development, and the importance for economic development of investments in health.[1] Programmes aimed at promoting healthy diets and physical activity for the prevention of diseases are key instruments in policies to achieve development goals.

THE OPPORTUNITY

16. A unique opportunity exists to formulate and implement an effective strategy for substantially reducing deaths and disease worldwide by improving diet and promoting physical activity. Evidence for the links between these health behaviours and later disease and ill-health is strong. Effective interventions to enable people to live longer and healthier lives, reduce inequalities, and enhance development can be designed and implemented. By mobilizing the full potential of the major stakeholders, this vision could become a reality for all populations in all countries.

GOAL AND OBJECTIVES

17. The overall goal of the Global Strategy on Diet, Physical Activity and Health is to promote and protect health by guiding the development of an enabling environment for sustainable actions at individual, community, national and global levels that, when taken together, will lead to reduced disease and death rates related to unhealthy diet and physical inactivity. These actions support the United Nations Millennium Development Goals and have immense potential for public health gains worldwide.

18. The Global Strategy has four main objectives:

(1) to reduce the risk factors for noncommunicable diseases that stem from unhealthy diets and physical inactivity by means of essential public health action and health-promoting and disease-preventing measures;

(2) to increase the overall awareness and understanding of the influences of diet and physical activity on health and of the positive impact of preventive interventions;

(3) to encourage the development, strengthening and implementation of global, regional, national and community policies and action plans to improve diets and increase physical activity that are sustainable, comprehensive, and actively engage all sectors, including civil society, the private sector and the media;

(4) to monitor scientific data and key influences on diet and physical activity; to support research in a broad spectrum of relevant areas, including evaluation of interventions; and to strengthen the human resources needed in this domain to enhance and sustain health.

[1] *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001.

EVIDENCE FOR ACTION

19. Evidence shows that, when other threats to health are addressed, people can remain healthy into their seventh, eighth and ninth decades, through a range of health-promoting behaviours, including healthy diets, regular and adequate physical activity, and avoidance of tobacco use. Recent research has contributed to understanding of the benefits of healthy diets, physical activity, individual action and population-based public health interventions. Although more research is needed, current knowledge warrants urgent public health action.

20. Risk factors for noncommunicable disease frequently coexist and interact. As the general level of risk factors rises, more people are put at risk. Preventive strategies should therefore aim at reducing risk throughout the population. Such risk reduction, even if modest, cumulatively yields sustainable benefits, which exceeds the impact of interventions restricted to high-risk individuals. Healthy diets and physical activity, together with tobacco control, constitute an effective strategy to contain the mounting threat of noncommunicable diseases.

21. Reports of international and national experts and reviews of the current scientific evidence recommend goals for nutrient intake and physical activity in order to prevent major noncommunicable diseases. These recommendations need to be considered when preparing national policies and dietary guidelines, taking into account the local situation.

22. **For diet,** recommendations for populations and individuals should include the following:

- achieve energy balance and a healthy weight
- limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and towards the elimination of *trans*-fatty acids
- increase consumption of fruits and vegetables, and legumes, whole grains and nuts
- limit the intake of free sugars
- limit salt (sodium) consumption from all sources and ensure that salt is iodized.

23. Physical activity is a key determinant of energy expenditure, and thus is fundamental to energy balance and weight control. Physical activity reduces risk for cardiovascular diseases and diabetes and has substantial benefits for many conditions, not only those associated with obesity. The beneficial effects of physical activity on the metabolic syndrome are mediated by mechanisms beyond controlling excess body weight. For example, physical activity reduces blood pressure, improves the level of high density lipoprotein cholesterol, improves control of blood glucose in overweight people, even without significant weight loss, and reduces the risk for colon cancer and breast cancer among women.

24. **For physical activity,** it is recommended that individuals engage in adequate levels throughout their lives. Different types and amounts of physical activity are required for different health outcomes: at least 30 minutes of regular, moderate-intensity physical activity on most days reduces the risk of cardiovascular disease and diabetes, colon cancer and breast cancer. Muscle strengthening and balance training can reduce falls and increase functional status among older adults. More activity may be required for weight control.

25. The realization of these recommendations, together with effective measures to prevent and control tobacco use, in the Global Strategy that leads to regional and national action plans, will require

sustained political commitment and the collaboration of many stakeholders. The Strategy will contribute to the effective prevention of noncommunicable diseases.

PRINCIPLES FOR ACTION

26. *The world health report 2002* highlights the potential for improving public health through measures that reduce the prevalence of risk factors (most notably the combination of unhealthy diets and physical inactivity) of noncommunicable diseases. The principles set out below guided the drafting of WHO's Global Strategy and are recommended for the development of national and regional strategies and action plans.

27. Strategies need to be based on the best available scientific research and evidence; comprehensive, incorporating both policies and action and addressing all major causes of noncommunicable diseases together; multisectoral, taking a long-term perspective and involving all sectors of society; and multidisciplinary and participatory, consistent with the principles contained in the Ottawa Charter for Health Promotion and confirmed in subsequent conferences on health promotion,[1] and recognizing the complex interactions between personal choices, social norms and economic and environmental factors.

28. A life-course perspective is essential for the prevention and control of noncommunicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age.

29. Strategies to reduce noncommunicable diseases should be part of broader, comprehensive and coordinated public health efforts. All partners, especially governments, need to address simultaneously a number of issues. In relation to diet, these include all aspects of nutrition (for example, both overnutrition and undernutrition, micronutrient deficiency and excess consumption of certain nutrients); food security (accessibility, availability and affordability of healthy food); food safety; and support for and promotion of six months of exclusive breastfeeding. Regarding physical activity, issues include requirements for physical activity in working, home and school life, increasing urbanization, and various aspects of city planning, transportation, safety and access to physical activity during leisure.

30. Priority should be given to activities that have a positive impact on the poorest population groups and communities. Such activities will generally require community-based action with strong government intervention and oversight.

31. All partners need to be accountable for framing policies and implementing programmes that will effectively reduce preventable risks to health. Evaluation, monitoring and surveillance are essential components of such actions.

32. The prevalence of noncommunicable diseases related to diet and physical activity may vary greatly between men and women. Patterns of physical activity and diets differ according to sex, culture and age. Decisions about food and nutrition are often made by women and are based on culture and traditional diets. National strategies and action plans should therefore be sensitive to such differences.

[1] See resolution WHA51.12.

33. Dietary habits and patterns of physical activity are often rooted in local and regional traditions. National strategies should therefore be culturally appropriate and able to challenge cultural influences and to respond to changes over time.

RESPONSIBILITIES FOR ACTION

34. Bringing about changes in dietary habits and patterns of physical activity will require the combined efforts of many stakeholders, public and private, over several decades. A combination of sound and effective actions is needed at global, regional, national and local levels, with close monitoring and evaluation of their impact. The following paragraphs describe the responsibilities of those involved and provide recommendations deriving from the consultation process.

Member States

35. The Global Strategy should foster the formulation and promotion of national policies, strategies and action plans to improve diet and encourage physical activity. National circumstances will determine priorities in the development of such instruments. Because of the great variations in and between different countries, regional bodies should collaborate in formulating regional strategies, which can provide considerable support to countries in implementing their national plans. For maximum effectiveness, countries should adopt the most comprehensive action plans possible.

36. **The role of government is crucial in achieving lasting change in public health**. Governments have a primary steering and stewardship role in initiating and developing the Strategy, ensuring that it is implemented and monitoring its impact in the long term.

37. **Governments are encouraged to build on existing structures and processes that already address aspects of diet, nutrition and physical activity**. In many countries, existing national strategies and action plans can be used in implementing the Strategy; in others they can form the basis for advancing control of noncommunicable diseases. Governments are encouraged to set up a national coordinating mechanism that addresses diet and physical activity within the context of a comprehensive plan for noncommunicable-disease prevention and health promotion. Local authorities should be closely involved. Multisectoral and multidisciplinary expert advisory boards should also be established. They should include technical experts and representatives of government agencies, and have an independent chair to ensure that scientific evidence is interpreted without any conflict of interest.

38. **Health ministries have an essential responsibility for coordinating and facilitating the contributions of other ministries and government agencies**. Bodies whose contributions should be coordinated include ministries and government institutions responsible for policies on food, agriculture, youth, recreation, sports, education, commerce and industry, finance, transportation, media and communication, social affairs and environmental and urban planning.

39. **National strategies, policies and action plans need broad support.** Support should be provided by effective legislation, appropriate infrastructure, implementation programmes, adequate funding, monitoring and evaluation, and continuing research.

(1) **National strategies on diet and physical activity.** National strategies describe the measures to promote healthy diets and physical activity that are essential to prevent disease and promote health, including those that tackle all aspects of unbalanced diets, including undernutrition and overnutrition. National strategies should include specific goals, objectives, and actions, similar to those outlined in the Strategy. Of particular importance are the elements

needed to implement the plan of action, including identification of necessary resources and national focal points (key national institutes); collaboration between the health sector and other key sectors such as agriculture, education, urban planning, transportation and communication; and monitoring and follow-up.

(2) **National dietary guidelines.** Governments are encouraged to draw up national dietary guidelines, taking account of evidence from national and international sources. Such guidelines advise national nutrition policy, nutrition education, other public health interventions and intersectoral collaboration. They may be updated periodically in the light of changes in dietary and disease patterns and evolving scientific knowledge.

(3) **National physical activity guidelines.** National guidelines for health-enhancing physical activity should be prepared in accordance with the goal and objectives of the Strategy and expert recommendations.

40. **Governments should provide accurate and balanced information**. Governments need to consider actions that will result in provision of balanced information for consumers to enable them easily to make healthy choices, and to ensure the availability of appropriate health promotion and education programmes. In particular, information for consumers should be sensitive to literacy levels, communication barriers and local culture, and understood by all segments of the population. In some countries, health-promoting programmes have been designed as a function of such considerations and should be used for disseminating information about diet and physical activity. Some governments already have a legal obligation to ensure that factual information available to consumers enables them to make fully informed choices on matters that may affect their health. In other cases, actions may be specific to government policies. Governments should select the optimal mix of actions in accordance with their national capabilities and epidemiological profile, which will vary from one country to another.

(1) **Education, communication and public awareness.** A sound basis for action is provided by public knowledge and understanding of the relationship between diet, physical activity and health, of energy intake and output, and healthy choice of food items. Consistent, coherent, simple and clear messages should be prepared and conveyed by government experts, nongovernmental and grass-roots organizations, and the appropriate industries. They should be communicated through several channels and in forms appropriate to local culture, age and gender. Behaviour can be influenced especially in schools, workplaces, and educational and religious institutions, and by nongovernmental organizations, community leaders, and mass media. Member States should form alliances for the broad dissemination of appropriate and effective messages about healthy diet and physical activity. Nutrition and physical activity education and acquisition of media literacy, starting in primary school, are important to promote healthier diets, and to counter food fads and misleading dietary advice. Support should also be provided for action that improves the level of health literacy, while taking account of local cultural and socioeconomic circumstances. Communication campaigns should be regularly evaluated.

(2) **Adult literacy and education programmes.** Health literacy should be incorporated into adult education programmes. Such programmes provide an opportunity for health professionals and service providers to enhance knowledge about diet, physical activity and prevention of noncommunicable diseases and to reach marginalized populations.

(3) **Marketing, advertising, sponsorship and promotion.** Food advertising affects food choices and influences dietary habits. Food and beverage advertisements should not exploit children’s inexperience or credulity. Messages that encourage unhealthy dietary practices or physical inactivity should be discouraged, and positive, healthy messages encouraged.

Governments should work with consumer groups and the private sector (including advertising) to develop appropriate multisectoral approaches to deal with the marketing of food to children, and to deal with such issues as sponsorship, promotion and advertising.

(4) **Labelling.** Consumers require accurate, standardized and comprehensible information on the content of food items in order to make healthy choices. Governments may require information to be provided on key nutritional aspects, as proposed in the Codex Guidelines on Nutrition Labelling.[1]

(5) **Health claims.** As consumers' interest in health grows, and increasing attention is paid to the health aspects of food products, producers increasingly use health-related messages. Such messages must not mislead the public about nutritional benefits or risks.

41. **National food and agricultural policies should be consistent with the protection and promotion of public health**. Where needed, governments should consider policies that facilitate the adoption of healthy diet. Food and nutrition policy should also cover food safety and sustainable food security. Governments should be encouraged to examine food and agricultural policies for potential health effects on the food supply.

(1) **Promotion of food products consistent with a healthy diet.** As a result of consumers' increasing interest in health and governments' awareness of the benefits of healthy nutrition, some governments have taken measures, including market incentives, to promote the development, production and marketing of food products that contribute to a healthy diet and are consistent with national or international dietary recommendations. Governments could consider additional measures to encourage the reduction of the salt content of processed foods, the use of hydrogenated oils, and the sugar content of beverages and snacks.

(2) **Fiscal policies.** Prices influence consumption choices. Public policies can influence prices through taxation, subsidies or direct pricing in ways that encourage healthy eating and lifelong physical activity. Several countries use fiscal measures, including taxes, to influence availability of, access to, and consumption of, various foods; and some use public funds and subsidies to promote access among poor communities to recreational and sporting facilities. Evaluation of such measures should include the risk of unintentional effects on vulnerable populations.

(3) **Food programmes.** Many countries have programmes to provide food to population groups with special needs or cash transfers to families for them to improve their food purchases. Such programmes often concern children, families with children, poor people, and people with HIV/AIDS and other diseases. Special attention should be given to the quality of the food items and to nutrition education as a main component of these programmes, so that food distributed to, or purchased by, the families not only provides energy, but also contributes to a healthy diet. Food and cash distribution programmes should emphasize empowerment and development, local production and sustainability.

(4) **Agricultural policies.** Agricultural policy and production often have a great effect on national diets. Governments can influence agricultural production through many policy measures. As emphasis on health increases and consumption patterns change, Member States need to take healthy nutrition into account in their agricultural policies.

[1] Codex Alimentarius Commission, document CAC/GL 2-1985, Rev. 1-1993.

42. **Multisectoral policies are needed to promote physical activity**. National policies to promote physical activity should be framed, targeting change in a number of sectors. Governments should review existing policies to ensure that they are consistent with best practice in population-wide approaches to increasing physical activity.

(1) **Framing and review of public policies.** National and local governments should frame policies and provide incentives to ensure that walking, cycling and other forms of physical activity are accessible and safe; transport policies include nonmotorized modes of transportation; labour and workplace policies encourage physical activity; and sport and recreation facilities embody the concept of sports for all. Public policies and legislation have an impact on opportunities for physical activity, such as those concerning transport, urban planning, education, labour, social inclusion, and health-care funding related to physical activity.

(2) **Community involvement and enabling environments.** Strategies should be geared to changing social norms and improving community understanding and acceptance of the need to integrate physical activity into everyday life. Environments should be promoted that facilitate physical activity, and supportive infrastructure should be set up to increase access to, and use of, suitable facilities.

(3) **Partnerships.** Ministries of health should take the lead in forming partnerships with key agencies, and public and private stakeholders in order to draw up jointly a common agenda and workplan aimed at promoting physical activity.

(4) **Clear public messages.** Simple, direct messages need to be communicated on the quantity and quality of physical activity sufficient to provide substantial health benefits.

43. **School policies and programmes should support the adoption of healthy diets and physical activity**. Schools influence the lives of most children in all countries. They should protect their health by providing health information, improving health literacy, and promoting healthy diets, physical activity, and other healthy behaviours. Schools are encouraged to provide students with daily physical education and should be equipped with appropriate facilities and equipment. Governments are encouraged to adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar and fats. Schools should consider, together with parents and responsible authorities, issuing contracts for school lunches to local food growers in order to ensure a local market for healthy foods.

44. **Governments are encouraged to consult with stakeholders on policy**. Broad public discussion and involvement in the framing of policy can facilitate its acceptance and effectiveness. Member States should establish mechanisms to promote participation of nongovernmental organizations, civil society, communities, the private sector and the media in activities related to diet, physical activity and health. Ministries of health should be responsible, in collaboration with other related ministries and agencies, for establishing these mechanisms, which should aim at strengthening intersectoral cooperation at the national, provincial and local levels. They should encourage community participation, and should be part of planning processes at community level.

45. **Prevention is a critical element of health services**. Routine contacts with health-service staff should include practical advice to patients and families on the benefits of healthy diets and increased levels of physical activity, combined with support to help patients initiate and maintain healthy behaviours. Governments should consider incentives to encourage such preventive services and identify opportunities for prevention within existing clinical services, including an improved financing structure to encourage and enable health professionals to dedicate more time to prevention.

(1) **Health and other services.** Health-care providers, especially for primary health care, but also other services (such as social services) can play an important part in prevention. Routine enquiries as to key dietary habits and physical activity, combined with simple information and skill-building to change behaviour, taking a life-course approach, can reach a large part of the population and be a cost-effective intervention. Attention should be given to WHO's growth standards for infants and preschool children which expand the definition of health beyond the absence of overt disease, to include the adoption of healthy practices and behaviours. The measurement of key biological risk factors, such as blood pressure, serum cholesterol and body weight, combined with education of the population and support for patients, helps to promote the necessary changes. The identification of specific high-risk groups and measures to respond to their needs, including possible pharmacological interventions, are important components. Training of health personnel, dissemination of appropriate guidelines, and availability of incentives are key underlying factors in implementing these interventions.

(2) **Involvement with health professional bodies and consumer groups.** Enlisting the strong support of professionals, consumers and communities is a cost-effective way to raise public awareness of government policies, and enhance their effectiveness.

46. **Governments should invest in surveillance, research and evaluation.** Long-term and continuous monitoring of major risk factors is essential. Over time, such data also provide the basis for analyses of changes in risk factors, which could be attributable to changes in polices and strategies. Governments may be able to build on systems already in place, at either national or regional levels. Emphasis should initially be given to standard indicators recognized by the general scientific community as valid measures of physical activity, to selected dietary components, and to body weight in order to compile comparative data at global level. Data that provide insight into within-country patterns and variations are useful in guiding community action. Where possible, other sources of data should be used, for example, from the education, transport, agriculture, and other sectors.

(1) **Monitoring and surveillance.** Monitoring and surveillance are essential tools in the implementation of national strategies for healthy diet and physical activity. Monitoring of dietary habits, patterns of physical activity and interactions between them; nutrition-related biological risk factors and contents of food products; and communication to the public of the information obtained, are important components of implementation. Of particular importance is the development of methods and procedures using standardized data-collection procedures and a common minimum set of valid, measurable and usable indicators.

(2) **Research and evaluation.** Applied research, especially in community-based demonstration projects and in evaluating different policies and interventions, should be promoted. Such research (e.g., into the reasons for physical inactivity and poor diet, and on key determinants of effective intervention programmes), combined with the increased involvement of behavioural scientists, will lead to better informed policies and ensure that a cadre of expertise is created at national and local levels. Equally important is the need to put in place effective mechanisms for evaluating the efficacy and cost-effectiveness of national disease-prevention programmes, and the health impact of policies in other sectors. More information is needed, especially on the situation in developing countries, where programmes to promote healthy diets and physical activity need to be evaluated and integrated into broader development and poverty-alleviation programmes.

47. **Institutional capacity.** Under the ministry of health, national institutions for public health, nutrition and physical activity play an important role in the implementation of national diet and physical activity programmes. They can provide the necessary expertise, monitor developments, help to coordinate activities, participate in collaboration at international level, and provide advice to decision-makers.

48. **Financing national programmes.** Various sources of funding, in addition to the national budget, should be identified to assist in implementation of the Strategy. The United Nations Millennium Declaration (September 2000) recognizes that economic growth is limited unless people are healthy. The most cost-effective interventions to contain the epidemic of noncommunicable diseases are prevention and a focus on the risk factors associated with these diseases. Programmes aimed at promoting healthy diets and physical activity should therefore be viewed as a developmental need and should draw policy and financial support from national development plans.

WHO

49. WHO, in cooperation with other organizations of the United Nations system, will provide the leadership, evidence-based recommendations and advocacy for international action to improve dietary practices and increase physical activity, in keeping with the guiding principles and specific recommendations contained in the Global Strategy.

50. It will hold discussions with the transnational food industry and other parts of the private sector in support of the aims of the Strategy, and of implementing the recommendations in countries.

51. WHO will provide support for implementation of programmes as requested by Member States, and will focus on the following broad, interrelated areas:

- **facilitating the framing, strengthening and updating of regional and national policies** on diet and physical activity for integrated noncommunicable disease prevention

- **facilitating the drafting, updating and implementation of national food-based dietary and physical activity guidelines**, in collaboration with national agencies and drawing upon global knowledge and experience

- **providing guidance to Member States on the formulation of guidelines, norms, standards and other policy-related measures** that are consistent with the objectives of the Global Strategy

- **identifying and disseminating information on evidence-based interventions, policies and structures** that are effective in promoting healthy diets and optimizing the level of physical activity in countries and communities

- **providing appropriate technical support** to build national capacity in planning and implementing a national strategy and in tailoring it to local circumstances

- **providing models and methods** so that interventions on diet and physical activity constitute an integral component of health care

- **promoting and providing support for training of health professionals in healthy diets and an active life**, either within existing programmes or in special workshops, as an essential part of their curricula

- **providing advice and support to Member States, using standardized surveillance methods and rapid assessment tools** (such as WHO's STEPwise approach to surveillance of risk factors for noncommunicable diseases), in order to measure changes in distribution of risk – including patterns in diet, nutrition and physical activity – and to assess the current situation, trends, and the impact of interventions. WHO, in collaboration with FAO, will

provide support to Member States in establishing national nutrition surveillance systems, linked with data on the content of food items

- **advising Member States on ways of engaging constructively with appropriate industries.**

52. WHO, in close collaboration with organizations of the United Nations system and other intergovernmental bodies (FAO, UNESCO, UNICEF, United Nations University and others), research institutes and other partners, will promote and support research in priority areas to facilitate programme implementation and evaluation. This could include commissioning scientific papers, conducting analyses, and holding technical meetings on practical research topics that are essential for effective country action. The decision-making process should be informed by better use of evidence, including health-impact assessment, cost-benefit analysis, national burden-of-disease studies, evidence-based intervention models, scientific advice and dissemination of good practices.

53. It will work with FAO and other organizations of the United Nations system, the World Bank, and research institutes on their evaluation of implications of the Strategy for other sectors.

54. The Organization will continue to work with WHO collaborating centres to establish networks for building up capacity in research and training, mobilizing contributions from nongovernmental organizations and civil society, and facilitating coordinated, collaborative research as it pertains to the needs of developing countries in the implementation of the Strategy.

International partners

55. The role of international partners is of paramount importance in achieving the goal and objectives of the Global Strategy, particularly with regard to issues of a transnational nature, or where the actions of a single country are insufficient. Coordinated work is needed among the organizations of the United Nations system, intergovernmental bodies, nongovernmental organizations, professional associations, research institutions and private sector entities.

56. The process of preparing the Strategy has led to closer interaction with other organizations of the United Nations system, such as FAO and UNICEF, and other partners, including the World Bank. WHO will build on its long-standing collaboration with FAO in implementing the Strategy. The contribution of FAO in the framing of agricultural policies can play a crucial part in this regard. More research into appropriate agriculture policies, and the supply, availability, processing and consumption of food will be necessary.

57. Cooperation is also planned with bodies such as the United Nations Economic and Social Council, ILO, UNESCO, WTO, the regional development banks and the United Nations University. Consistent with the goal and objectives of the Strategy, WHO will develop and strengthen partnerships, including through the establishment and coordination of global and regional networks, in order to disseminate information, exchange experiences, and provide support to regional and national initiatives. WHO proposes to set up an ad hoc committee of partners within the United Nations system in order to ensure continuing policy coherence and to draw upon each organization's unique strengths. Partners can play an important role in a global network that targets such areas as advocacy, resource mobilization, capacity building and collaborative research.

58. International partners could be involved in implementing the Strategy by:

- contributing to comprehensive intersectoral strategies to improve diet and physical activity, including, for instance, the promotion of healthy diets in poverty-alleviation programmes

- drawing up guidelines for prevention of nutritional deficiencies in order to harmonize future dietary and policy recommendations designed to prevent and control noncommunicable diseases

- facilitating the drafting of national guidelines on diet and physical activity, in collaboration with national agencies

- cooperating in the development, testing and dissemination of models for community involvement, including local food production, nutrition and physical activity education, and raising of consumer awareness

- promoting the inclusion of noncommunicable disease prevention and health promotion policies relating to diet and physical activity in development policies and programmes

- promoting incentive-based approaches to encourage prevention and control of chronic diseases.

59. **International standards**. Public health efforts may be strengthened by the use of international norms and standards, particularly those drawn up by the Codex Alimentarius Commission.[1] Areas for further development could include: labelling to allow consumers to be better informed about the benefits and content of foods; measures to minimize the impact of marketing on unhealthy dietary patterns; fuller information about healthy consumption patterns, including steps to increase the consumption of fruit and vegetables; and production and processing standards regarding the nutritional quality and safety of products. Involvement of governments and nongovernmental organizations as provided for in the Codex should be encouraged.

Civil society and nongovernmental organizations

60. Civil society and nongovernmental organizations have an important role to play in influencing individual behaviour and the organizations and institutions that are involved in healthy diet and physical activity. They can help to ensure that consumers ask governments to provide support for healthy lifestyles, and the food industry to provide healthy products. Nongovernmental organizations can support the Strategy effectively if they collaborate with national and international partners. Civil society and nongovernmental organizations can particularly:

- lead grass-roots mobilization and advocate that healthy diets and physical activity should be placed on the public agenda

- support the wide dissemination of information on prevention of noncommunicable diseases through balanced, healthy diets and physical activity

- form networks and action groups to promote the availability of healthy foods and possibilities for physical activity, and advocate and support health-promoting programmes and health education campaigns

- organize campaigns and events that will stimulate action

[1] See resolution WHA56.23.

- emphasize the role of governments in promoting public health, healthy diets and physical activity; monitor progress in achieving objectives; and monitor and work with other stakeholders such as private sector entities

- play an active role in fostering implementation of the Global Strategy

- contribute to putting knowledge and evidence into practice.

Private sector

61. The private sector can be a significant player in promoting healthy diets and physical activity. The food industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreation businesses, insurance and banking groups, pharmaceutical companies and the media all have important parts to play as responsible employers and as advocates for healthy lifestyles. All could become partners with governments and nongovernmental organizations in implementing measures aimed at sending positive and consistent messages to facilitate and enable integrated efforts to encourage healthy eating and physical activity. Because many companies operate globally, international collaboration is crucial. Cooperative relationships with industry have already led to many favourable outcomes related to diet and physical activity. Initiatives by the food industry to reduce the fat, sugar and salt content of processed foods and portion sizes, to increase introduction of innovative, healthy, and nutritious choices; and review of current marketing practices, could accelerate health gains worldwide. Specific recommendations to the food industry and sporting-goods manufacturers include the following:

- promote healthy diets and physical activity in accordance with national guidelines and international standards and the overall aims of the Global Strategy

- limit the levels of saturated fats, *trans*-fatty acids, free sugars and salt in existing products

- continue to develop and provide affordable, healthy and nutritious choices to consumers

- consider introducing new products with better nutritional value

- provide consumers with adequate and understandable product and nutrition information

- practise responsible marketing that supports the Strategy, particularly with regard to the promotion and marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, especially to children

- issue simple, clear and consistent food labels and evidence-based health claims that will help consumers to make informed and healthy choices with respect to the nutritional value of foods

- provide information on food composition to national authorities

- assist in developing and implementing physical activity programmes.

62. Workplaces are important settings for health promotion and disease prevention. People need to be given the opportunity to make healthy choices in the workplace in order to reduce their exposure to risk. Further, the cost to employers of morbidity attributed to noncommunicable diseases is increasing rapidly. Workplaces should make possible healthy food choices and support and encourage physical activity.

FOLLOW-UP AND FUTURE DEVELOPMENTS

63. WHO will report on progress made in implementing the Global Strategy and in implementing national strategies, including the following aspects:

- patterns and trends of dietary habits and physical activity and related risk factors for major noncommunicable diseases
- evaluation of the effectiveness of policies and programmes to improve diet and increase physical activity
- constraints or barriers encountered in implementation of the Strategy and the measures taken to overcome them
- legislative, executive, administrative, financial or other measures taken within the context of the Strategy.

64. WHO will work at global and regional levels to set up a monitoring system and to design indicators for dietary habits and patterns of physical activity.

CONCLUSIONS

65. Actions, based on the best available scientific evidence and the cultural context, need to be designed, implemented and monitored with WHO's support and leadership. Nonetheless, a truly multisectoral approach that mobilizes the combined energy, resources and expertise of all global stakeholders is essential for sustained progress.

66. Changes in patterns of diet and physical activity will be gradual, and national strategies will need a clear plan for long-term and sustained disease-prevention measures. However, changes in risk factors and in incidence of noncommunicable diseases can occur quite quickly when effective interventions are made. National plans should therefore also have achievable short-term and intermediate goals.

67. The implementation of the Strategy by all those involved will contribute to major and sustained improvements in people's health.

(Eighth plenary meeting, 22 May 2004 –
Committee A, third report)

WHA57.18 Human organ and tissue transplantation

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation;

Having considered the report on human organ and tissue transplantation;[1]

Noting the global increase in allogeneic transplantation of cells, tissues and organs;

Concerned by the growing insufficiency of available human material for transplantation to meet patient needs;

Aware of ethical and safety risks arising in the transplantation of allogeneic cells, tissues and organs, and the need for special attention to the risks of organ trafficking;

Recognizing that living xenogeneic cells, tissues or organs, and human bodily fluids, cells, tissues or organs that have had *ex vivo* contact with these living xenogeneic materials, have the potential to be used in human beings when suitable human material is not available;

Mindful of the risk associated with xenogeneic transplantation of the transmission of known or as yet unrecognized xenogeneic infectious agents from animals to human beings and from recipients of xenogeneic transplants to their contacts and the public at large;

Recognizing that transplantation encompasses not only medical but also legal and ethical aspects, and involves economic and psychological issues,

I

Allogeneic transplantation

1. URGES Member States:

(1) to implement effective national oversight of procurement, processing and transplantation of human cells, tissues and organs, including ensuring accountability for human material for transplantation and its traceability;

(2) to cooperate in the formulation of recommendations and guidelines to harmonize global practices in the procurement, processing and transplantation of human cells, tissues and organs, including development of minimum criteria for suitability of donors of tissues and cells;

(3) to consider setting up ethics commissions to ensure the ethics of cell, tissue and organ transplantation;

(4) to extend the use of living kidney donations when possible, in addition to donations from deceased donors;

(5) to take measures to protect the poorest and vulnerable groups from “transplant tourism” and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs;

[1] Document A57/17.

2. REQUESTS the Director-General:

(1) to continue examining and collecting global data on the practices, safety, quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues, including living donation, in order to update the Guiding Principles on Human Organ Transplantation;[1]

(2) to promote international cooperation so as to increase the access of citizens to these therapeutic procedures;

(3) to provide, in response to requests from Member States, technical support for developing suitable transplantation of cells, tissues or organs, in particular by facilitating international cooperation;

(4) to provide support for Member States in their endeavours to prevent organ trafficking, including drawing up guidelines to protect the poorest and most vulnerable groups from being victims of organ trafficking;

II

Xenogeneic transplantation

1. URGES Member States:

(1) to allow xenogeneic transplantation only when effective national regulatory control and surveillance mechanisms overseen by national health authorities are in place;

(2) to cooperate in the formulation of recommendations and guidelines to harmonize global practices, including protective measures in accordance with internationally accepted scientific standards to prevent the risk of potential secondary transmission of any xenogeneic infectious agent that could have infected recipients of xenogeneic transplants or contacts of recipients, especially across national borders;

(3) to support international collaboration and coordination for the prevention and surveillance of infections resulting from xenogeneic transplantation;

2. REQUESTS the Director-General:

(1) to facilitate communication and international collaboration among health authorities in Member States on issues relating to xenogeneic transplantation;

(2) to collect data globally for the evaluation of practices in xenogeneic transplantation;

(3) to inform proactively Member States of infectious events of xenogeneic origin arising from xenogeneic transplantation;

(4) to provide, in response to requests from Member States, technical support in strengthening capacity and expertise in the field of xenogeneic transplantation, including policy-making and oversight by national regulatory authorities;

[1] Document WHA44/1991/REC/1, Annex 6.

(5) to report at an appropriate time to the Health Assembly, through the Executive Board, on implementation of this resolution.

(Eighth plenary meeting, 22 May 2004 –
Committee A, third report)

WHA57.19 International migration of health personnel: a challenge for health systems in developing countries

The Fifty-seventh World Health Assembly,

Recalling United Nations General Assembly resolution 2417 (XXIII) of 17 December 1968;

Recalling United Nations General Assembly resolution 58/208 on International migration and development, and the decision therein that, in 2006, the General Assembly will devote a high-level dialogue to international migration and development;

Further recalling resolutions WHA22.51 (1969) and WHA25.42 (1972);

Noting that the African Union declared 2004 "Year for Development of Human Resources in Africa";

Taking note of the Commonwealth Code of Practice for the International Recruitment of Health Workers, which was adopted at the meeting of Commonwealth health ministers (Geneva, 18 May 2003);

Noting the work in progress on international labour migration in the International Organization for Migration, the Global Commission on International Migration, and in other international bodies;

Recognizing the importance of human resources in strengthening health systems and in successful realization of the internationally agreed goals contained in the United Nations Millennium Declaration;

Noting with concern that highly trained and skilled health personnel from the developing countries continue to emigrate at an increasing rate to certain countries, which weakens health systems in the countries of origin;

Being aware of the work undertaken in United Nations organizations and in other international organizations with a view to strengthening the capacity of governments to manage migration flows at national and regional levels, and the need for further action to address, at both national and international levels, as an integrated part of the Sector Wide Approaches and other development plans, the issue of migration of trained health-care personnel;

Noting further that many developing countries are not yet technically equipped to assess adequately the magnitude and characteristics of the outflow of their health personnel;

Recognizing the significant efforts and investment made by developing countries in training and development of human resources for health;

Further recognizing the efforts made to reverse the migration of health personnel from developing countries and aware of the need to increase these efforts;

Concerned that HIV/AIDS, tuberculosis, malaria and other such communicable diseases are placing additional burdens on the health workforce;

1. URGES Member States:

(1) to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems;

(2) to frame and implement policies and strategies that could enhance effective retention of health personnel including, but not limited to, strengthening of human resources for health planning and management, and review of salaries and implementation of incentive schemes;

(3) to use government-to-government agreements to set up health-personnel exchange programmes as a mechanism for managing their migration;

(4) to establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin;

2. REQUESTS the Director-General:

(1) to establish and maintain, in collaboration with relevant countries, institutions or organizations, information systems which will enable the appropriate international bodies to monitor independently the movement of human resources for health;

(2) in cooperation with international organizations within their respective mandates, including the World Trade Organization, to conduct research on international migration of health personnel, including in relation to trade agreements and remittances, in order to determine any adverse effects and possible options to address them;

(3) to explore additional measures that might assist in developing fair practices in the international recruitment of health personnel, including the feasibility, cost and appropriateness of an international instrument;

(4) to support Member States in strengthening their planning mechanisms and processes in order to provide for adequate training of personnel to match their needs;

(5) to develop, in consultation with Member States and all relevant partners, including development agencies, a code of practice[1] on the international recruitment of health personnel, especially from developing countries, and to report on progress to the Fifty-eighth World Health Assembly;

(6) to support efforts of countries by facilitating dialogue and raising awareness at the highest national and international levels and between stakeholders about migration of health personnel and its effects, including examination of modalities for receiving countries to offset the loss of health workers, such as investing in training of health professionals;

[1] It is understood that, within the United Nations system, the expression “code of practice” refers to instruments that are not legally binding.

(7) to mobilize all relevant programme areas within WHO, in collaboration with Member States, in order to develop human-resources capability and to improve health support to developing countries by setting up appropriate mechanisms;

(8) to consult with the United Nations and specialized agencies on the possibility of declaring a year or a decade of "Human Resources for Health Development";

(9) to declare the theme of World Health Day 2006 to be "Human Resources for Health Development";

(10) to include human resources for health development as a top-priority programme area in WHO's General Programme of Work 2006–2015;

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

(Eighth plenary meeting, 22 May 2004 –
Committee A, third report)

DECISIONS

WHA57(1) Composition of the Committee on Credentials

The Fifty-seventh World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Austria, Belize, Canada, Djibouti, Gambia, India, Italy, Kenya, Mali, Myanmar, Papua New Guinea, Uzbekistan.

(First plenary meeting, 17 May 2004)

WHA57(2) Composition of the Committee on Nominations

The Fifty-seventh World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, China (People's Republic of), Democratic Republic of the Congo, Eritrea, Estonia, France, Guyana, Israel, Mexico, Micronesia (Federated States of), Monaco, Mozambique, Nicaragua, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Dr Khandaker Mosharraf Hossain, Bangladesh (President, Fifty-sixth World Health Assembly, ex officio).

(First plenary meeting, 17 May 2004)

WHA57(3) Election of officers of the Fifty-seventh World Health Assembly

The Fifty-seventh World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers:

President: Mr Muhammad Nasir Khan (Pakistan)

Vice-Presidents: Dr M.E. Tshabalala-Msimang (South Africa)
Mrs A. David-Antoine (Grenada)
Mr S. Bogoev (Bulgaria)
Dr R. Maria de Araujo (Timor-Leste)
Dr Chua Soi Lek (Malaysia)

(First plenary meeting, 17 May 2004)

WHA57(4) Election of officers of the main committees

The Fifty-seventh World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers of the main committees:

Committee A:	**Chairman**	Dr Ponmek Dalaloy (Lao People's Democratic Republic)
Committee B:	**Chairman**	Dr Jigmi Singay (Bhutan)

(First plenary meeting, 17 May 2004)

The main committees subsequently elected the following officers:

Committee A:	**Vice-Chairmen**	Dr D. Slater (Saint Vincent and the Grenadines) Mrs A. Van Bolhuis (Netherlands)
	Rapporteur	Professor M. Mizanur Rahman (Bangladesh)
Committee B:	**Vice-Chairmen**	Professor N. M. Nali (Central African Republic) Dr S. Al Kharabseh (Jordan)
	Rapporteur	Mrs Z. Jakab (Hungary)

(First meetings of Committees A and B, 18 and 20 May 2004)

WHA57(5) Establishment of the General Committee

The Fifty-seventh World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: Botswana, Chad, Chile, China (People's Republic of), Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America, and Yemen.

(First plenary meeting, 17 May 2004)

WHA57(6) Adoption of the agenda

The Fifty-seventh World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 113th session with the deletion of one item and three subitems, and the addition of a supplementary item.

(Second plenary meeting, 17 May 2004)

WHA57(7) Verification of credentials

The Fifty-seventh World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia;[1] Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Micronesia (Federated States of); Mexico; Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia and Montenegro, Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Venezuela; Viet Nam; Yemen; Zambia; Zimbabwe.

(Fourth and seventh plenary meetings, 19 and 21 May 2004)

WHA57(8) Election of Members entitled to designate a person to serve on the Executive Board

The Fifty-seventh World Health Assembly, after considering the recommendations of the General Committee,[2] elected the following as Members entitled to designate a person to serve on the Executive Board: Australia, Bahrain, Bolivia, Brazil, Jamaica, Kenya, Lesotho, Libyan Arab Jamahiriya, Luxembourg, Romania, Thailand, Tonga.

(Seventh plenary meeting, 21 May 2004)

[1] Credentials provisionally accepted.

[2] Document A57/38.

WHA57(9) Intellectual property rights, innovation and public health

The Fifty-seventh World Health Assembly decided to request the Director-General to delay submission of the final report on the outcome of the work of the Commission on Intellectual Property Rights, Innovation and Public Health, established pursuant to resolution WHA56.27, until the 117th session of the Executive Board (January 2006) since additional time was necessary for the Commission to complete its work.

(Seventh plenary meeting, 21 May 2004)

WHA57(10) Budget allocations to regions

The Fifty-seventh World Health Assembly, after considering the report on regular budget allocations to regions,[1] noting the recommendations contained in paragraph 21, decided to request the Director-General to draw up, in consultation with Member States and regions, guiding principles, based on objective criteria, to be applied in the allocation of funds from all sources, taking into account equity, efficiency and performance, and support to countries in greatest need, in particular least developed countries, which would be considered by the Executive Board at its 115th session.

(Eighth plenary meeting, 22 May 2004)

WHA57(11) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Fifty-seventh World Health Assembly nominated Dr J. Larivière, delegate of Canada, as member of the WHO Staff Pension Committee, and Dr A.A. Yoosuf, delegate of Maldives, as alternate member, each for a three-year period, namely until May 2007.

The Fifty-seventh World Health Assembly also nominated Dr L. Waqatakirewa, delegate of Fiji, as member of the Committee for the remainder of the term of office of Mr L. Rokovada, namely, until May 2005.

(Eighth plenary meeting, 22 May 2004)

WHA57(12) Policy for relations with nongovernmental organizations

The Fifty-seventh World Health Assembly decided to postpone consideration of the new policy on nongovernmental organizations[2] in order to provide the Director-General time to consult all interested parties with a view to reaching consensus on the terms of the relevant resolution to be submitted to a subsequent Health Assembly through the Executive Board.

(Eighth plenary meeting, 22 May 2004)

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[1] Document A57/24.

[2] See document A57/32.

WHA57(13) Selection of the country in which the Fifty-eighth World Health Assembly would be held

The Fifty-seventh World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Fifty-eighth World Health Assembly would be held in Switzerland.

(Eighth plenary meeting, 22 May 2004)

WHA57(14) Reports of the Executive Board on its 112th and 113th sessions

The Fifty-seventh World Health Assembly, after reviewing the Executive Board's reports on its 112th[1] and 113th[2] sessions, took note of the reports, commended the work the Board had performed, and expressed its appreciation of the dedication with which the Board had carried out the tasks entrusted to it.

(Ninth plenary meeting, 22 May 2004)

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[1] Document EB112/2003/REC/1.

[2] Documents EB113/2004/REC/1 and EB113/2004/REC/2.

ANNEXES

ANNEX 1

Agreement between the Office International des Epizooties (OIE) and the World Health Organization (WHO)[1]

[A57/28, Annex – 8 April 2004]

The World Health Organization (hereinafter referred to as WHO) and the Office International des Epizooties (hereinafter referred to as the OIE) wishing to co-ordinate their efforts for the promotion and improvement of veterinary public health (VPH) and food security and safety, and to collaborate closely for this purpose

Have agreed to the following:

Article 1

1.1 WHO and the OIE agree to cooperate closely in matters of common interest pertaining to their respective fields of competence as defined by their respective constitutional instruments and by the decisions of their Governing Bodies.

Article 2

2.1 WHO shall transmit relevant resolutions of the World Health Assembly and the recommendations of relevant WHO consultations, workshops and other official WHO meetings to OIE for the purpose of circulating them to OIE Members.

2.2 The OIE shall transmit the recommendations and resolutions of its International Committee as well as the recommendations of relevant OIE consultations, workshops and other official OIE meetings to WHO for the purpose of circulating them to WHO Member States.

2.3 These resolutions and recommendations sent for the consideration of the respective bodies of the two Organizations (hereinafter referred to as the Parties) shall form the basis for coordinated international action between the two Parties.

Article 3

3.1 Representatives of WHO shall be invited to attend the meetings of the International Committee and Regional Conferences of OIE and to participate without vote in the deliberations of these bodies with respect to items on their agenda in which WHO has an interest.

3.2 Representatives of OIE shall be invited to attend the meetings of the Executive Board and of the World Health Assembly and Regional Committees of WHO and to participate without vote in the deliberations of these bodies with respect to items on their agenda in which OIE has an interest.

[1] See resolution WHA57.7.

3.3 Appropriate arrangements shall be made by agreement between the Director-General of WHO and the Director-General of OIE for participation of WHO and OIE in other meetings of a non-private character convened under their respective auspices which consider matters in which the other party has an interest; this especially involves those meetings leading to the definition of norms and standards.

3.4 The two Parties agree to avoid holding meetings and conferences dealing with matters of mutual interest without prior consultation with the other party.

Article 4

WHO and OIE shall collaborate in areas of common interest particularly by the following means:

4.1 Reciprocal exchange of reports, publications and other information, particularly the timely exchange of information on zoonotic and foodborne disease outbreaks. Special arrangements will be concluded between the two Parties to coordinate the response to outbreaks of zoonotic or/and foodborne diseases of recognized or potential international public health importance.

4.2 Organizing on both a regional and a world-wide basis meetings and conferences on zoonoses, foodborne diseases and related issues such as animal feeding practices and anti-microbial resistance related to the prudent use of anti-microbials in animal husbandry and their containment/control policies and programmes.

4.3 Joint elaboration, advocacy and technical support to national, regional or global programmes for the control or elimination of major zoonotic and foodborne diseases or emerging/re-emerging issues of common interest.

4.4 Promoting and strengthening, especially in developing countries, VPH education, operationalization of VPH and effective co-operation between the public health and animal health/veterinary sectors.

4.5 International promotion and coordination of research activities on zoonoses, VPH and food safety.

4.6 Promoting and strengthening collaboration between the network of OIE Reference Centres and Laboratories and that of WHO Collaborating Centres and Reference Laboratories to consolidate their support to WHO Member States and OIE Members on issues of common interest.

Article 5

5.1 WHO and OIE will, in the course of the preparation of their respective programmes of work, exchange their draft programmes for comment.

5.2 Each party will take into account the recommendations of the other in preparing its final programme for submission to its governing body.

5.3 WHO and OIE will conduct one annual coordinating meeting of high level officials from headquarters and/or regional representation.

5.4 The two Parties should devise administrative arrangements necessary to implement these policies, such as the sharing of experts, common organization of joint scientific and technical meetings, joint training of health and veterinary personnel.

Article 6

6.1 The present Agreement shall enter into force on the date on which it is signed by the Director-General of WHO and the Director-General of the OIE, subject to the approval of the International Committee of the OIE and the World Health Assembly.

6.2 This Agreement may be modified by mutual consent expressed in writing. It may also be terminated by either party by giving 6 months' notice in writing to the other party.

Article 7

7.1 This Agreement supersedes the Agreement between the WHO and OIE adopted by WHO on 4 August 1960 and by the OIE on 8 August 1960.

Adopted by WHO on 18 December 2002 and the OIE on 26 May 2003

Dr D.L. Heymann,
Executive Director
Communicable Diseases

Dr B. Vallat
Director-General

ANNEX 2

Strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health[1]

[A57/13, Annex – 15 April 2004]

INTRODUCTION

1. Reproductive and sexual health[2] is fundamental to individuals, couples and families, and the social and economic development of communities and nations. Concerned about the slow progress made in improving reproductive and sexual health over the past decade, and knowing that the international development goals would not be achieved without renewed commitment by the international community, the Fifty-fifth World Health Assembly adopted resolution WHA55.19 requesting WHO to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health. The resolution recalled and recognized the programmes and plans of action agreed by governments at the International Conference on Population and Development (Cairo, 1994) and the United Nations Fourth World Conference on Women (Beijing, 1995), and at their respective five-year follow-up review conferences.[3]

2. In response to resolution WHA55.19, and following consultations with Member States and partners, WHO has designed a strategy that builds on actions taken by Member States pursuant to resolution WHA48.10 on Reproductive health: WHO's role in the global strategy, which urged Member States to further develop and strengthen their reproductive health programmes.

3. The strategy presented in this document is intended for a broad audience of policy-makers within governments, international agencies, professional associations, nongovernmental organizations and other institutions. Part I sets out the major discrepancies between global goals and global realities, and describes the principal barriers to progress, noting in particular the inequities related to gender and poverty and the exposure to risk of adolescents. Part II lays out the strategy, which is guided by principles based on international human rights. It highlights the core aspects of reproductive and sexual health services and proposes ways for countries and WHO to take innovative approaches. It concludes by reaffirming WHO's corporate commitment to collaboration with its partners in order to encourage and support Member States in their efforts to attain the United Nations Millennium Development Goals and other internationally agreed goals and targets relating to reproductive and sexual health.

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[1] See resolution WHA57.12.

[2] The definition of reproductive health proposed by WHO and agreed to at the International Conference on Population and Development (Cairo, 1994) includes sexual health (see box).

[3] Twenty-first special session of the United Nations General Assembly for an overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development (New York, 1999) and twenty-third special session of the United Nations General Assembly on Women 2000: gender equality, development and peace for the 21st century (New York, 2000).

I. GLOBAL GOALS, GLOBAL REALITIES

4. The Millennium Development Goals, which grew out of the United Nations Millennium Declaration adopted by 189 Member States in 2000, provide the new international framework for measuring progress towards sustaining development and eliminating poverty. Of the eight Goals, three – improve maternal health, reduce child mortality and combat HIV/AIDS, malaria and other diseases – are directly related to reproductive and sexual health, while four others – eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, and ensure environmental sustainability – have a close relationship with health, including reproductive health. Among the specific targets are:

- to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio;
- to reduce by two thirds, between 1990 and 2015, the under-five mortality rate;
- to have halted by 2015, and begun to reverse, the spread of HIV/AIDS.

5. Additional benchmarks were agreed in 1999 at the twenty-first special session of the United Nations General Assembly for an overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development. For example, by 2015, the proportion of all births assisted by skilled attendants should reach 90% globally and at least 60% in countries with high rates of maternal death.[1]

Reproductive and sexual health and rights as defined in the Programme of Action of the International Conference on Population and Development[1]

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (Paragraph 7.2)

"Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ..." (Paragraph 7.3)

[1] United Nations document A/CONF.171/13: Report of the ICPD.

[1] United Nations document A/S-21/5/Add.1, paragraph 64.

6. The definition of reproductive health adopted at the International Conference on Population and Development in 1994 (see box) captures the essential characteristics that make reproductive and sexual health unique compared to other fields of health. Reproductive health extends before and beyond the years of reproduction, and is closely associated with sociocultural factors, gender roles and the respect and protection of human rights, especially – but not only – in regard to sexuality and personal relationships.

7. The adoption of these comprehensive definitions at the International Conference on Population and Development marked the beginning of a new era, and the achievements of the past decade are many and profound. For example, the concept of reproductive and sexual health and rights has, with few exceptions, been widely accepted and has begun to be used by international health and development bodies, national governments, nongovernmental organizations and other parties. New reproductive health policies and programmes have been defined in almost all countries. Their adoption has produced significant changes in some countries in the conventional modes of delivering maternal and child health or family planning services.

8. Following this conceptualization of, and commitment to, reproductive and sexual health, new partnerships have been forged at national, regional and global levels. New evidence has also been collected in previously neglected areas such as the burden of disease due to reproductive and sexual ill-health and its relation to poverty, and gender-based violence. The number of evidence-based best practices in reproductive and sexual health care has grown substantially, and the scope of clinical and behavioural research and of internationally recognized standards, norms and guidelines has broadened.

9. Experience has shown that, even in low-income settings, innovative country-specific approaches can considerably reduce maternal mortality and morbidity, for example. The challenge now is to formulate innovative national strategies for making health services accessible to the people in greatest need, such as adolescents and the poor, in order to attain international goals. At present, many countries suffer from persistently high rates of maternal mortality and morbidity, perinatal mortality, reproductive tract infections and sexually transmitted infections including HIV, unwanted pregnancies, unsafe abortion, and risky sexual behaviour, as the data below show.

Global situation

Pregnancy, childbirth and health of newborns

10. Each year, some eight million of the estimated 210 million women who become pregnant, suffer life-threatening complications related to pregnancy, many experiencing long-term morbidities and disabilities. In 2000, an estimated 529 000 women died during pregnancy and childbirth from largely preventable causes. Globally, the maternal mortality ratio has not changed substantially over the past decade.

11. Regional inequities are extreme, with 99% of these maternal deaths occurring in developing countries. The lifetime risk of death from maternal causes in sub-Saharan Africa is 1 in 16 and in South-East Asia 1 in 58, compared with 1 in 4000 in industrialized countries.

12. Most maternal deaths arise from complications during childbirth (e.g. severely obstructed labour, especially in early first pregnancies; haemorrhage and hypertensive complications), in the immediate postpartum period (sepsis and haemorrhage), or after unsafe abortion. Factors commonly

associated with these deaths are the absence of skilled health personnel[1] during childbirth, lack of services able to provide emergency obstetric care and deal with the complications of unsafe abortion, and ineffective referral systems.

13. More than 50% of women living in the world's poorest regions – the percentage is higher than 80% in some countries – deliver their babies without the help of a skilled birth attendant. In sub-Saharan Africa these proportions have not changed over the past decade. Antenatal care is available and widely used in industrialized countries; by contrast, in the late 1990s, almost half of pregnant women in southern Asia and one third in western Asia and sub-Saharan Africa received no antenatal care at all, compared with less than one fifth in eastern Asia and in Latin America and the Caribbean.

14. Of the 10.8 million deaths worldwide of children under five, 3.0 million occur during the first seven days of the neonatal period. Additionally, an estimated 2.7 million infants are stillborn. Many of these deaths are related to the poor health of the woman and inadequate care during pregnancy, childbirth and the postpartum period. The neonatal mortality rate (death in the first 28 days) in developing countries has remained unchanged since the early 1980s at about 30 deaths per 1000 live births. Furthermore, a mother's death can seriously compromise the survival of her children.

Family planning

15. Contraceptive use has substantially increased in many developing countries and in some is approaching that practised in developed countries. Yet surveys indicate that, in developing countries and countries in transition, more than 120 million couples have an unmet need for safe and effective contraception despite their expressed desire to avoid or to space future pregnancies.

16. Between 9% and 39% of married women (including women in union) have this unmet need for family planning. Data suggest that unmarried sexually active adolescents and adults also face this unmet need. About 80 million women every year have unintended or unwanted pregnancies, some of which occur through contraceptive failure, as no contraceptive method is 100% effective.

Unsafe abortion

17. Some 45 million unintended pregnancies are terminated each year, an estimated 19 million of which abortions are unsafe;[2] 40% of all unsafe abortions are performed on young women aged 15 to 24. Unsafe abortions kill an estimated 68 000 women every year, representing 13% of all pregnancy-related deaths. In addition, they are associated with considerable morbidity; for instance, studies indicate that of every five women who have an unsafe abortion, at least one suffers a reproductive tract infection as a result; some of these infections are serious, leading to infertility.

Sexually transmitted infections, including HIV, and reproductive tract infections

18. An estimated 340 million new cases of sexually transmitted bacterial infections, most of which are treatable, occur annually. Many are untreated because they are difficult to diagnose and because

[1] "Skilled birth attendant" or "skilled health personnel" refers to a health professional such as a midwife, doctor or nurse, who is trained and competent in the skills needed to manage normal childbirth and the immediate postnatal period, and who can identify complications and, as necessary, provide emergency management and/or refer the case to a higher level of health care.

[2] An unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both (see The prevention and management of unsafe abortion, Report of a technical working group, document WHO/MSM/92.5, 1992).

competent, affordable services are lacking. In addition, millions of cases of mostly-incurable viral infections occur annually, including five million new HIV infections, 600 000 of which are in infants owing to mother-to-child transmission.

19. Sexually transmitted human papillomavirus infection is closely associated with cervical cancer, which is diagnosed in more than 490 000 women and causes 240 000 deaths every year. Three quarters of all cervical cancer cases occur in developing countries where programmes for screening and treatment are seriously deficient or lacking.

20. More than 100 million mostly-curable sexually transmitted infections occur each year in young people aged 15 to 24. These infections facilitate the acquisition and spread of HIV. Almost half all new HIV infections occur in young people. Despite recent positive trends among young people (especially females) in some African countries, overall about twice as many young women as men are infected with HIV in sub-Saharan Africa. In 2001, an estimated 6% to 11% of young women in sub-Saharan Africa were living with HIV/AIDS, compared with 3% to 6% of young men. In other developing regions, the proportion of women with HIV/AIDS is also higher than for men. Additionally, reproductive tract infections, such as bacterial vaginosis and genital candidiasis, which are not sexually transmitted, are known to be widespread, although the prevalence and consequences of these infections are not well documented.

21. Sexually transmitted infections are also a leading cause of infertility: some 60 to 80 million couples worldwide suffer from infertility and consequent involuntary childlessness, often as a result of tubal blockage caused by an untreated or inadequately treated sexually transmitted infection.

22. Together, these aspects of reproductive and sexual ill-health (maternal and perinatal mortality and morbidity, cancers, sexually transmitted infections and HIV/AIDS) account for nearly 20% of the global burden of ill-health for women and some 14% for men. These statistics do not capture the full burden of ill-health, however. Gender-based violence, and gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, uterine prolapse, pregnancy loss, and sexual dysfunction – all of which have major social, emotional and physical consequences – are currently severely underestimated in present global burden of disease estimates. WHO estimates unsafe sex to be the second most important global risk factor to health.

Barriers to progress

Inequities related to gender

23. Gender disparities in health are often striking. Families may invest less in nutrition, health care, schooling and vocational training for girls than for boys. Sex discrimination and low social status of girls and women frequently result in poor physical and mental health, physical or emotional abuse, and low levels of control over their own lives, particularly their sexual and reproductive lives.

24. Violence against women in its many forms has an impact on their reproductive and sexual health. In particular, violence from an intimate partner, which occurs throughout the world, includes physical, sexual and emotional abuse. Studies show that between 4% and 20% of women experience violence during pregnancy, with consequences both for them and their babies, such as miscarriage, premature labour and low birth weight. Available data suggest that in some countries nearly one woman in four experiences sexual violence from an intimate partner. Rape and sexual assault by acquaintances and strangers is also common. Trafficking of women and children and forced prostitution are also serious problems, particularly in some regions. The consequences for reproductive and sexual health are extensive and include unwanted pregnancy, unsafe abortion, chronic pain syndromes, sexually transmitted infections including HIV, and gynaecological disorders.

Adolescents' exposure to risk

25. In most countries, taboos and norms about sexuality (including practices such as child marriage, female genital mutilation and early sexual initiation) pose strong barriers to providing the information, reproductive health services and other forms of support that young people need to be healthy. Yet, sexual and reproductive behaviours during adolescence (between the ages of 10 and 19) have immediate and long-term consequences. In some parts of the world, sexual activity begins during adolescence, and is often risky, whether within or outside marriage. Adolescents rarely have the ability or support to resist pressure to have sexual relations, negotiate safer sex, or protect themselves against unintended pregnancy and sexually transmitted infections. For very young girls, pregnancy carries a high risk of maternal mortality and morbidity. Meeting the needs and protecting the rights of the 1200 million adolescents worldwide are essential to safeguard the health of this and future generations.

Inequities related to poverty and access to health services

26. Poverty is almost universally associated with inequitable access to health services, particularly maternal health services. The burden of reproductive and sexual ill-health is greatest in the poorest countries where health services tend to be scattered or physically inaccessible, poorly staffed, resourced and equipped, and beyond the reach of many poor people. Too often, improvements in public health services disproportionately benefit the better-off, and it is theoretically possible to achieve some of the international health goals without including the lowest income quintile and vulnerable population groups.

27. Since the 1980s, various health-sector reforms have been introduced in many countries, affecting availability of, and access to, health services, including those for reproductive and sexual health. Financing projects, such as prepaid insurance schemes and means-tested subsidies, have frequently failed to result in the desired equitable access for poor people. Thus, special attention is needed to ensure that disadvantaged groups can access prevention, treatment and life-saving services such as emergency obstetric care.

Other challenges

28. Recent years have witnessed a decline in overall development aid, while new mechanisms of external financing for health have come into play, such as poverty reduction strategy papers, sector-wide approaches and direct budget support. Also, major new sources of health-sector funding, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, concentrate resources on specific diseases and interventions. It is important to ensure that these new developments contribute to the building of sustainable health-system capacity, including that for reproductive and sexual health services.

29. In many countries, inadequate human resources are a major barrier to the expansion of comprehensive reproductive and sexual health services, and to better quality of care. Weaknesses include the severe shortage of personnel, inadequate skills of available personnel, rapid turnover and loss of skilled workers, and the inefficient use and distribution of those who are already in the system. Low or unpaid salaries and poor training, supervision and working conditions are root causes of poor performance and high turnover of health-care professionals. Strategic planning for building and retaining an appropriately skilled health workforce, including for instance skilled birth attendants, is crucial to progress in reproductive and sexual health care.

30. In addition to the barriers that poor and other disadvantaged people face in accessing health services generally, such as distance from services, lack of transport, cost of services and

discriminatory treatment of users, reproductive health presents special difficulties. These derive from social and cultural factors such as taboos surrounding reproduction and sexuality, women's lack of decision-making power related to sex and reproduction, low values placed on women's health, and negative or judgmental attitudes of family members and health-care providers. A holistic examination by communities and local health-care providers of beliefs, attitudes and values offers an important start to overcoming these fundamental obstacles.

31. Over the past two decades, advances have been made in life-saving technologies in reproductive health and effective clinical and programmatic practices. Even with electronic databases and interactive tools, however, many health systems and service providers have little or no access to this new information. Effective demonstration projects in many countries, including introduction of technology and best practices, often fail to be implemented on a larger scale. Failure to use appropriate strategic planning based on adequate qualitative and quantitative data has limited the understanding of reasons for poor quality of services and people's lack of access to, and use of, services.

32. In some countries, laws, policies and regulations may hinder access to services (e.g. excluding unmarried people from contraceptive services), unnecessarily limit the roles of health personnel (e.g. preventing midwives from performing life-saving procedures such as removal of the placenta), bar the provision of some services (e.g. over-the-counter provision of emergency contraception), or restrict the importation of some essential drugs and technologies. Removal of such restrictions is likely to contribute significantly to improving people's access to services.

II. THE STRATEGY TO ACCELERATE PROGRESS

33. The overarching objective of the strategy is to accelerate progress towards meeting internationally agreed reproductive health targets and, ultimately, to attain the highest achievable standard of reproductive and sexual health for all.

Guiding principle: human rights

34. WHO's strategy for accelerating progress rests on internationally agreed instruments and global consensus declarations on human rights, including the right of all persons to the highest attainable standard of health; the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over, and decide freely and responsibly on, matters related to their sexuality, including sexual and reproductive health – free of coercion, discrimination and violence; the right of men and women to choose a spouse and to enter into marriage only with their free and full consent; the right of access to relevant health information; and the right of everyone to enjoy the benefits of scientific progress and its applications. In order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality, give priority to poor and underserved populations and population groups, especially adolescents, and provide special support to those countries that bear the largest burden of reproductive and sexual ill-health.

Core aspects of reproductive and sexual health services

35. The five core aspects of reproductive and sexual health are: improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health. Because of the close links between the different aspects of reproductive and sexual health, interventions in one area are likely to have a positive impact on the others. It is critical for

countries to strengthen existing services and use them as entry points for new interventions, looking for maximum synergy.

36. In most countries, the major entry point will be antenatal, childbirth and postpartum services, which form the backbone of primary health care. Central to reducing maternal morbidity and mortality, and perinatal mortality, are the attendance at every birth of skilled health personnel and comprehensive emergency obstetric care to deal with complications. Provision of these services requires effective referral systems for communication and transport between service points. Maternal health services offer a key opportunity to reach women with family planning. They are also an excellent means through which to offer women prevention, counselling, testing and treatment for HIV infection and for preventing HIV transmission during pregnancy and birth and through breastfeeding. Indeed, it is only through these services that these interventions can be adequately provided. These points are further elaborated in the WHO strategy for making pregnancy safer.

37. As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health and other international development goals and targets. Several urgent actions are needed, including strengthening family planning services to prevent unintended pregnancies, and, to the extent allowed by law, ensuring that services are available and accessible. Also to the extent allowed by law, provision of safe abortion services requires training health-service providers in modern techniques and equipping them with appropriate drugs and supplies, all of which should be available for gynaecological and obstetric care; providing social and other support to women with unintended pregnancies; and, to the extent allowed by law, providing abortion services at primary health care level. For those women who suffer complications of unsafe abortion, prompt and humane treatment through post-abortion care must be available.

38. The success of family planning services in most countries of the world is evidenced by the great increase in contraceptive use in developing countries over the past two to three decades. These programmes are an essential part of services to reduce maternal and perinatal morbidity and mortality because they enable women to postpone, space and limit pregnancies. As these services are directly concerned with the outcomes of sexual relationships, they also have great potential for leading the way in promoting sexual health and efforts to prevent sexually transmitted infections and HIV transmission.

39. Sexually transmitted infections are being diagnosed and treated by pharmacists, drug sellers and traditional healers, often ineffectively. Various attempts have been made to reach women by integrating sexually transmitted infections management into existing maternal and child health and/or family planning services, but with limited success. Nonetheless, experience shows that integration of sexually transmitted infection prevention into family planning services, especially through counselling and discussion of sexuality and partner relationships, has increased the use of services and improved quality of care. These approaches can be built on and improved in order to expand coverage and outreach to men, youth and other groups not previously the focus of family planning. In addition, presumptive treatment in groups at high risk and comprehensive, community-based programmes to control sexually transmitted infections could greatly contribute to the reduction of HIV transmission rates.

40. Additional gains from strengthening reproductive health services are numerous. They include attention to violence against women, which is now being tackled in various country settings with, for instance, provision of emergency contraception, abortion (to the extent allowed by law) if requested, treatment of sexually transmitted infections and post-exposure prophylaxis for HIV infection after rape, screening and treatment of cervical cancer, prevention of primary and secondary infertility, and treatment of gynaecological conditions. Well-designed and effectively delivered reproductive and sexual health services, especially those involving community participation, can also contribute to

improved user-provider relations, men's participation, and women's empowerment to make reproductive choices.

41. All reproductive and sexual health services have a key role to play in providing information and counselling in promoting sexual health. Appropriate information can also contribute to better communication between partners and healthier sexual decision-making, including abstinence and condom use.

Actions

42. WHO proposes the following key action areas for countries, and is committed to supporting Member States in building and strengthening their capacity to improve reproductive and sexual health. Each country needs to identify problems, set priorities and formulate strategies for accelerated action through consultative processes involving all stakeholders. Five overarching activities are: strengthening health systems capacity, improving information for priority setting, mobilizing political will, creating supportive legislative and regulatory frameworks, and strengthening monitoring, evaluation and accountability.

Strengthening health systems capacity

43. A prerequisite for attaining the Millennium Development Goals relating to maternal and infant survival and HIV/AIDS, as well as the broader reproductive and sexual health goals, is the existence of a functioning system of essential health care at the primary, secondary and tertiary levels. In some countries, basic health service capacity will have to be strengthened substantially in order to enable provision of a comprehensive range of essential reproductive and sexual health services. Planning at national level for reproductive and sexual health will have to cover sustainable financing mechanisms, human resources, quality in service provision and use of services.

44. **Sustainable financing mechanisms.** The central importance of reproductive and sexual health needs to be reflected in national health-sector planning and strategic development. Health-sector reforms and related initiatives such as sector-wide approaches to donor funding have been promoted as a means of strengthening health systems. The challenge is to ensure that these initiatives and other financing mechanisms foster good quality, comprehensive reproductive and sexual health services, and progress towards universal access.

45. Necessary **actions** in this area are:

(1) to make reproductive and sexual health central to national planning and strategy development processes, including poverty reduction strategy papers and WHO country cooperation strategies;

(2) to ensure that reproductive and sexual health is appropriately reflected in national health-sector plans, including those covering the "3 by 5" initiative, proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other relevant initiatives;

(3) to prioritize reproductive and sexual health in essential service packages under health-sector reforms and sector-wide approaches; and

(4) where new financing mechanisms such as cost sharing are being introduced, to design ways to facilitate access to services by adolescents, poor people and other disadvantaged groups, to monitor the effects of such policies and to adapt them to local conditions.

46. **Human resources**. Training, recruiting, deploying and retaining skilled health personnel are central elements in improving health and health care generally. Many core reproductive and sexual health interventions can be made by mid-level professionals and paramedical workers. The challenge is to determine the cadres of health workers, skills and forms of training that are most necessary to provide the prioritized reproductive and sexual health services. Enabling conditions will have to be created for health workers to realize their full potential and to motivate them to work with all population groups, including the poorest.

47. Necessary **actions** in this area are:

(1) to determine the essential requirements at all levels for numbers and distribution of health workers with the skills needed to perform prioritized reproductive and sexual health interventions;

(2) to assess and improve work environments, conditions of employment and supervision;

(3) to formulate a strategy to motivate and retain skilled personnel; and

(4) to promote policies that enable health-care workers to use their skills to the full.

48. **Quality in service provision**. Up-to-date practices implemented in teaching hospitals and special projects are frequently not adopted throughout the system, with the result that overall performance remains poor and inequalities in both quality and access persist. Decentralized planning and responsibility associated with health-sector reforms need to give special attention to facilitating system-wide adoption of good practices. Logistical systems for sustained provision of essential commodities must be established.

49. Necessary **actions** in this area are:

(1) to conduct strategic planning, involving health professionals and managers, to assess current quality of care and to determine the best way to improve quality within existing resource constraints;

(2) to design and test strategies to expand interventions of proven effectiveness;

(3) to formulate, adopt and monitor standards for clinical practice in private and public sectors;

(4) to recruit partners among nongovernmental organizations and within the private and commercial sectors to maximize availability and use of reproductive health services; and

(5) to promote the sharing of lessons learnt within and between countries.

50. **Use of services**. Where health services exist, there are many reasons – social, economic and cultural – why people nevertheless do not use them, particularly in relation to reproductive and sexual health. Identifying and overcoming obstacles requires working with women, young people, and other community groups to understand better their needs, analyse problems and find acceptable solutions.

51. Necessary **actions** in this area are:

(1) to carry out social and operations research to identify barriers to use of services and devise and test measures to overcome them; and

(2) to use participatory approaches to work with communities, public and private sector institutions, and nongovernmental organizations to overcome such barriers and promote appropriate use of available services.

Improving information for priority setting

52. Analysis of epidemiological and social science data is needed to understand the type, severity and distribution of reproductive and sexual risk exposure and ill-health in the population, to interpret the dynamics that drive poor reproductive and sexual health, and to illuminate the links between such ill-health and poverty, gender and social vulnerability. Improved data collection and analysis, including information about costs and cost-effectiveness, are essential bases for selecting among competing priorities for action and for aiming health-system interventions at targets that are most likely to make a difference within the limits of available resources.

53. The process of setting priorities on the basis of good data, however, must involve multiple stakeholders from government, bilateral and multilateral agencies, professional associations, women's groups and other sectors of civil society. Bringing together these different stakeholders with their varied perspectives will help to build a broad consensus, foster collaboration and increase the likelihood that interventions will be successful. Stakeholders must carefully balance cost-effectiveness with equity and consider the need to invest more in order to reach the poor and other underserved groups.

54. Necessary **actions** in this area are:

(1) to strengthen the capabilities for collecting and analysing data about health status, its underlying determinants and the functioning of health services at local, district and national levels; and

(2) to set priorities based on data, using a multiple stakeholder consultative process, with attention being paid to equitable access especially for poor and other underserved groups.

Mobilizing political will

55. Creating a dynamic environment of strong international, national and local support for rights-based reproductive and sexual health initiatives will help to overcome inertia, galvanize investment and establish high standards and mechanisms for performance accountability. This requires the involvement of not only ministries of health, but also ministries of finance, education and possibly other sectors, and their counterparts at district and local levels. Political commitment and advocacy must be sufficiently strong to sustain good policies and programmes, particularly for underserved groups.

56. Necessary **actions** in this area are:

(1) to build strong support for investment in reproductive and sexual health using evidence of benefits to public health and human rights;

(2) to mobilize crucial constituencies (e.g. health professionals, legal experts, human rights groups, women's associations, governmental ministries, political leaders and parties, religious and community leaders) to support a national reproductive and sexual health agenda and make concerted use of the mass media; and

(3) to build a strong, evidence-based case for strategic investment in adolescent sexual and reproductive health and rights, and place them high on the national agenda; to disseminate information on the nature, causes and consequences of adolescents' reproductive health needs and problems, such as their vulnerability to sexually transmitted infections including HIV, unwanted pregnancies, unsafe abortion, early marriage or childbearing, and sexual coercion and violence, both within and outside marriage.

Creating supportive legislative and regulatory frameworks

57. Removal of unnecessary restrictions from policies and regulations, in order to create a supportive framework for reproductive and sexual health, is likely to contribute significantly to improved access to services.

58. Regulations are needed to ensure that commodities (medicines, equipment and supplies) are made available on a consistent and equitable basis and that they meet international quality standards. In addition, an effective regulatory environment is needed to ensure public and private sector accountability for providing high-quality care for all the population.

59. Necessary **actions** in this area are:

(1) to review, and if necessary modify, laws and policies in order to ensure that they facilitate universal and equitable access to reproductive and sexual health education, information and services;

(2) to ensure that regulations and standards are in place so that necessary commodities, which meet international quality standards, are available on a consistent and equitable basis; and

(3) to set performance standards and devise monitoring and accountability mechanisms for the provision of services and for collaboration and complementary action among the private, nongovernmental and public sectors.

Strengthening monitoring, evaluation and accountability

60. Monitoring and evaluation are essential for learning what does and does not work, and why. They may also reveal changing needs and unexpected impacts, both positive and negative.

61. Necessary **actions** in this area are:

(1) to establish and strengthen monitoring and evaluation mechanisms based on a clear plan of what is to be achieved, how and by when, with a clear set of indicators and strong baseline data;

(2) to monitor health-sector reforms, sector-wide approaches, and the implementation of other financing mechanisms such as poverty reduction strategy papers, cost-sharing and direct budget support in order to ensure that they benefit the poor and other socially or economically marginalized groups, and contribute to strengthening reproductive and sexual health services at all levels; and

(3) to develop mechanisms (such as local committees or community meetings) to increase accountability at facility and district levels.

WHO's commitment to attaining global reproductive health goals

62. In all the action areas outlined above, WHO will continue and intensify its technical assistance to countries by:

- supporting action-oriented research and research-capacity strengthening
- streamlining and carefully focusing evidence-based norms and standards
- advocating globally for reproductive and sexual health.

63. All these activities will systematically pay attention to and promote equity, including gender equity, and the human rights dimensions of reproductive and sexual health.

64. At the global level, WHO will:

(1) redouble its efforts to implement the Making Pregnancy Safer initiative, as a priority component of the reproductive and sexual health strategy, particularly for countries where maternal mortality is highest;

(2) continue to strengthen its partnerships with other organizations in the United Nations system (in particular UNICEF, UNFPA and UNAIDS), the World Bank, associations of health professionals, nongovernmental organizations and other partners in order to ensure collaboration and coordinated actions by a broad range of partners. The new partnership for safe motherhood and newborn health, to be hosted by WHO, will play a critical role in this;

(3) promote and strengthen reproductive and sexual health services as the basis of the prevention and treatment of HIV/AIDS, particularly through family planning; antenatal, childbirth and postpartum care; control of sexually transmitted infections; the promotion of safer sex; and the prevention of mother-to-child transmission of HIV. WHO will also ensure attention to reproductive and sexual health by strengthening collaboration with other key public health programmes including immunization, nutrition and prevention and treatment of malaria and tuberculosis, especially in pregnant women; and

(4) ensure accountability through reporting on progress towards reproductive and sexual health as part of achieving the Millennium Development Goals.