



WORLD HEALTH ORGANIZATION

FIFTY-NINTH WORLD HEALTH ASSEMBLY

GENEVA, 22-27 MAY 2006

**RESOLUTIONS AND DECISIONS
ANNEXES**

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The Fifty-ninth World Health Assembly was held at the Palais des Nations, Geneva, from 22 to 27 May 2006, in accordance with the decision of the Executive Board at its 116th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA59/2006/REC/1

Verbatim records of plenary meetings, list of participants – document WHA59/2006/REC/2

Summary records of committees, reports of committees – document WHA59/2006/REC/3

CONTENTS

	Page
Preface.....	iii
Agenda.....	ix
List of documents	xiii
Officers of the Health Assembly and membership of its committees	xix

RESOLUTIONS AND DECISIONS

Resolutions

WHA59.1	Eradication of poliomyelitis	1
WHA59.2	Application of the International Health Regulations (2005).....	3
WHA59.3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan	6
WHA59.4	Eleventh General Programme of Work, 2006-2015	8
WHA59.5	Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution	9
WHA59.6	Arrears in payment of contributions: Afghanistan.....	10
WHA59.7	Arrears in payment of contributions: Armenia	11
WHA59.8	Arrears in payment of contributions: Central African Republic.....	12
WHA59.9	Arrears in payment of contributions: Dominican Republic.....	13
WHA59.10	Arrears in payment of contributions: Turkmenistan.....	14
WHA59.11	Nutrition and HIV/AIDS	15
WHA59.12	Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors	18
WHA59.13	Financial report on the accounts of WHO for 2004-2005	19

		Page
WHA59.14	Salaries of staff in ungraded posts and of the Director-General	19
WHA59.15	Strategic Approach to International Chemicals Management.....	20
WHA59.16	Codex Alimentarius Commission: amendments to Statutes	22
WHA59.17	Outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control.....	23
WHA59.18	Rules of Procedure of the World Health Assembly. Rule 14: dispatch of documents	23
WHA59.19	Prevention and control of sexually transmitted infections: global strategy	24
WHA59.20	Sickle-cell anaemia	26
WHA59.21	Infant and young child nutrition 2006.....	28
WHA59.22	Emergency preparedness and response.....	29
WHA59.23	Rapid scaling up of health workforce production	30
WHA59.24	Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action.....	32
WHA59.25	Prevention of avoidable blindness and visual impairment.....	35
WHA59.26	International trade and health.....	37
WHA59.27	Strengthening nursing and midwifery	38
Decisions		
WHA59(1)	Composition of the Committee on Credentials.....	41
WHA59(2)	Composition of the Committee on Nominations	41
WHA59(3)	Election of officers of the Fifty-ninth World Health Assembly.....	41
WHA59(4)	Election of officers of the main committees	42
WHA59(5)	Establishment of the General Committee	42
WHA59(6)	Adoption of the agenda	42
WHA59(7)	Verification of credentials.....	43
WHA59(8)	Election of Members entitled to designate a person to serve on the Executive Board.....	43
WHA59(9)	United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee	43

		Page
WHA59(10)	WHO's role and responsibilities in health research.....	44
WHA59(11)	Health promotion in a globalized world	44
WHA59(12)	Smallpox eradication: destruction of variola virus stocks	44
WHA59(13)	Selection of the country in which the Sixtieth World Health Assembly would be held.....	44
WHA59(14)	Reports of the Executive Board on its 116th and 117th sessions	44

ANNEXES

1.	Strategic Approach to International Chemicals Management.....	47
2.	Global strategy for the prevention and control of sexually transmitted infections, 2006-2015.....	73

AGENDA¹

1. Opening of the Assembly
 - 1.1 Appointment of the Committee on Credentials
 - 1.2 Election of the Committee on Nominations
 - 1.3 Reports of the Committee on Nominations
 - Election of the President
 - Election of the five Vice-Presidents, the Chairman of the main committees and establishment of the General Committee
 - 1.4 Adoption of the agenda and allocation of items to the main committees
2. Reports of the Executive Board on its 116th and 117th sessions
3. Address of Dr Lee Jong-wook, Director-General
4. Invited speaker
5. [deleted]
6. Executive Board: election
7. Awards
8. Reports of the main committees
9. Closure of the Assembly

¹ Adopted at the second plenary meeting.

COMMITTEE A

10. Opening of the Committee¹
11. Technical and health matters
 - 11.1 Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005)
 - 11.2 Eradication of poliomyelitis
 - 11.3 HIV/AIDS
 - WHO's contribution to universal access to HIV/AIDS prevention, treatment and care
 - Nutrition and HIV/AIDS
 - Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors
 - 11.4 Sickle-cell anaemia
 - 11.5 Smallpox eradication: destruction of variola virus stocks
 - 11.6 Prevention and control of sexually transmitted infections: draft global strategy
 - 11.7 Prevention of avoidable blindness and visual impairment
 - 11.8 Infant and young child nutrition: quadrennial report
 - 11.9 WHO's contribution to implementation of the strategy for child and adolescent health and development
 - 11.10 International trade and health
 - 11.11 Intellectual property rights
 - Commission on Intellectual Property Rights, Innovation and Public Health: report
 - [Global framework on] essential health research and development
 - 11.12 International migration of health personnel: a challenge for health systems in developing countries

¹ Including election of Vice-Chairmen and Rapporteur.

AGENDA

11.13 WHO's role and responsibilities in health research

11.14 Emergency preparedness and response

11.15 Health promotion in a globalized world

11.16 Patient safety

11.17 Implementation of resolutions: progress reports

- Global strategy on diet, physical activity and health (resolution WHA57.17)
- Health action in relation to crises and disasters (resolution WHA58.1)
- Control of human African trypanosomiasis (resolution WHA57.2)
- Family and health in the context of the tenth anniversary of the International Year of the Family (resolution WHA57.11)
- Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)
- Sustainable health financing, universal coverage and social health insurance (resolution WHA58.33)
- The role of contractual arrangements in improving health systems' performance (resolution WHA56.25)
- Strengthening nursing and midwifery (resolution WHA54.12)

COMMITTEE B

12. Opening of the Committee¹
13. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan: progress report
14. Eleventh General Programme of Work, 2006-2015

¹ Including election of Vice-Chairmen and Rapporteur.

15. Programme budget and financial matters
 - 15.1 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
 - 15.2 Special arrangements for settlement of arrears
 - 15.3 Programme budget 2004-2005: performance assessment
 - 15.4 Financial report on the accounts of WHO for 2004-2005
 - 15.5 [deleted]
 - 15.6 [deleted]
16. Audit and oversight matters
 - 16.1 Report of the External Auditor and comments thereon made on behalf of the Executive Board
 - 16.2 Report of the Internal Auditor and comments thereon made on behalf of the Executive Board
17. [deleted]
18. Staffing matters
 - 18.1 Human resources: annual report
 - 18.2 Amendments to the Staff Regulations and Staff Rules
 - 18.3 Appointment of representatives to the WHO Staff Pension Committee
19. Collaboration within the United Nations system and with other intergovernmental organizations, including United Nations reform process
 - Strategic Approach to International Chemicals Management
20. Codex Alimentarius Commission: amendment to Statutes
21. Outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control
22. Rules of Procedure of the World Health Assembly. Rule 14: dispatch of documents

List of documents

A59/1 Rev.1	Agenda ¹
A59/2	Report of the Executive Board on its 116th and 117th sessions
A59/3	Address by the Director-General to the Fifty-ninth World Health Assembly
A59/4	Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005)
A59/5	Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005)
A59/6	Eradication of poliomyelitis
A59/7	Nutrition and HIV/AIDS
A59/8	HIV/AIDS. Implementation by WHO of the recommendations of the Global Task Team on improving AIDS Coordination among Multilateral Institutions and International Donors
A59/9	Sickle-cell anaemia
A59/10	Smallpox eradication: destruction of variola virus stocks
A59/10 Add.1	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A59/11	Prevention and control of sexually transmitted infections: draft global strategy ²
A59/11 Add.1	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A59/12	Prevention of avoidable blindness and visual impairment
A59/13	Infant and young child nutrition: quadrennial report

¹ See page ix.

² See Annex 2.

A59/14	WHO's contribution to implementation of the strategy for child and adolescent health and development
A59/15	International trade and health
A59/16	Commission on Intellectual Property Rights, Innovation and Public Health: report
A59/16 Add.1 and Add.1 Corr. 1	Intellectual property rights Commission on Intellectual Property Rights, Innovation and Public Health: report Report of the meeting of the committee of the Executive Board
A59/16 Add.2	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the World Health Assembly
A59/17	[Global framework on] essential health research and development
A59/18	International migration of health personnel: a challenge for health systems in developing countries
A59/19	WHO's role and responsibilities in health research
A59/20	Emergency preparedness and response
A59/20 Add.1	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A59/21	Health promotion in a globalized world
A59/22	Patient safety
A59/23	Implementation of resolutions: progress reports
A59/24	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan: progress report
A59/25	Eleventh General Programme of Work, 2006-2015
A59/25 Add.1	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A59/25 Add.2	Eleventh General Programme of Work, 2006-2015: monitoring

LIST OF DOCUMENTS

- A59/26 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution and special arrangements for settlement of arrears. First report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly
- A59/27 Rules of Procedure of the World Health Assembly.
Rule 14: dispatch of documents
- A59/28 Financial Report and Audited Financial Statements for the period 1 January 2004 – 31 December 2005 and Report of the External Auditor to the World Health Assembly
- A59/28 Add.1 Financial report and Audited Financial Statements for the financial period 1 January 2004 – 31 December 2005
Annex: Extrabudgetary Resources for Programme Activities
- A59/29 Financial report on the accounts of WHO for 2004-2005.
Second report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly
- A59/30 Programme budget 2004-2005: performance assessment
- A59/31 Report of the External Auditor and comments thereon made on behalf of the Executive Board. Third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly
- A59/32 Report of the Internal Auditor
- A59/33 Report of the Internal Auditor and comments thereon made on behalf of the Executive Board. Fourth report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly
- A59/35 Human resources: annual report
- A59/36 Appointment of representatives to the WHO Staff Pension Committee
- A59/37 Collaboration within the United Nations system and with other intergovernmental organizations, including United Nations reform process
- A59/38 Codex Alimentarius Commission: amendments to Statutes
- A59/39 HIV/AIDS. WHO's contribution to universal access to HIV/AIDS prevention, treatment and care

A59/40	Outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control
A59/40 Add.1	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A59/41	Collaboration within the United Nations system and with other intergovernmental organizations, including United Nations reform process. Strategic Approach to International Chemicals Management ¹
A59/41 Add.1	Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A59/42	Committee on Nominations. First report
A59/43	Committee on Nominations. Second report
A59/44	Committee on Nominations. Third report
A59/45	Committee on Credentials. First report
A59/46	Election of Members entitled to designate a person to serve on the Executive Board
A59/47	First report of Committee A (Draft)
A59/48	First report of Committee B (Draft)
A59/49	Second report of Committee A (Draft)
A59/50	Third report of Committee A (Draft)
A59/51	Second report of Committee B (Draft)
A59/52	Fourth report of Committee A (Draft)
A59/53	Fifth report of Committee A (Draft)
A59/54	Third report of Committee B ²
A59/55	Sixth report of Committee A (Draft) ²

¹ See Annex 1.

² Available in electronic form only, on WHO web site.

LIST OF DOCUMENTS

Information documents

- A59/INF.DOC./1 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
- A59/INF.DOC./2 Status of collection of assessed contributions
- A59/INF.DOC./3 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan: progress report
- A59/INF.DOC./4 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan: progress report

Diverse

- A59/DIV/1 Rev.1 List of delegates and other participants
- A59/DIV/2 Guide to documentation
- A59/DIV/3 Guide for delegates to the World Health Assembly
- A59/DIV/4 [Document not issued]
- A59/DIV/5 Decisions and list of resolutions
- A59/DIV/6 List of documents
- A59/DIV/7 Address by His Royal Highness The Prince of Wales to the Fifty-ninth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Professor P.I. GARRIDO (Mozambique)

Vice-Presidents

Dr M. SOLEDAD BARRÍA (Chile)

Mr A.A. MIGUIL (Djibouti)

Mr E. NICOLAESCU (Romania)

Dr S.F. SUPARI (Indonesia)

Pehin SUYOI OSMAN (Brunei Darussalam)

Secretary

Dr A. NORDSTRÖM, Acting Director-General¹

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Burundi, Cambodia, Cyprus, Democratic People's Republic of Korea, Ecuador, Estonia, Guinea-Bissau, Honduras, Jordan, Nigeria, Pakistan and Poland.

Chairman: Mr NUTH SOKHOM (Cambodia)

Vice-Chairman: Ms A. TAPAKOUDI (Cyprus)

Rapporteur: Mr KIM YUN HUM (Democratic People's Republic of Korea)

Secretary: Mr G.L. BURCI, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Brazil, Cambodia, Canada, China, Colombia, Costa Rica, Dominican Republic, France, Hungary, Iran, (Islamic Republic of), Israel, Italy, Kenya, Libyan Arab Jamahiriya, Mauritania, Nepal, New Zealand, Russian Federation, Sao Tome and Principe, Sierra Leone, Sudan, Thailand, Uganda, Zambia and Ms E. Salgado, Spain (President, Fifty-eighth World Health Assembly, ex officio).

Chairman: Ms E. SALGADO (Spain)

Secretary: Dr A. NORDSTRÖM, Acting Director-General¹

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: Angola, Austria, Barbados, China, Cuba, Egypt, France, Gabon, Gambia, Georgia, New Zealand, Panama, Republic of Moldova, Russian Federation, Senegal, Togo and United States of America.

Chairman: Professor P.I. GARRIDO (Mozambique)

Secretary: Dr A. NORDSTRÖM, Acting Director-General¹

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 A. RAMADOSS (India)

Vice-Chairmen: Dr K. LEPPÖ (Finland) and Dr P. MAZZETTI SOLER (Peru)

Rapporteur: Dr A. Cissé (Guinea)

Secretary: Dr Q.M. ISLAM, Director, Making Pregnancy Safer

Committee B

Chairman: Dr A.J. MOHAMMAD (Oman)

Vice-Chairmen: Dr F.T. DUQUE III (Philippines) and Mr V. MERITON (Seychelles)

Rapporteur: Dr B. CAREY (Bahamas)

Secretary: Dr S. HOLCK, Director, General Management

¹ As from 24 May 2006: see document EBSS-EB118/2006/REC/1, decision EBSS(1).

RESOLUTIONS

WHA59.1 Eradication of poliomyelitis

The Fifty-ninth World Health Assembly,

Having considered the report on eradication of poliomyelitis;¹

Recalling the 2004 Geneva Declaration for the Eradication of Poliomyelitis, committing the six countries in which poliomyelitis is endemic and spearheading partners to interrupting the final chains of poliovirus transmission through intensified poliomyelitis immunization campaigns;

Recognizing that the occurrence of poliomyelitis is increasingly rare due to the intensification of poliomyelitis eradication activities globally, and that all Member States are enhancing surveillance for the detection of circulating polioviruses and are in the process of implementing biocontainment activities;

Noting the significant support extended by partners, appreciating their ongoing cooperation, and calling for their continuing support to national programmes in the final phase of the global eradication effort;

Noting with concern that there is a substantial unmet funding requirement of US\$ 485 million for planned activities during the mop-up and certification phase between 2006 and 2008;

Noting that most of the new cases in 2005 have come from areas where transmission of indigenous polioviruses had already been stopped;

Noting that poliovirus importations into poliomyelitis-free areas constitute potential international health threats;

Noting the importance of high-quality surveillance systems in countries where poliomyelitis has been eradicated;

Recalling the standing recommendations of the Advisory Committee on Poliomyelitis Eradication;²

1. URGES Member States in which poliomyelitis is endemic to act on their commitment to interrupting transmission of wild-type poliovirus through the administration of appropriate monovalent oral poliomyelitis vaccines;

¹ Document A59/60.

² *Weekly Epidemiological Record*, 2004, **79**(32): 289-291; 2005, **80**(38): 330-331, and 2005, **80**(47): 410-416.

2. URGES all poliomyelitis-free Member States to respond rapidly to the detection of circulating polioviruses by:

(1) conducting an initial investigation, activating local responses and, when necessary, requesting international expert risk-assessment within 72 hours of confirmation of the index case in order to establish an emergency plan of action;

(2) implementing a minimum of three large-scale rounds of immunization using a type-specific monovalent oral poliomyelitis vaccine, or another composition of vaccine if appropriate, including, where applicable, house-to-house vaccination, the first round to be conducted within four weeks of confirmation of the index case, with an interval of four weeks between subsequent rounds;

(3) targeting all children aged less than five years in the affected and adjacent geographical areas, or a minimum of two million to five million children in large population countries, using independent monitoring to determine whether at least 95% immunization coverage has been reached;

(4) ensuring that at least two full rounds of poliomyelitis immunization are conducted in the targeted area after the most recent detection of poliovirus;

(5) enhancing surveillance for acute flaccid paralysis to a level of greater than two cases per 100 000 children aged less than 15 years, for the duration of the outbreak and at least 12 months immediately thereafter;

(6) sustaining high routine immunization coverage, of at least 80%, with oral poliomyelitis vaccine, and highly sensitive disease surveillance;

3. REQUESTS the Director-General:

(1) to ensure the availability of technical expertise to support Member States in their planning and emergency response related to an outbreak;

(2) to assist in mobilizing funds to implement emergency response to an outbreak and to ensure adequate supplies of monovalent oral poliomyelitis vaccine;

(3) to advise at-risk Member States, on the basis of each risk assessment, on which, if any, additional measures are required nationally and internationally to reduce the further spread of poliovirus, taking into account the recommendations of the Advisory Committee on Poliomyelitis Eradication;

(4) to continue to prepare for other potential risks to poliomyelitis eradication and a poliomyelitis-free world in the short and longer term, and to propose a mechanism for their management to the Executive Board at its 119th session;

(5) to report to the Executive Board at its 119th session on progress made in the implementation of this resolution.

(Eighth plenary meeting, 26 May 2006 –
Committee A, first report)

WHA59.2 Application of the International Health Regulations (2005)

The Fifty-ninth World Health Assembly,

Having considered the report on application of the International Health Regulations (2005);¹

Recalling resolutions WHA58.3 on revision of the International Health Regulations and WHA58.5 on strengthening pandemic-influenza preparedness and response;

Reaffirming the serious risk to human health, including the possible emergence of a pandemic virus, arising from ongoing outbreaks in poultry of highly pathogenic avian influenza, caused by the H5N1 strain of *Influenzavirus A*, in parts of Asia and elsewhere;

Noting with concern the persistence of outbreaks in poultry, the continuing occurrence of sporadic cases of severe human disease associated with these outbreaks, the endemicity of the virus in several countries, the spread of the virus to new areas through the migration of wild waterfowl, and its predicted further spread;

Aware that these and other developments have increased the probability that a pandemic may occur;

Highlighting the importance of WHO's global influenza preparedness plan and the control measures recommended therein;²

Mindful that rapid detection of human cases, supported by adequate national capacity, and rapid and transparent reporting of findings underpin WHO's ability to issue a reliable risk assessment and declare an appropriate phase of pandemic alert, and are further needed to ensure that the earliest epidemiological signals of increased transmissibility of the virus among humans are not missed;

Aware that several provisions in the International Health Regulations (2005) would be useful in ensuring a strengthened and coordinated response on the part of the international community to both the present situation and a possible pandemic;

Further aware that strengthened capacity to respond to human cases of avian influenza and the corresponding pandemic threat will strengthen the capacity to respond to many other emerging and epidemic-prone infectious diseases, and thus increase global public-health security against the threat of infectious diseases;

Noting that the International Health Regulations (2005) will not enter into force until 15 June 2007;

Recalling the main conclusions reached, and recommended actions agreed on, at a joint meeting convened by WHO, FAO, OIE and the World Bank on avian influenza and human pandemic influenza (Geneva, 7-9 November 2005);

¹ Document A59/5.

² Document WHO/CDS/CSR/GIP/2005.5.

Responding to the specific request made during that meeting to put forward proposals to the Fifty-ninth World Health Assembly through the Executive Board at its 117th session for immediate voluntary compliance with relevant provisions of the International Health Regulations (2005),

1. CALLS UPON Member States to comply immediately, on a voluntary basis, with provisions of the International Health Regulations (2005) considered relevant to the risk posed by avian influenza and pandemic influenza;
2. DECIDES that relevant provisions of the International Health Regulations (2005) shall include the following:
 - (1) Annex 2, in so far as it requires prompt notification to WHO of human influenza caused by a new virus subtype;
 - (2) Article 4 pertaining to the designation or establishment of a National IHR Focal Point within countries and the designation of WHO IHR Contact Points, and the definition of their functions and responsibilities;
 - (3) Articles in Part II pertaining to surveillance, information-sharing, consultation, verification and public health response;
 - (4) Articles 23 and 30-32 in Part V pertaining to general provisions for public health measures for travellers on arrival or departure and special provisions for travellers;
 - (5) Articles 45 and 46 in Part VIII pertaining to the treatment of personal data and the transport and handling of biological substances, reagents and materials for diagnostic purposes;
3. NOTES that such voluntary compliance is without prejudice to the position of any Member State with regard to the International Health Regulations (2005);
4. URGES Member States:
 - (1) to designate or establish immediately a National IHR Focal Point, as provided for in Article 4 of the Regulations, and to inform WHO accordingly within 90 days, the said Focal Point having the authority to communicate official information and to provide support for, and if so decided by the Member State, to participate in, collaborative risk assessment with WHO;
 - (2) to follow, in matters pertaining to human cases of avian influenza, mechanisms and procedures set out in the Regulations for a disease that may constitute a public health emergency of international concern;
 - (3) to provide transparent and urgent notification and subsequent continued communication to WHO of any probable or confirmed human cases of avian influenza, including exported or imported cases;
 - (4) to disseminate to WHO collaborating centres information and relevant biological materials related to highly pathogenic avian influenza and other novel influenza strains in a timely and consistent manner;
 - (5) to develop domestic capacity to produce influenza vaccine or to work with neighbouring States to establish regional vaccine-production capacity, in order to promote adequate supplies

of vaccine in the event of a public health emergency of international concern caused by a novel influenza virus;

(6) to strengthen collaboration on human and zoonotic influenzas among national organizations responsible for human and animal health in order to strengthen surveillance and implement immediate measures to control outbreaks of avian influenza in humans and animals;

(7) to respect time frames stipulated in the Regulations for undertaking and completing urgent activities and communications, particularly for the reporting of human cases of avian influenza, verification of events, and response to requests for further information from WHO;

(8) to collaborate, including through the mobilization of financial support, in building, strengthening and maintaining the capacity for influenza surveillance and response in countries affected by avian influenza or pandemic influenza;

(9) to follow recommendations issued by the Director-General, with technical advice from the influenza pandemic task force, considered necessary for the international response to avian influenza or pandemic influenza;

(10) to inform the Director-General of the measures that they have taken in voluntary compliance with the International Health Regulations (2005);

(11) to initiate a process of identifying and addressing the constraints – administrative and legal – for timely implementation of the Regulations with a view to promoting intersectoral participation;

5. REQUESTS the Director-General:

(1) to designate immediately WHO IHR Contact Points, as provided for in Article 4 of the Regulations;

(2) to implement, in so far as feasible and relevant for the purpose of this resolution, measures in Parts II and III of the Regulations falling under the responsibility of WHO;

(3) to further accelerate steps to establish a roster of experts and to invite proposals for its membership, pursuant to Article 47;

(4) to use the influenza pandemic task force as a temporary mechanism until entry into force of the International Health Regulations (2005) in order to advise the Organization on the response to avian influenza, the appropriate phase of pandemic alert and the corresponding recommended response measures, the declaration of an influenza pandemic, and the international response to a pandemic;

(5) to collaborate with Member States in implementation of the present resolution, and in voluntary compliance with the International Health Regulations (2005), as appropriate, including through:

(a) provision or facilitation of technical cooperation and logistical support;

(b) mobilization of international assistance, including financial support, in consultation with Member States, especially for avian influenza or pandemic influenza-affected countries lacking sufficient operational capacity;

- (c) production of guidelines as support to Member States in development of capacities for a public-health response specific to the risk posed by avian influenza and pandemic influenza;
 - (d) reasonable stockpiling of necessary drugs;
 - (e) facilitation, in collaboration with international partners, of development and commercial production of vaccines against avian influenza and pandemic influenza;
- (6) to collaborate with Member States to the extent possible in providing support to developing countries in building and strengthening the capacities required under the International Health Regulations (2005);
- (7) immediately to search for solutions to reduce the current global shortage of, and inequitable access to, influenza vaccines, and also to make them more affordable for both epidemics and global pandemics;
- (8) to mobilize and dedicate WHO's technical resources where possible, using capacities available in regional offices and collaborating centres, in order to expand and accelerate training efforts in the areas of epidemic surveillance, alert and response, laboratory capacity including regional networking of laboratories, biosafety, and quality control, in order to provide support to Member States in implementation of the International Health Regulations (2005);
- (9) to report to the Sixtieth World Health Assembly through the Executive Board at its 119th session on implementation of this resolution, and to report annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of, the International Health Regulations (2005).

(Eighth plenary meeting, 26 May 2006 –
Committee A, first report)

WHA59.3 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

The Fifty-ninth 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 in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;¹

Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

¹ Document A59/24.

Expressing its concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory due to Israel's withholding of Palestinian customs revenues and the severance of external aid;

Affirming the need for guaranteeing universal coverage of health services and for preserving the functions of the public health services in the occupied Palestinian territory;

Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

Affirming the right of Palestinian patients and medical staff to the health facilities available at the Palestinian health institutions in occupied east Jerusalem;

Deploring the Israeli army's continuous assault on Palestinian ambulances and medical personnel and the Israeli-imposed restriction on their movement, in violation of international humanitarian law,

1. DEMANDS that Israel lift the closure in the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of drugs and medical supplies therein;
2. DEMANDS that Israel dismantle and stop the construction of the wall and abide by its legal obligations mentioned in the advisory opinion rendered on 9 July 2004 by the International Court of Justice;
3. EXPRESSES deep concern at the grave implication of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
4. EXPRESSES deep concern also at the serious implications on pregnant women and patients of Israeli restriction of movement imposed on Palestinian ambulances and medical personnel;
5. URGES Israel, the occupying power, to shoulder its responsibility towards the humanitarian needs of the Palestinian people, in compliance with international humanitarian law;
6. DEMANDS that Israel, the occupying power, pay the Palestinian Authority regularly and without delay its customs revenues in order to enable it to fulfil its responsibilities with respect to basic human needs, including health services;
7. CALLS UPON Israel, the occupying power, to halt immediately all its practices, policies and plans, including its closure regime, which seriously affect the health conditions of civilians under occupation;
8. URGES Member States and intergovernmental and nongovernmental organizations to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
9. CALLS UPON Member States to provide financial support to public health and veterinary services in order to implement the Palestinian national plan for fighting the potential spread of avian influenza in the occupied Palestinian territory;

10. EXPRESSES its deep appreciation to the Director-General for his efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;

11. REQUESTS the Director-General:

- (1) to organize a one-day emergency meeting addressing the health crisis in the occupied Palestinian territory;
- (2) to provide support for Palestinian health and veterinary services in establishing a modern public health laboratory capable of diagnosing avian influenza in humans and animals;
- (3) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
- (4) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
- (5) to continue providing necessary technical assistance to meet the health needs of the Palestinian people, including the handicapped and injured;
- (6) to support the development of the health system in Palestine, including development of human resources;
- (7) to report on implementation of this resolution to the Sixtieth World Health Assembly.

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.4 Eleventh General Programme of Work, 2006-2015

The Fifty-ninth World Health Assembly,

Having considered the draft Eleventh General Programme of Work, 2006-2015,¹ submitted to it by the Programme, Budget and Administration Committee on behalf of the Executive Board;

Noting that the General Programme of Work focuses on the actions and responsibilities of WHO as the world's specialized health agency and its role in global health, while examining the interrelatedness of the many sectors and disciplines influencing health;

Mindful of the changing context of international health, and the need for WHO and partners to respond effectively to these changes;

Noting that the General Programme of Work calls for collective action to improve health over the next decade through a proposed global health agenda;

Acknowledging that the General Programme of Work is designed to be the first step in WHO's results-based management process, giving broad direction to the work of WHO;

¹ Document A59/25.

Welcoming the framework provided by the General Programme of Work and its underpinning of the medium-term strategic plan in preparation, which reflects an effort to introduce a more strategic approach in the Secretariat's planning, monitoring and evaluation, and the Organization's work with partners,

1. APPROVES the Eleventh General Programme of Work, 2006-2015;
2. URGES Member States to identify their role and specific actions to be taken to fulfil the global health agenda, and to encourage multidisciplinary partnerships;
3. INVITES concerned organizations of the United Nations system, international development partners and agencies, nongovernmental organizations and the private sector to consider harmonizing their work in line with the global health agenda contained in the Eleventh General Programme of Work;
4. REQUESTS the Director-General to use the Eleventh General Programme of Work as the basis for strategic planning, monitoring and evaluation of WHO's work during the period 2006-2015; to review and update the General Programme of Work, as needed to reflect the changing state of global health; and to report through the Executive Board to the Sixty-third World Health Assembly and the Sixty-seventh World Health Assembly on the continued relevance and use of the Eleventh General Programme of Work.

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.5 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Fifty-ninth World Health Assembly,

Having considered the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly on Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears;¹

Noting that, at the time of opening of the Fifty-ninth World Health Assembly, the voting rights of Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Comoros, Dominican Republic, Guinea-Bissau, Kyrgyzstan, Liberia, Nauru, Niger, Somalia 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 which would justify invoking Article 7 of the Constitution;

Noting that Democratic Republic of Congo and Dominica were in arrears at the time of the opening of the Fifty-ninth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of those countries should be suspended at the opening of the Sixtieth Health Assembly,

¹ Document A59/26.

DECIDES:

- (1) that in accordance with the statement of principles set out in resolution WHA41.7 if, by the time of the opening of the Sixtieth World Health Assembly, Democratic Republic of the Congo and Dominica are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;
- (2) that any suspension that takes effect as aforesaid shall continue at the Sixtieth and subsequent Health Assemblies, until the arrears of Democratic Republic of the Congo and Dominica have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;
- (3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.6 Arrears in payment of contributions: Afghanistan

The Fifty-ninth World Health Assembly,

Having considered the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly on the Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears,¹ with respect to the request of Afghanistan for the settlement of its outstanding contributions,

1. DECIDES to restore the voting privileges of Afghanistan at the Fifty-ninth World Health Assembly;
2. ACCEPTS that Afghanistan shall pay its outstanding contributions, totalling US\$ 232 500, in 14 annual instalments payable in each of the years 2007 to 2020, as set out below, in addition to the annual contributions due during the period:

¹ Document A59/26.

	US\$
2007	16 600
2008	16 600
2009	16 600
2010	16 600
2011	16 600
2012	16 600
2013	16 600
2014	16 600
2015	16 600
2016	16 600
2017	16 600
2018	16 600
2019	16 600
2020	16 700
Total	232 500

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

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

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

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.7 Arrears in payment of contributions: Armenia

The Fifty-ninth World Health Assembly,

Having considered the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly on the Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears,¹ with respect to the request of Armenia for the settlement of its outstanding contributions,

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

¹ Document A59/26.

2. ACCEPTS that Armenia shall pay its outstanding contributions, totalling US\$ 2 446 150, in 18 annual instalments payable in each of the years 2006 to 2023, as set out below, in addition to the annual contributions due during the period:

	US\$
2006	45 300
2007	45 300
2008	67 950
2009	67 950
2010	90 600
2011	90 600
2012	113 250
2013	113 250
2014	135 900
2015	135 900
2016	158 550
2017	158 550
2018	181 200
2019	181 200
2020	203 850
2021	203 850
2022	226 500
2023	226 450
Total:	2 446 150

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

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

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

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.8 Arrears in payment of contributions: Central African Republic

The Fifty-ninth World Health Assembly,

Having considered the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly on the Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, and special arrangements for settlement of

arrears,¹ with respect to the request of Central African Republic for the settlement of its outstanding contributions,

1. DECIDES to restore the voting privileges of Central African Republic at the Fifty-ninth World Health Assembly;

2. ACCEPTS that Central African Republic shall pay its outstanding contributions, totalling US\$ 164 841, in five annual instalments payable in each of the years 2006 to 2010, as set out below, in addition to the annual contributions due during the period:

	US\$
2006	32 970
2007	32 970
2008	32 970
2009	32 970
2010	32 961
Total	164 841

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

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

5. REQUESTS the Director-General to communicate this resolution to the Government of Central African Republic.

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.9 Arrears in payment of contributions: Dominican Republic

The Fifty-ninth World Health Assembly,

Having considered the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly on the Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears,¹ with respect to the request of Dominican Republic for the settlement of its outstanding contributions,

1. DECIDES to restore the voting privileges of Dominican Republic at the Fifty-ninth World Health Assembly;

¹ Document A59/26.

2. ACCEPTS that Dominican Republic shall pay its outstanding contributions, totalling US\$ 1 019 572, in 15 annual instalments payable in each of the years 2006 to 2020, as set out below, in addition to the annual contributions due during the period:

	US\$
2006	67 970
2007	67 970
2008	67 970
2009	67 970
2010	67 970
2011	67 970
2012	67 970
2013	67 970
2014	67 970
2015	67 970
2016	67 970
2017	67 970
2018	67 970
2019	67 970
2020	67 992
Total	1 019 572

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

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

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

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.10 Arrears in payment of contributions: Turkmenistan

The Fifty-ninth World Health Assembly,

Having considered the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly on the Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which

would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears,¹ with respect to the request of Turkmenistan for the settlement of its outstanding contributions,

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

2. ACCEPTS that Turkmenistan shall pay its outstanding contributions, totalling US\$ 1 259 014, in 10 annual instalments payable in each of the years 2006 to 2015, as set out below, in addition to the annual contributions due during the period:

	US\$
2006	125 900
2007	125 900
2008	125 900
2009	125 900
2010	125 900
2011	125 900
2012	125 900
2013	125 900
2014	125 900
2015	125 914
Total	1 259 014

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

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

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

(Ninth plenary meeting, 27 May 2006 –
Committee B, first report)

WHA59.11 Nutrition and HIV/AIDS

The Fifty-ninth World Health Assembly,

Having considered the report on nutrition and HIV/AIDS;²

Recalling resolution WHA57.14 which urged Member States, inter alia, to pursue policies and practices that promote integration of nutrition into a comprehensive response to HIV/AIDS;

¹ Document A59/26.

² Document A59/7.

Bearing in mind WHO's efforts to support access to antiretroviral treatment as part of the "3 by 5" initiative and to ensure a comprehensive package of care and support for people living with HIV/AIDS;

Recalling the recommendations of WHO's technical consultation on nutrition and HIV/AIDS in Africa (Durban, South Africa, 10-13 April 2005), which were based on the main findings of a detailed review of the latest scientific evidence on the macronutrient and micronutrient needs of HIV-infected people, including pregnant and lactating women and patients on antiretroviral therapy;¹

Noting that food and adequate nutrition are often identified as the most immediate and critical needs by people living with, or affected by, the HIV/AIDS pandemic;

Bearing in mind that nutrition and food security require systematic and simultaneous action to meet the challenges of the pandemic;

Mindful of the complex interactions between nutrition and HIV/AIDS, and the increased risk of opportunistic infections and malnutrition;

Noting that some Member States already have policies and programmes related to nutrition and HIV/AIDS that can be used as a basis for developing priorities and workplans;

Underlining the importance of ensuring cooperation on this question with other bodies of the United Nations system, in particular, FAO, UNICEF and WFP,

1. URGES Member States:

(1) to make nutrition an integral part of their response to HIV/AIDS by identifying nutrition interventions for immediate integration into HIV/AIDS programming, including:

(a) strengthening political commitment to nutrition and HIV/AIDS as part of their health agenda;

(b) reinforcing nutrition components in HIV/AIDS policies and programmes and incorporating HIV/AIDS issues in national nutrition policies and programmes;

(c) developing specific advocacy tools to raise decision-makers' awareness of the urgency and steps needed to incorporate nutrition into HIV/AIDS prevention, treatment and care programmes;

(d) assessing existing policies and programmes related to nutrition and HIV/AIDS and identifying gaps to be filled and further opportunities for integrating nutrition interventions;

(e) ensuring close multisectoral collaboration and coordination between agricultural, health, social-service, education, financial and nutrition sectors;

(2) to strengthen, revise or establish new guidelines and assessment tools for nutrition care and support of people living with HIV and AIDS at different stages of the disease, and for sex-

¹ Document EB116/12, Annex.

and age-specific approaches to providing antiretroviral therapy, including nutrition counselling and special nutritional needs of vulnerable and marginalized populations;

(3) to provide support and expand existing interventions for improving nutrition and managing severe malnutrition in infants and young children in the context of HIV by:

(a) implementing fully the global strategy for infant and young child feeding, with its approach to feeding in exceptionally difficult circumstances, and the United Nations framework for priority action in HIV and infant feeding;¹

(b) building the capability of hospital- and community-based health workers, mothers, family members and other caregivers in order to improve the care of severely malnourished children exposed to, or infected by, HIV/AIDS;

(c) encouraging revitalization of the Baby-friendly Hospital Initiative in the light of HIV/AIDS;

(d) accelerating training in, and expanding use of, guidelines and tools for infant-feeding programmes that provide counselling on prevention of mother-to-child transmission of HIV;

(e) ensuring that institutions training health workers review their curricula and bring them in line with current recommendations;

2. REQUESTS the Director-General:

(1) to strengthen technical guidance to Member States for incorporating nutrition considerations in HIV and AIDS policies and programmes;

(2) to provide support for the development of advocacy tools to raise decision-makers' awareness of the urgency and the need to include nutrition and HIV/AIDS as a priority on the health agenda;

(3) to provide support, as a matter of priority, to development and dissemination of science-based recommendations, guidelines and tools on nutritional care and support for people living with HIV/AIDS;

(4) to contribute to incorporation of nutrition in training, including pre-service training, of health workers, in technical advice, and in training materials for community and home-based settings, and during emergencies;

(5) to continue to promote research relative to nutrition and HIV/AIDS, addressing gaps in knowledge and operational issues;

(6) to provide support for development of appropriate indicators for measuring progress towards integration of nutrition into HIV programmes and impact of nutrition interventions;

(7) to ensure collaboration between all concerned parties in this area so that progress may be made by building on each other's achievements;

¹ *HIV and infant feeding: framework for priority action*. Geneva, World Health Organization, 2003.

(8) to foster establishment of guidelines for including appropriate food and nutrition interventions in funding proposals.

(Ninth plenary meeting, 27 May 2006 –
Committee A, second report)

WHA59.12 Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors

The Fifty-ninth World Health Assembly,

Taking note of the report on HIV/AIDS and universal access to prevention, care and treatment;¹

Recognizing the role of WHO as a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS);

Recalling the decisions of the Seventeenth Programme Coordinating Board of UNAIDS, (27-29 June 2005, Geneva);

Commending the final report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;²

Noting, in that regard, that improved coordination and harmonization of efforts and a clear division of responsibilities between UNAIDS and its cosponsors will be required, together with coordination with national and global partners;

Noting the emphasis placed on support for action at country level and on developing the national response;

Recognizing that leadership, national ownership of plans and priorities, fostering of effective coordination, and alignment and harmonization of programmes and support at country level are key determinants of effective national responses,

1. ENDORSES the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, and further endorses all the related decisions as contained in the report of the Seventeenth Programme Coordinating Board of UNAIDS;³

2. URGES Member States to identify barriers and strengthen institutional capacity, including human resources, in order to accelerate implementation of the “Three Ones” principle according to country realities;⁴

¹ Document A59/8.

² Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors: Final Report, 14 June 2005.

³ Document UNAIDS/PCB(17)/05.10.

⁴ 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.

3. REQUESTS the Director-General:

(1) to implement the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, to prepare appropriate plans of action, in collaboration with UNAIDS and the other cosponsors, and to maintain the momentum created by the Global Task Team, within the deadlines set;

(2) to report to the Executive Board at its 119th session and to the Sixtieth World Health Assembly, and every two years thereafter, on progress made in implementation of the recommendations of the Global Task Team, and to use that report to inform the Programme Coordinating Board of UNAIDS;

(3) to provide effective technical support to national governments and, in conformity with the agreed division of labour, to focus on those areas in which WHO has an advantage compared to other bodies, in particular strengthening of health systems and human resources for health in response to scaled-up interventions.

(Ninth plenary meeting, 27 May 2006 –
Committee A, third report)

WHA59.13 Financial report on the accounts of WHO for 2004-2005

The Fifty-ninth World Health Assembly,

Having examined the Financial report and audited financial statements for the period 1 January 2004 – 31 December 2005 and report of the External Auditor to the World Health Assembly;¹

Having noted the second and third reports of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-ninth World Health Assembly,²

ACCEPTS the Director-General's Financial report and audited financial statements for the period 1 January 2004 – 31 December 2005 and report of the External Auditor to the World Health Assembly.

(Ninth plenary meeting, 27 May 2006 –
Committee B, second report)

WHA59.14 Salaries of staff in ungraded posts and of the Director-General

The Fifty-ninth World Health Assembly,

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

¹ Documents A59/28 and A59/28 Add.1.

² Documents A59/29 and A59/31.

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 160 574 per annum before staff assessment, resulting in a net salary of US\$ 117 373 (dependency rate) or US\$ 106 285 (single rate);
2. ESTABLISHES the salary of the Director-General at US\$ 217 945 per annum before staff assessment, resulting in a net salary of US\$ 154 664 (dependency rate) or US\$ 137 543 (single rate);
3. DECIDES that those adjustments in remuneration shall take effect from 1 January 2006.

(Ninth plenary meeting, 27 May 2006 –
Committee B, second report

WHA59.15 Strategic Approach to International Chemicals Management

The Fifty-ninth World Health Assembly,

Having considered the Strategic Approach to International Chemicals Management;¹

Recalling the request in resolution WHA56.22 on the participation of global health partners in the further development of the strategic approach to international chemicals management for the completed strategic approach to be submitted to the Health Assembly for consideration;

Recalling the first principle of the Rio Declaration on Environment and Development, namely, that “Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature”;²

Recalling paragraph 23 of the Johannesburg Plan of Implementation adopted by the World Summit on Sustainable Development on 4 September 2002,³ and paragraph 56 of the 2005 World Summit Outcome adopted by the United Nations General Assembly on 16 December 2005,⁴ in which Heads of State and Government resolved to promote such a strategic approach;

Welcoming the Strategic Approach to International Chemicals Management, consisting of the Dubai Declaration on International Chemicals Management, the Overarching Policy Strategy and the Global Plan of Action, as adopted by the International Conference on Chemicals Management in Dubai, United Arab Emirates, on 6 February 2006;

Noting the endorsement of the Strategic Approach by the Governing Council of the United Nations Environment Programme at its 9th Special Session, in Dubai, United Arab Emirates, on 9 February 2006;

Welcoming the multisectoral nature of the Strategic Approach and the spirit of coordination and cooperation between the participating organizations of the Inter-Organization Programme for the

¹ See Annex 1.

² Document A/CONF.151/26 (Vol. I), Principle 1.

³ Report of the World Summit on Sustainable Development, Johannesburg, South Africa, 26 August - 4 September 2002 (United Nations publications, Sales no. E.03.II.A1) chap. I, resolution 2, annex.

⁴ United Nations General Assembly resolution 60/1.

Sound Management of Chemicals, and the important role of UNEP in the development and implementation of the Strategic Approach;

Noting the active participation of the health sector, including WHO, in the development of the Strategic Approach, that comprises the priorities determined by the health sector, as noted by the Fifty-eighth World Health Assembly;¹

Mindful of WHO's role in providing international leadership on the human-health aspects of the sound management of chemicals;

Mindful also of WHO's contribution to the sound management of chemicals through the International Programme on Chemical Safety, a cooperative venture between ILO, WHO and UNEP, and the established joint programme of cooperation between WHO and the ILO on workers' health;

Recognizing the need for health interests at country level to be addressed in the implementation of the Strategic Approach to International Chemicals Management,

1. NOTES the Strategic Approach to International Chemicals Management consisting of the Dubai Declaration on International Chemicals Management, the Overarching Policy Strategy and the Global Plan of Action;²

2. URGES Member States:

(1) to take full account of the health aspects of chemical safety in national implementation of the Strategic Approach to International Chemicals Management;

(2) to participate in national, regional and international efforts to implement the Strategic Approach, including the International Conference on Chemicals Management;

(3) to nominate a national Strategic Approach focal point from the health sector, where appropriate, in order to maintain contact with WHO;

3. REQUESTS the Director-General:

(1) to facilitate implementation by the health sector of the Strategic Approach to International Chemicals Management, focusing on human health-related elements;

(2) to provide support for implementation of the Strategic Approach by working with partners in the Inter-Organization Programme on the Sound Management of Chemicals and the International Programme on Chemical Safety, and with ILO on workers' health as related to the Strategic Approach;

(3) to inform, on behalf of the Health Assembly, the International Conference on Chemicals Management of progress in implementing its resolution.³

(Ninth plenary meeting, 27 May 2006 –
Committee B, second report)

¹ Document WHA58/2005/REC/3, summary record of the eleventh meeting of Committee A.

² Document UNEP/GCSS.IX/6/Add.1.

³ Resolution 1, paragraph 3, in document UNEP/GCSS.IX/6/Add.1, Annex III.

WHA59.16 Codex Alimentarius Commission: amendments to Statutes

The Fifty-ninth World Health Assembly,

Having considered the report on amendments to the Statutes of the Codex Alimentarius Commission;¹

Having considered the recommendation of the Twenty-eighth Session of the Codex Alimentarius Commission that the FAO Conference and the Health Assembly should amend its Statutes by deleting any reference to the procedure of acceptance of standards;

Noting that the above-mentioned amendments shall enter into force only after their approval by both the FAO Conference and the Health Assembly;

Considering that the Thirty-third session of the FAO Conference adopted the amendments to the Statutes of the Codex Alimentarius Commission in accordance with the recommendation made by the said Commission,

APPROVES amended Article 1 of the Statutes of the Codex Alimentarius Commission reproduced in the annex to the present resolution.

ANNEX**ARTICLE 1**

The Codex Alimentarius Commission shall, subject to Article 5 below, be responsible for making proposals to, and shall be consulted by, the Directors-General of the Food and Agriculture Organization (FAO) and the World Health Organization (WHO) on all matters pertaining to the implementation of the Joint FAO/WHO Food Standards Programme, the purpose of which is:

- (a) protecting the health of the consumers and ensuring fair practices in the food trade;
- (b) promoting coordination of all food standards work undertaken by international governmental and nongovernmental organizations;
- (c) determining priorities and initiating and guiding the preparation of draft standards through and with the aid of appropriate organizations;
- (d) finalizing standards elaborated under (c) above and publishing them in a Codex Alimentarius either as regional or worldwide standards, together with international standards already finalized by other bodies under (b) above, wherever this is practicable;
- (e) amending published standards, as appropriate, in the light of developments.

(Ninth plenary meeting, 27 May 2006 –
Committee B, second report)

¹ Document A59/38.

WHA59.17 Outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control

The Fifty-ninth World Health Assembly,

Having considered the report on the outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control;¹

Recalling resolutions WHA49.17 and WHA52.18 calling for the development of the Framework Convention in accordance with Article 19 of the Constitution of WHO, and resolution WHA56.1 adopting the WHO Framework Convention on Tobacco Control;

Recognizing the urgent need for all Contracting Parties to fulfil their obligations under the Framework Convention, and noting the essential role of a permanent secretariat of the Convention in this work;

Reaffirming the objective of the Framework Convention as described in Article 3 thereof,

1. WELCOMES the successful convening of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Geneva, 6-17 February 2006;
2. NOTES the decision of the Conference of the Parties to establish a permanent secretariat of the Convention;²
3. REQUESTS the Director-General:
 - (1) to establish a permanent secretariat of the Convention within the World Health Organization and located in Geneva pursuant to decision FCTC/COP1(10);
 - (2) to continue to support and, where appropriate, to strengthen the Tobacco Free Initiative in 2008-2009 in order to assist the Convention secretariat in the implementation of the Convention pursuant to decision FCTC/COP1(12);
4. CALLS UPON Member States which have not yet done so, to consider ratifying, accepting, approving, formally confirming or acceding to the Convention at the earliest opportunity.

(Ninth plenary meeting, 27 May 2006 –
Committee B, second report)

WHA59.18 Rules of Procedure of the World Health Assembly. Rule 14: dispatch of documents

The Fifty-ninth World Health Assembly,

Recalling resolution WHA51.30 on method of work of the Health Assembly, which requested the Director-General to ensure that the governing body documents for forthcoming sessions were

¹ Document A59/40.

² Decision FCTC/COP1(10).

dispatched and made available on the Internet in the six official languages not less than 30 days before the date fixed for the opening of the session;

Concerned that documents related to the agenda of meetings of the Health Assembly are being made available on the Internet and dispatched increasingly late;

Stressing the need for Member States, particularly those whose national languages are not one of the official languages of the Organization, to receive documents in time in order to prepare adequately to participate in the Health Assembly;

Noting Rule 5 of the Rules of Procedure of the Executive Board, which requires documents for sessions of the Executive Board to be dispatched by the Director-General not less than six weeks before the commencement of a regular session of the Board,

DECIDES to amend Rule 14 of its Rules of Procedure, in accordance with Rule 121 of those Rules, so that Rule 14 shall henceforth read as follows:

Rule 14

Copies of all reports and other documents relating to the provisional agenda of any session shall be made available on the Internet and sent by the Director-General to Members and Associate Members and to participating intergovernmental organizations at the same time as the provisional agenda or not less than six weeks before the commencement of a regular session of the Health Assembly; appropriate reports and documents shall also be sent to nongovernmental organizations admitted into relationship with the Organization in the same manner.

(Ninth plenary meeting, 27 May 2006 –
Committee B, second report)

WHA59.19 Prevention and control of sexually transmitted infections: global strategy

The Fifty-ninth World Health Assembly,

Having considered the draft global strategy for the prevention and control of sexually transmitted infections;¹

Recalling resolution WHA46.37, which recognized the role of other sexually transmitted diseases in the spread of HIV; resolution WHA53.14, which requested the Director-General to develop a global health-sector strategy for responding to the epidemics of HIV/AIDS and sexually transmitted infections; resolution WHA56.30, which took note of the global health-sector strategy for HIV/AIDS; and resolution WHA57.12, which endorsed the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;

Recognizing and reaffirming that, at the 2005 World Summit (New York, 14-16 September 2005), world leaders committed themselves to achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development (Cairo, September 1994), integrating this goal in strategies to attain the internationally

¹ See Annex 2.

agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty, and recognizing further that attainment of the Millennium Development Goals requires investment in, and political commitment to, sexual and reproductive health, which includes prevention and control of sexually transmitted infections,¹

1. ENDORSES the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, recognizing that “age-appropriate” interventions are those that respond to people’s rights and health and development needs, and provide access to sexual and reproductive health information, life-skills, education and care and, in the case of young people, in a manner consistent with their evolving capacities;

2. URGES Member States:

(1) to adopt and draw on the Strategy, as appropriate to national circumstances, in order to ensure that national efforts to achieve the Millennium Development Goals include plans and actions appropriate to the local epidemiological situation, for prevention and control of sexually transmitted infections, including mobilization of political will and financial resources for this purpose;

(2) to include prevention and control of sexually transmitted infections as an integral part of HIV prevention and of sexual and reproductive health programmes;

(3) to monitor implementation of the national plans in order to ensure that populations at increased risk of sexually transmitted infections have access to prevention information and supplies, and to timely diagnosis and treatment;

3. REQUESTS the Director-General:

(1) to prepare an action plan, in collaboration with other organizations of the United Nations system, that sets out priorities, actions, a time frame and performance indicators for implementing the Strategy at global and regional levels, and to provide support for country-level implementation and monitoring of national plans for control and prevention of sexually transmitted infections;

(2) to raise awareness, among Member States, of the importance of drawing up, promoting and funding supportive legislation, plans and strategies for prevention and control of sexually transmitted infections;

(3) to provide support to Member States, on request, for adapting and implementing the Strategy in ways that are appropriate to the local epidemiology of sexually transmitted infections, and for evaluating its impact and effectiveness;

(4) to report to the Health Assembly through the Executive Board in 2009, 2012 and 2015 on progress in implementing the Strategy.

(Ninth plenary meeting, 27 May 2006 –
Committee A, fourth report)

¹ United Nations General Assembly resolution 60/1.

WHA59.20 Sickle-cell anaemia

The Fifty-ninth World Health Assembly,

Having examined the report on sickle-cell anaemia;¹

Recalling resolution WHA57.13 on genomics and world health, and the discussion of the Executive Board at its 116th session on control of genetic diseases, which recognized the role of genetic services in improving health globally and in reducing the global health divide;²

Recalling decision Assembly/AU/Dec.81 (V) of the Assembly of the African Union at its Fifth Ordinary Session;

Noting the conclusions of the 4th International African American Symposium on sickle-cell anaemia (Accra, 26-28 July 2000), and the results of the first and second international congresses of the International Organization to Combat Sickle-Cell Anaemia (respectively, Paris, 25-26 January 2002 and Cotonou, 20-23 January 2003);

Concerned at the impact of genetic diseases, and of sickle-cell anaemia in particular, on global mortality and morbidity, especially in developing countries, and by the suffering of patients and families affected by the disease;

Recognizing that the prevalence of sickle-cell anaemia varies between communities, and that insufficiency of relevant epidemiological data may present a challenge to effective and equitable management;

Deeply concerned at the absence of official recognition of sickle-cell anaemia as a priority in public health;

Recognizing the current inequality of access to safe and appropriate genetic services throughout the world;

Recognizing that effective programmes for sickle-cell anaemia must be sensitive to cultural practices and appropriate for the given social context;

Recognizing that pre-natal screening for sickle-cell anaemia raises specific ethical, legal and social issues that require appropriate consideration,

1. URGES Member States in which sickle-cell anaemia is a public health problem:

(1) to design, implement and reinforce in a systematic, equitable and effective manner, comprehensive national, integrated programmes for the prevention and management of sickle-cell anaemia, including surveillance, dissemination of information, awareness-raising, counselling and screening, such programmes being tailored to specific socioeconomic, health system, and cultural contexts and aimed at reducing the incidence, morbidity and mortality associated with this genetic disease;

¹ Document A59/9.

² See document EB116/2005/REC/1, Summary record of the first meeting, section 4.

- (2) to work to ensure that adequate, appropriate and accessible emergency care is available to persons living with sickle-cell anaemia;
- (3) to develop their capacity to evaluate the situation regarding sickle-cell anaemia and the impact of national programmes;
- (4) to intensify the training of all health professionals and community volunteers in high-prevalence areas;
- (5) to develop and strengthen systematic medical-genetics services and holistic care within existing primary health care systems, in partnership with national and local government agencies and nongovernmental organizations, including parent or patient organizations;
- (6) to promote relevant community education, including health counselling and ethical, legal and social issues;
- (7) to promote effective international cooperation in combating sickle-cell anaemia;
- (8) in collaboration with international organizations, to provide support for basic and applied research on sickle-cell anaemia;

2. REQUESTS the Director-General:

- (1) to raise awareness of the international community of the global burden of sickle-cell anaemia, and to promote equitable access to health services for prevention and management of the disease;
- (2) to provide technical support and advice to Member States through the framing of national policies and strategies for prevention and management of sickle-cell anaemia;
- (3) to promote and support:
 - (a) intercountry collaboration to develop training and expertise of personnel, and the further transfer of advanced technologies and expertise to developing countries;
 - (b) the construction and equipment of referral centres for care, training and research;
- (4) to continue WHO's normative functions by drafting guidelines, including good practices and practical models, on prevention and management of sickle-cell anaemia with a view to elaborating regional plans and fostering the establishment of regional groups of experts;
- (5) to promote, support and coordinate the research needed on sickle-cell disorders in order to improve the duration and quality of life of those affected by such disorders.

(Ninth plenary meeting, 27 May 2006 –
Committee A, fourth report)

WHA59.21 Infant and young child nutrition 2006

The Fifty-ninth World Health Assembly,

Having considered the report on infant and young child nutrition which highlights the contribution of optimal infant feeding practices to achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;¹

Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA47.5, WHA49.15, WHA54.2 and WHA58.32 on infant and young child nutrition, appropriate feeding practices and related questions;

Reaffirming in particular resolutions WHA44.33 and WHA55.25 which respectively welcomed the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding and endorsed the Global Strategy for Infant and Young Child Feeding as the foundations for action in the protection, promotion and support of breastfeeding;

Welcoming the Call for Action contained in the Innocenti Declaration 2005 on Infant and Young Child Feeding;

Mindful that 2006 marks the twenty-fifth anniversary of the adoption of the International Code of Marketing of Breast-milk Substitutes, and recognizing its increased relevance in the wake of the HIV/AIDS pandemic, rising frequency of complex human and natural emergencies, and concerns about the risks of intrinsic contamination of powdered infant formula,

1. REITERATES its support for the Global Strategy for Infant and Young Child Feeding;
2. WELCOMES the Call for Action made in the Innocenti Declaration 2005 on Infant and Young Child Feeding as a significant step towards achievement of the fourth Millennium Development Goal to reduce child mortality;
3. URGES Member States to support activities on this Call for Action and, in particular, to renew their commitment to policies and programmes related to implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions and to revitalization of the Baby-Friendly Hospital Initiative to protect, promote and support breastfeeding;
4. CALLS on multilateral and bilateral donor arrangements and international financial institutions to direct financial resources for Member States to carry out these efforts;
5. REQUESTS the Director-General to mobilize technical support for Member States in the implementation and independent monitoring of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions.

(Ninth plenary meeting, 27 May 2006 –
Committee A, fifth report)

¹ Document A59/13.

WHA59.22 Emergency preparedness and response

The Fifty-ninth World Health Assembly,

Having considered the report on emergency preparedness and response;¹

Aware of the suffering caused by natural and man-made disasters;

Noting that the resilience of nations and communities affected by crises is being eroded by the extreme pressures they face on a daily basis and over a protracted period;

Concerned that emergency preparedness in many countries is weak, and that existing mechanisms may not be able to cope with large-scale disasters such as the earthquakes in Bam, Islamic Republic of Iran and, more recently, in northern India and Pakistan, the earthquakes and tsunamis in south Asia, and the hurricanes Katrina and Rita in the United States of America;

Appreciating the progress made, particularly in the Eastern Mediterranean and South-East Asia regions with regard to emergency response to the south Asian earthquake;

Recalling resolution WHA58.1 on health action in relation to crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004, and the United Nations General Assembly resolution 60/124 on Strengthening of the coordination of emergency humanitarian assistance of the United Nations,

1. EXPRESSES its sympathy, support and solidarity for the victims of disasters, their families and their governments;
2. REQUESTS Member States to further strengthen national emergency mitigation, preparedness, response and recovery programmes through, as appropriate, legislative, planning, technical, financial and logistical measures, with a special focus on building health systems and community resilience;
3. URGES Member States to provide support to affected countries and to WHO so that it may address immediately, within its mandate, humanitarian health crises;
4. REQUESTS the Director-General, to take the necessary steps:
 - (1) to provide the necessary technical guidance and support to Member States for building their health-sector emergency preparedness and response programmes at national and local levels, including a focus on strengthening community preparedness and resilience;
 - (2) to build on the Hyogo Framework for Action 2005-2015, stemming from the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005), when providing support to Member States to assess the status of health-sector emergency preparedness, including assessment of the resilience and risk-management capability of hospitals and other key health infrastructures;
 - (3) to work to ensure that WHO, within its mandate, is able to respond effectively to emergencies and crises and, in doing so, continues to work closely with other organizations of the United Nations system, under the coordination of the United Nations Office for the

¹ Document A59/20.

Coordination of Humanitarian Affairs, and other relevant international organizations and mechanisms;

5. REQUESTS the Director-General in particular:

(1) to explore and implement measures to enhance WHO participation in the overall humanitarian response through existing mechanisms such as the Central Emergency Response Fund, International Search and Rescue Advisory Group, or the United Nations Disaster Assessment and Coordination team;

(2) to compile a global database of authoritative technical health references in order to facilitate health-sector response to emergencies and crises;

(3) to establish and maintain, in collaboration with relevant organizations of the United Nations system and other partners, a tracking service that will monitor and assess mortality rates in humanitarian emergencies;

(4) to take part in United Nations system-wide mechanisms for logistics and supply management that would assure immediate mobilization of vital supplies in emergencies and crises;

6. FURTHER REQUESTS the Director-General to report to the Sixtieth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

(Ninth plenary meeting, 27 May 2006 –
Committee B, third report)

WHA59.23 Rapid scaling up of health workforce production

The Fifty-ninth World Health Assembly,

Recognizing the centrality of human resources for health for the effective operation of country health systems as highlighted in *The world health report 2006*;¹

Recognizing that shortages of these health workers are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

Aware of alliances that aim to achieve a rapid increase in the number of qualified health workers in countries experiencing shortages through partnerships between industrialized and developing countries;²

Recalling resolution WHA57.19 on the challenge posed by the international migration of health personnel;

¹ *The world health report 2006: Working together for health*. Geneva, World Health Organization, 2006.

² For example, the Global Health Workforce Alliance, whose secretariat is at WHO.

Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train sufficient health workers for adequate coverage of the population;

Concerned that many countries lack the financial means, facilities and sufficient educators to train an adequate health workforce;

Mindful of the need for a comprehensive national policy and plan on human resources for health, and that production is one of its elements;

Recognizing the importance of achieving the goals of self-sufficiency in health workforce development,

1. URGES Member States to affirm their commitment to the training of more health workers by:
 - (1) considering the establishment of mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for receiving industrialized countries to provide support for the strengthening of health systems, in particular development of human resources, in the countries of origin;
 - (2) promoting training in accredited institutions of a full spectrum of high-quality professionals, and also community health workers, public health workers and paraprofessionals;
 - (3) encouraging financial support by global health partners, including bilateral donors and priority disease and intervention partnerships, for health training institutions in developing countries;
 - (4) promoting the concept of training partnerships between schools in industrialized and developing countries involving exchanges of faculty and students;
 - (5) promoting the creation of planning teams in each country facing health-worker shortages, drawing on wider stakeholders, including professional bodies, the public and private sectors and nongovernmental organizations, whose task would be to formulate a comprehensive national strategy for the health workforce, including consideration of effective mechanisms for use of trained volunteers;
 - (6) using innovative approaches to teaching in industrialized and developing countries, with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;
2. REQUESTS the Director-General:
 - (1) to provide technical support to Member States, as needed, in their efforts to revitalize health training institutions and rapidly to increase the health workforce;
 - (2) to encourage global health partners to support health-training institutions;
 - (3) to encourage Member States to engage in training partnerships intended to improve the capacity and quality of health-professional education in developing countries;
 - (4) to encourage and support Member States in development of health-workforce planning teams and use of innovative approaches to teaching in developing countries, with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;

(5) to report to the Sixty-third World Health Assembly on progress made in the implementation of this resolution.

(Ninth plenary meeting, 27 May 2006 –
Committee A, sixth report)

WHA59.24 Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action

The Fifty-ninth World Health Assembly,

Recalling resolution WHA56.27, which requested the Director-General to establish terms of reference for an appropriate time-limited body to collect data and proposals from the different actors involved and produce an analysis of intellectual property rights, innovation and public health;

Further recalling resolutions WHA52.19, WHA53.14, WHA54.10, and WHA57.14;

Having considered the report of the Commission on Intellectual Property Rights, Innovation and Public Health;¹

Conscious of the growing burden of diseases and conditions disproportionately affecting developing countries, particularly those affecting women and children, including an upsurge in noncommunicable diseases;

Considering the need to continue to develop safe and affordable new products² for such communicable diseases as AIDS, malaria and tuberculosis, and for other diseases or illnesses disproportionately affecting developing countries;

Conscious of the opportunities opened up by advances in biomedical science, and the need to harness them more effectively to develop new products, particularly in order to meet public health needs in developing countries;

Aware of the considerable progress that has been made in recent years by governments, industry, charitable foundations, and nongovernmental organizations in funding initiatives to develop new products to fight diseases affecting developing countries, and to increase access to existing ones;

Recognizing, however, that much more needs to be done in relation to the scale of avoidable suffering and mortality;

Concerned about the need for appropriate, effective and safe health tools for patients living in resource-poor settings;

Considering the urgency of developing new products to address emerging health threats such as multidrug-resistant tuberculosis, and other infectious diseases of particular relevance to developing countries;

¹ Public health, innovation and intellectual property rights. Report of the Commission on Intellectual Property Rights, Innovation and Public Health. Document CIPH/2006/1.

² The term “products” hereafter should be understood to include vaccines, diagnostics and medicines.

Aware of the need for additional funding for research and development for new vaccines, diagnostics and pharmaceuticals, including microbicides, for illnesses, including AIDS, that disproportionately affect developing countries;

Recognizing the importance of, and need for, public/private partnerships devoted to the development of new essential drugs and research tools, and aware of the need for governments to set a needs-based priority agenda for health, and to provide political support and sustainable sources of funding for such initiatives;

Recognizing the importance of public and private investment in the development of new medical technologies;

Considering that a number of developing countries have been strengthening their research and development capacity in new health technologies and that their role will be increasingly critical, and recognizing the need for continued support for research in and by developing countries;

Noting that intellectual property rights are an important incentive for the development of new health-care products;

Noting, however, that this incentive alone does not meet the need for the development of new products to fight diseases where the potential paying market is small or uncertain;

Noting that the Doha Ministerial Declaration on the TRIPS Agreement and Public Health confirms that the Agreement does not and should not prevent Members from taking measures to protect public health;

Further noting that the Declaration, while reiterating commitment to the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) affirms that the Agreement can and should be interpreted and implemented in a manner supportive of the rights of WTO Members to protect public health and, in particular, to promote access to medicines for all;

Taking into account Article 7 of the TRIPS agreement that states that “the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations”;

Stressing that the Universal Declaration of Human Rights provides that “everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits” and that “everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author”;

Concerned about the impact of high prices of medicines on access to treatment;

Aware of the need to promote new thinking on the mechanisms that support innovation;

Recognizing the importance of strengthening capacity of local public institutions and businesses in developing countries to contribute to, and participate in, research and development efforts;

Noting that the report of the Commission requests WHO to prepare a global plan of action to secure enhanced and sustainable funding for developing and making accessible products to address diseases that disproportionately affect developing countries,

1. WELCOMES the report of the Commission on Intellectual Property Rights, Innovation and Public Health and expresses its appreciation to the Chair, Vice-Chair and Members of the Commission for their work;

2. URGES Member States:¹

(1) to make global health and medicines a priority sector, to take determined action to emphasize priorities in research and development addressed to the needs of patients, especially those in resource-poor settings, and to harness collaborative research and development initiatives involving disease-endemic countries;

(2) to consider the recommendations of the report and to contribute actively to the development of a global strategy and plan of action, and to take an active part, working with the Secretariat and international partners, in providing support for essential medical research and development;

(3) to work to ensure that progress in basic science and biomedicine is translated into improved, safe and affordable health products – drugs, vaccines and diagnostics – to respond to all patients' and clients' needs, especially those living in poverty, taking into account the critical role of gender, and to ensure that capacity is strengthened to support rapid delivery of essential medicines to people;

(4) to encourage trade agreements to take into account the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;

(5) to ensure that the report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health is included on the agendas of WHO's regional committees in 2006;

3. DECIDES:

(1) to establish, in accordance with Rule 42 of the Rules of Procedure of the World Health Assembly, an intergovernmental working group open to all interested Member States to draw up a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission; such strategy and plan of action would aim, inter alia, at securing an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

(2) that regional economic integration organizations constituted by sovereign States, Members of WHO, to which their Member States have transferred competence over matters governed by this resolution, including the competence to enter into international legally binding regulations, may participate, in accordance with Rule 55 of the Rules of Procedure of the World Health Assembly, in the work of the intergovernmental working group referred to under paragraph 3(1);

¹ Where applicable, also regional economic integration organizations.

(3) that the above-mentioned working group shall report to the Sixtieth World Health Assembly through the Executive Board on the progress made, giving particular attention to needs-driven research and other potential areas for early implementation;

(4) that the working group shall submit the final global strategy and plan of action to the Sixty-first World Health Assembly through the Executive Board;

4. REQUESTS the Director-General:

(1) to convene immediately the intergovernmental working group and to allocate the necessary resources to it;

(2) to invite, as observers at the sessions of the intergovernmental working group, representatives of non-Member States, of liberation movements referred to in resolution WHA27.37, of organizations of the United Nations system, of intergovernmental organizations with which WHO has established effective relations, and of nongovernmental organizations in official relations with WHO, which shall attend the sessions of the working group in accordance with the relevant Rules of Procedure and resolutions of the Health Assembly;

(3) to invite experts and a limited number of concerned public and private entities to attend the sessions of the intergovernmental working group and to provide advice and expertise, as necessary, upon request of the Chairman, taking into account the need to avoid conflicts of interest;

(4) to continue to issue public health-based research and development reports, identifying from a public health perspective gaps and needs related to pharmaceuticals, and to report on them periodically;

(5) to continue to monitor, from a public health perspective, in consultation as appropriate with other international organizations, the impact of intellectual property rights and other issues addressed in the Commission's report, on the development of, and access to, health care products, and to report thereon to the Health Assembly.

(Ninth plenary meeting, 27 May 2006 –
Committee A, sixth report)

WHA59.25 Prevention of avoidable blindness and visual impairment

The Fifty-ninth World Health Assembly,

Having considered the report on prevention of avoidable blindness and visual impairment;¹

Recognizing that more than 161 million people worldwide are visually impaired, of whom 37 million are blind, and that an estimated 75% of blindness is avoidable or curable using established and affordable technologies;

Recalling resolution WHA56.26 on the elimination of avoidable blindness;

¹ Document A59/12.

Noting that many Member States have committed themselves to providing support for the Global Initiative for the Elimination of Avoidable Blindness, known as Vision 2020 – the Right to Sight;

Noting with concern that only 32% of targeted countries had drafted a national Vision 2020 plan by August 2005;

Acknowledging the links between poverty and blindness, and that blindness places a heavy economic burden on families, communities and countries, particularly developing countries;

Further acknowledging that control of both onchocerciasis and trachoma has come about through the commitment of broad international alliances;

Welcoming the important actions undertaken at regional, subregional and international levels by Member States with a view to achieving substantial progress in the elimination of avoidable blindness through greater international cooperation and solidarity,

1. URGES Member States:

- (1) to reinforce efforts to set up national Vision 2020 plans as called for in resolution WHA56.26;
- (2) to provide support for Vision 2020 plans by mobilizing domestic funding;
- (3) to include prevention of avoidable blindness and visual impairment in national development plans and goals;
- (4) to advance the integration of prevention of avoidable blindness and visual impairment in primary health care and in existing health plans and programmes at regional and national levels;
- (5) to encourage partnerships between the public sector, nongovernmental organizations, the private sector, civil society and communities in programmes and activities for prevention of blindness at all levels;
- (6) to develop and strengthen eye-care services and integrate them in the existing health-care system at all levels, including the training and re-training of health workers in visual health;
- (7) to promote and provide improved access to health services both with regard to prevention as well as treatment for ocular conditions;
- (8) to encourage integration, cooperation and solidarity between countries in the areas of prevention and care for blindness and visual impairment;
- (9) to make available within health systems essential medicines and medical supplies needed for eye care;

2. REQUESTS the Director-General:

- (1) to give priority to prevention of avoidable blindness and visual impairment, and to provide necessary technical support to Member States;

- (2) to provide support to collaboration among countries for prevention of avoidable blindness and visual impairment in particular in the area of training of all categories of relevant staff;
- (3) to monitor progress in the Global Initiative for the Elimination of Avoidable Blindness in collaboration with international partners, and to report to the Executive Board every three years;
- (4) to ensure that prevention of blindness and visual impairment are included in the implementation and monitoring of WHO's Eleventh General Programme of Work, and to strengthen global, regional and national activities for prevention of blindness;
- (5) to add prevention of blindness and visual impairment to WHO's medium-term strategic plan 2008-2013 and proposed programme budget 2008-2009 which are currently in preparation;
- (6) to strengthen cooperation through regional, subregional and international efforts with the view to achieving the goals set out in this resolution.

(Ninth plenary meeting, 27 May 2006 –
Committee A, sixth report)

WHA59.26 International trade and health

The Fifty-ninth World Health Assembly,

Having considered the report on international trade and health,¹

Recalling resolutions WHA52.19, WHA53.14, WHA56.23, WHA56.27, WHA57.14 and WHA57.19;

Recognizing the demand for information on the possible implications of international trade and trade agreements for health and health policy at national, regional and global levels;

Mindful of the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated,

1. URGES Member States:

- (1) to promote multi-stakeholder dialogue at national level to consider the interplay between international trade and health;
- (2) to adopt, where necessary, policies, laws and regulations that deal with issues identified in that dialogue, and to take advantage of the potential opportunities, and address the potential challenges, that trade and trade agreements may have for health, considering, where appropriate, using their inherent flexibilities;
- (3) to apply or establish, where necessary, coordination mechanisms involving ministries of finance, health, and trade, and other relevant institutions, to address public-health related aspects of international trade;

¹ Document A59/15.

(4) to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in national trade and health policies;

(5) to continue to develop capacity at national level to track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes;

2. REQUESTS the Director-General:

(1) to provide support to Member States, at their request and in collaboration with the competent international organizations, in their efforts to frame coherent policies to address the relationship between trade and health;

(2) to respond to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health and to address relevant issues through policies and legislation that take advantage of the potential opportunities, and address the potential challenges, that trade and trade agreements may have for health;

(3) to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health;

(4) to report to the Sixty-first World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

(Ninth plenary meeting, 27 May 2006 –
Committee A, sixth report)

WHA59.27 Strengthening nursing and midwifery

The Fifty-ninth World Health Assembly,

Having considered the progress report on strengthening nursing and midwifery;¹

Recognizing the centrality of human resources for health to the effective operation of country health systems as highlighted in *The world health report 2006*;²

Recognizing the crucial contribution of the nursing and midwifery professions to health systems, to the health of the people they serve, and to efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

Recalling resolution WHA57.19 on the challenge posed by the international migration of health personnel;

¹ Document A59/23.

² *The world health report 2006. Working together for health.* Geneva, World Health Organization, 2006.

Recognizing the impact of “push” and “pull” factors in the countries concerned;

Concerned at the continuing shortage of nurses and midwives in many countries, and its impact on health care and more widely;

Mindful of previous resolutions to strengthen nursing and midwifery, including resolutions WHA42.27, WHA45.5, WHA49.1 and WHA54.12, and the strategic directions for nursing and midwifery services in place for the years 2002-2008;¹

Concerned that some Member States do not yet give full recognition to the contribution of nursing and midwifery in their programmes and practices,

1. URGES Member States to confirm their commitment to strengthen nursing and midwifery by:
 - (1) establishing comprehensive programmes for the development of human resources which support recruitment and retention, while ensuring equitable geographical distribution, in sufficient numbers of a balanced skill mix, and a skilled and motivated nursing and midwifery workforce within their health services;
 - (2) actively involving nurses and midwives in the development of their health systems and in the framing, planning and implementation of health policy at all levels, including ensuring that nursing and midwifery is represented at all appropriate governmental levels, and have real influence;
 - (3) ensuring continued progress toward implementation at country level of WHO’s strategic directions for nursing and midwifery;
 - (4) regularly reviewing legislation and regulatory processes relating to nursing and midwifery in order to ensure that they enable nurses and midwives to make their optimum contribution in the light of changing conditions and requirements;
 - (5) to provide support for the collection and use of nursing and midwifery core data as part of national health-information systems;
 - (6) to support the development and implementation of ethical recruitment of national and international nursing and midwifery staff;
2. REQUESTS the Director-General:
 - (1) to ensure the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nursing and midwifery personnel;
 - (2) to provide continuing support for the work of the Global Advisory Group on Nursing and Midwifery, and to recruit nurses and midwives in all relevant WHO programmes in order to ensure the contribution of nursing and midwifery in the development and implementation of WHO’s policy and programmes;

¹ *Nursing and midwifery services. Strategic directions 2002-2008*. Geneva, World Health Organization, 2002.

- (3) to provide support to Member States, in collaboration with local and global partners, in strengthening the application of ethical recruitment guidelines;
- (4) to provide support to Member States in optimizing the contribution of nursing and midwifery to meeting national health policies and the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (5) to encourage and support Member States in the provision of workplace environments that are safe and support the retention of nurses and midwives;
- (6) to report to the Sixty-first and Sixty-third World Health Assembly in 2008 and 2010 on progress made in the implementation of this resolution.

(Ninth plenary meeting, 27 May 2006 –
Committee A, sixth report)

DECISIONS

WHA59(1) Composition of the Committee on Credentials

The Fifty-ninth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following twelve Member States: Burundi, Cambodia, Cyprus, Democratic People's Republic of Korea, Ecuador, Estonia, Guinea-Bissau, Honduras, Jordan, Nigeria, Pakistan and Poland.

(First plenary meeting, 22 May 2006)

WHA59(2) Composition of the Committee on Nominations

The Fifty-ninth World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Brazil, Cambodia, Canada, China, Colombia, Costa Rica, Dominican Republic, France, Hungary, Iran (Islamic Republic of), Israel, Italy, Kenya, Libyan Arab Jamahiriya, Mauritania, Nepal, New Zealand, Russian Federation, Sao Tome and Principe, Sierra Leone, Sudan, Thailand, Uganda, Zambia, and Ms E. Salgado, Spain (President, Fifty-eighth World Health Assembly, ex officio).

(First plenary meeting, 22 May 2006)

WHA59(3) Election of officers of the Fifty-ninth World Health Assembly

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

President:	Professor P.I. Garrido (Mozambique)
Vice-Presidents:	Dr M. Soledad Barría (Chile) Mr A.A. Miguil (Djibouti) Mr E. Nicolaescu (Romania) Dr S.F. Supari (Indonesia) Pehin Suyoi Osman (Brunei Darussalam)

(First plenary meeting, 22 May 2006)

WHA59(4) Election of officers of the main committees

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

Committee A: Chairman Dr A. Ramadoss (India)

Committee B: Chairman Dr Ali Jaffer Mohammad (Oman)

(First plenary meeting, 22 May 2006)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Dr K. Leppo (Finland)
Dr P. Mazzetti Soler (Peru)

Rapporteur Dr A. Cissé (Guinea)

Committee B: Vice-Chairmen Dr F.T. Duque III (Philippines)
Mr V. Meriton (Seychelles)

Rapporteur Dr B. Carey (Bahamas)

(First meetings of Committees A and B, 23 and 25 May 2006)

WHA59(5) Establishment of the General Committee

The Fifty-ninth 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: Angola, Austria, Barbados, China, Cuba, Egypt, France, Gabon, Gambia, Georgia, New Zealand, Panama, Republic of Moldova, Russian Federation, Senegal, Togo, United States of America.

(First plenary meeting, 22 May 2006)

WHA59(6) Adoption of the agenda

The Fifty-ninth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 117th session with the deletion of two items and two subitems, and the addition of a supplementary item.

(Second plenary meeting, 22 May 2006)

WHA59(7) Verification of credentials

The Fifty-ninth 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; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; 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; 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; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nauru; 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 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; South Africa; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; 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; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(Fifth plenary meeting, 24 May 2006)

WHA59(8) Election of Members entitled to designate a person to serve on the Executive Board

The Fifty-ninth World Health Assembly, after considering the recommendations of the General Committee,¹ elected the following as Members entitled to designate a person to serve on the Executive Board: Afghanistan, China, Denmark, Djibouti, El Salvador, Latvia, Mali, Singapore, Slovenia, Sri Lanka, Turkey and United States of America.

(Eighth plenary meeting, 26 May 2006)

WHA59(9) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Fifty-ninth World Health Assembly nominated Dr A.J. Mohammad of the delegation of Oman as a member, and Mr D.Á. Gunnarsson of the delegation of Iceland as an alternate member, of the WHO Staff Pension Committee for a three-year term until May 2009.

(Ninth plenary meeting, 27 May 2006)

¹ Document A59/46.

WHA59(10) WHO's role and responsibilities in health research

The Fifty-ninth World Health Assembly decided to submit the text of the draft resolution entitled "WHO's role and responsibilities in health research", incorporating the amendments proposed by Member States, to the Executive Board at its 120th session for further consideration.

(Ninth plenary meeting, 27 May 2006)

WHA59(11) Health promotion in a globalized world

The Fifty-ninth World Health Assembly decided to submit the text of the draft resolution entitled "Health promotion in a globalized world", incorporating the amendments proposed by Member States, to the Executive Board at its 120th session for further consideration.

(Ninth plenary meeting, 27 May 2006)

WHA59(12) Smallpox eradication: destruction of variola virus stocks

The Fifty-ninth World Health Assembly decided to submit the text of the draft resolution entitled "Smallpox eradication: destruction of variola virus stocks", as proposed by a working group of Committee A, to the Executive Board at its 120th session for further consideration.

(Ninth plenary meeting, 27 May 2006)

WHA59(13) Selection of the country in which the Sixtieth World Health Assembly would be held

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

(Ninth plenary meeting, 27 May 2006)

WHA59(14) Reports of the Executive Board on its 116th and 117th sessions

The Fifty-ninth World Health Assembly, after reviewing the Executive Board's reports on its 116th and 117th sessions,¹ 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.

(Tenth plenary meeting, 27 May 2006)

¹ Document A59/2.

ANNEXES

ANNEX 1

Strategic Approach to International Chemicals Management¹

[A59/41, Annex – 11 May 2006]

1. As requested by resolution WHA56.22 on participation of global health partners in the development of the strategic approach, the completed Strategic Approach to International Chemicals Management was submitted to the Health Assembly for consideration. The Strategic Approach was completed and adopted by the International Conference on Chemicals Management (Dubai, United Arab Emirates, 4-6 February 2006), whose participants included representatives of 151 governments, nine organizations of the United Nations system, eight intergovernmental organizations and 47 nongovernmental organizations. The Conference commended the Strategic Approach to the attention of the governing bodies of relevant intergovernmental organizations. The Governing Council of UNEP, at its 9th Special Session (Dubai, United Arab Emirates, 7-9 February 2006) adopted a decision endorsing the completed Strategic Approach and the role and activities of UNEP in relation to its implementation.

Overview of the Strategic Approach

2. The Strategic Approach to International Chemicals Management comprises three core texts: the Dubai Declaration on International Chemicals Management, the Overarching Policy Strategy and the Global Plan of Action, attached as appendices. Among the resolutions adopted by the Conference were decisions on implementation arrangements, the Quick Start Programme and the Intergovernmental Forum on Chemical Safety.

3. The Strategic Approach aims inter alia to meet the concern that chemicals continue to contaminate the environment worldwide, impairing the health and welfare of millions. It responds to the stated need to assess and manage chemicals more effectively in order to achieve the 2020 goal, articulated in paragraph 23 of the Johannesburg Plan of Implementation,² for the sound management of chemicals. The scope of the Strategic Approach includes (a) environmental, economic, social, health and labour aspects of chemical safety and (b) agricultural and industrial chemicals, with a view to promoting sustainable development and covering chemicals at all stages of their life-cycle, including in products. It does not cover products to the extent that the health and environmental aspects of the safety of the chemicals and products are regulated by a domestic food or pharmaceutical authority or arrangement. The Strategic Approach is not a legally binding instrument. The Global Plan of Action contains activities that may be undertaken voluntarily by stakeholders, according to their applicability, in order to pursue the commitments and objectives expressed in the Declaration and the Overarching Policy Strategy.

¹ See resolution WHA59.15.

² Adopted by the World Summit on Sustainable Development (Johannesburg, South Africa, September 2002). See Appendix 2, Attachment, for text of paragraph 23.

4. The Conference will be reconvened in 2009, 2012, 2015 and 2020 in order periodically to review progress in the implementation of the Strategic Approach, and will be served by a UNEP-based secretariat. Other institutional arrangements to support implementation and take stock of progress will include national focal points, national coordination (interministerial processes are recommended), regional focal points, regional meetings (as appropriate) and, at the international level, a periodic review process. In addition, the Inter-Organization Programme for the Sound Management of Chemicals¹ was requested to continue to perform a coordinating function for intergovernmental organization activities and work programmes. WHO currently acts as the administering organization for the Inter-Organization Programme. In addition, it was decided that future sessions of the Conference should be held back-to-back with meetings of the governing bodies of relevant intergovernmental organizations, where appropriate.²

5. The objective of the Quick Start Programme, which includes establishment of a Trust Fund, is to support initial capacity-building and implementation in developing countries, least developed countries, small island developing States and countries with economies in transition. The Conference invited the representatives of the seven participating organizations of the Inter-Organization Programme for the Sound Management of Chemicals and UNDP to form an implementation committee for projects financed by the Quick Start Programme Trust Fund, and decided to establish the Quick Start Programme Executive Board, consisting of two government representatives from each of the United Nations regions and all the bilateral and multilateral donors and other contributors to the Programme.

Main outcomes for the health sector

6. The main outcomes of the negotiations on the Strategic Approach for the health sector, including WHO, relate to inclusion of the priorities expressed by the health sector and submitted to the Fifty-eighth World Health Assembly³ (see below); confirmation that the Strategic Approach is multisectoral; institutional arrangements that facilitate participation of the health sector; recognition of the important role of the health sector in implementation; confirmation of WHO's lead role on health matters in the secretariat of the Strategic Approach; and inclusion of WHO in the trust-fund implementation committee. In relation to the secretariat, the Conference welcomed a potential offer from WHO of a professional staff member.

7. The priorities identified by the health sector and which are fully reflected in the Strategic Approach are:

- improving ability to access, interpret and apply scientific knowledge
- filling gaps in scientific knowledge
- elaborating globally harmonized methods for chemical risk assessment
- devising better ways to determine impacts of chemicals on health, to set priorities for action and to monitor progress of the Strategic Approach

¹ Participating organizations are ILO, FAO, WHO, the United Nations Institute for Training and Research, UNEP, UNIDO and OECD; UNDP and the World Bank are observers.

² Overarching Policy Strategy, paragraph 25.

³ See document WHA58/2005/REC/3, summary record of the eleventh meeting of Committee A.

- building capabilities of countries to deal with poisonings and chemical incidents
- formulating strategies directed specifically at the health of children and workers
- promoting alternatives to highly toxic and persistent chemicals
- formulating strategies aimed at prevention of ill-health and disease caused by chemicals.

Possible next steps for the health sector

8. The next steps fall into two main categories: health-focused implementation and institutional arrangements. The health sector, including WHO, has an established track-record of work on high-level health priorities. Implementation would focus on those activities of the Strategic Approach of most relevance to the health sector at country, regional and international levels. The Conference encouraged the governing bodies of relevant intergovernmental organizations to endorse or otherwise appropriately acknowledge the Strategic Approach with a view to incorporating its objectives into their programmes of work within their mandates, and to report thereon to the International Conference on Chemicals Management. For WHO, the Strategic Approach could be taken into account in future programmes of work. In addition, the priority activity of formulating strategies for the health of workers is also within the mandate of ILO, with which WHO has an established joint programme of cooperation.

9. Given that resolution WHA56.22 requested the Director-General to contribute health-focused elements to the development of the Strategic Approach, a similar arrangement could be made for its implementation. In view of the Strategic Approach's institutional arrangements, the next steps for the health sector at country level would include engagement in the national and regional processes that are being established. There should be one national focal point for official contact with the secretariat of the Strategic Approach and some governments may wish to nominate such focal points from the health sector. In any case, a network of national health contacts would aid WHO in facilitating the implementation activities of the health sector, through its regional offices as appropriate.

10. The presence of WHO in the trust-fund implementation committee will allow due weight to be given to health considerations in funding decisions.

ACTION BY THE HEALTH ASSEMBLY

11. [The Health Assembly adopted resolution WHA59.15 at its ninth plenary meeting, 27 May 2006.]

Appendix 1

Dubai Declaration on International Chemicals Management

We, the ministers, heads of delegation and representatives of civil society and the private sector, assembled at the International Conference on Chemicals Management in Dubai from 4 to 6 February 2006, declare the following:

1. The sound management of chemicals is essential if we are to achieve sustainable development, including the eradication of poverty and disease, the improvement of human health and the environment and the elevation and maintenance of the standard of living in countries at all levels of development;
2. Significant, but insufficient, progress has been made in international chemicals management through the implementation of chapter 19 of Agenda 21¹ and International Labour Organization Conventions No. 170 on Safety in the Use of Chemicals at Work and No. 174 on the Prevention of Major Industrial Accidents and the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal, as well as in addressing particularly hazardous chemicals through the recent entry into force of the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade and the Stockholm Convention on Persistent Organic Pollutants and the adoption of the Globally Harmonized System for the Classification and Labelling of Chemicals;
3. The private sector has made considerable efforts to promote chemical safety through voluntary programmes and initiatives such as product stewardship and the chemicals industry's Responsible Care programme;
4. Non-governmental public health and environmental organizations, trade unions and other civil society organizations have made important contributions to the promotion of chemical safety;
5. Progress in chemicals management has not, however, been sufficient globally and the environment worldwide continues to suffer from air, water and land contamination, impairing the health and welfare of millions;
6. The need to take concerted action is accentuated by a wide range of chemical safety concerns at the international level, including a lack of capacity for managing chemicals in developing countries and countries with economies in transition, dependency on pesticides in agriculture, exposure of workers to harmful chemicals and concern about the long-term effects of chemicals on both human health and the environment;
7. The global production, trade and use of chemicals are increasing, with growth patterns placing an increasing chemicals management burden on developing countries and countries with economies in transition, in particular the least developed among them and small island developing States, and presenting them with special difficulties in meeting this challenge. As a result, fundamental changes are needed in the way that societies manage chemicals;

¹ *Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3-14 June 1992* (United Nations publication, Sales No. E.93.I.8 and corrigenda) vol. I: Resolutions adopted by the Conference, resolution 1, annex II.

8. We are determined to implement the applicable chemicals management agreements to which we are Party, strengthen the coherence and synergies that exist between them and work to address, as appropriate, existing gaps in the framework of international chemicals policy;
9. We commit ourselves in a spirit of solidarity and partnership to achieving chemical safety and thereby assisting in fighting poverty, protecting vulnerable groups and advancing public health and human security;
10. We commit ourselves to respecting human rights and fundamental freedoms, understanding and respecting ecosystem integrity and addressing the gap between the current reality and our ambition to elevate global efforts to achieve the sound management of chemicals;
11. We are unwavering in our commitment to promoting the sound management of chemicals and hazardous wastes throughout their life-cycle, in accordance with Agenda 21 and the Johannesburg Plan of Implementation,¹ in particular paragraph 23. We are convinced that the Strategic Approach to International Chemicals Management constitutes a significant contribution towards the internationally agreed development goals set out in the Millennium Declaration. It builds upon previous international initiatives on chemical safety and promotes the development of a multi- and cross-sectoral and participatory strategic approach;
12. We therefore adopt the Overarching Policy Strategy, which, together with the present declaration, constitutes our firm commitment to the Strategic Approach and its implementation;
13. We recommend the use and further development of the Global Plan of Action, to address current and ever-changing societal needs, as a working tool and guidance document for meeting the commitments to chemicals management expressed in the Rio Declaration on Environment and Development,² Agenda 21, the Bahia Declaration on Chemical Safety,³ the Johannesburg Plan of Implementation, the 2005 World Summit Outcome⁴ and this Strategic Approach;
14. We are determined to realize the benefits of chemistry, including green chemistry, for improved standards of living, public health and protection of the environment, and are resolved to continue working together to promote the safe production and use of chemicals;
15. We are committed to strengthening the capacities of all concerned to achieve the sound management of chemicals and hazardous wastes at all levels;
16. We will continue to mobilize national and international financing from public and private sources for the life-cycle management of chemicals;
17. We will work towards closing the gaps and addressing the discrepancies in the capacity to achieve sustainable chemicals management between developed countries on the one hand and

¹ *Report of the World Summit on Sustainable Development, Johannesburg, South Africa, 26 August–4 September 2002* (United Nations publication, Sales No. E.03.II.A1 and corrigendum), chap. I, resolution 2, annex.

² *Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3–14 June 1992*, vol. I, *Resolutions Adopted by the Conference* (United Nations publication, Sales No. E.93.I.8 and corrigendum), resolution 1, annex I.

³ Intergovernmental Forum on Chemical Safety, third session, Forum III final report (IFCS/Forum III/23w), annex 6.

⁴ General Assembly resolution 60/1 of 6 September 2005.

developing countries and countries with economies in transition on the other by addressing the special needs of the latter and strengthening their capacities for the sound management of chemicals and the development of safer alternative products and processes, including non-chemical alternatives, through partnerships, technical support and financial assistance;

18. We will work towards effective and efficient governance of chemicals management by means of transparency, public participation and accountability involving all sectors of society, in particular striving for the equal participation of women in chemicals management;

19. We will engage actively in partnerships between Governments, the private sector and civil society, including strengthening participation in the implementation of the Strategic Approach by small and medium-sized enterprises and the informal sector;

20. We stress the responsibility of industry to make available to stakeholders such data and information on health and environmental effects of chemicals as are needed safely to use chemicals and the products made from them;

21. We will facilitate public access to appropriate information and knowledge on chemicals throughout their life-cycle, including the risks that they pose to human health and the environment;

22. We will ensure that, when information is made available, confidential commercial and industrial information and knowledge are protected in accordance with national laws or regulations or, in the absence of such laws and regulations, are protected in accordance with international provisions. In making information available, information on chemicals relating to the health and safety of humans and the environment should not be regarded as confidential;

23. We recognize the need to make special efforts to protect those groups in society that are particularly vulnerable to risks from hazardous chemicals or are highly exposed to them;

24. We are determined to protect children and the unborn child from chemical exposures that impair their future lives;

25. We will endeavour to prevent illegal traffic in toxic, hazardous, banned and severely restricted chemicals and chemical products and wastes;

26. We will promote the sound management of chemicals and hazardous waste as a priority in national, regional and international policy frameworks, including strategies for sustainable development, development assistance and poverty reduction;

27. We will strive to integrate the Strategic Approach into the work programmes of all relevant United Nations organizations, specialized agencies, funds and programmes consistent with their mandates as accorded by their respective governing bodies;

28. We acknowledge that as a new voluntary initiative in the field of international management of chemicals, the Strategic Approach is not a legally binding instrument;

29. We collectively share the view that implementation and taking stock of progress are critical to ensuring success and that, in this regard, a stable and long-term fully participatory and multi-sectoral structure for guidance, review and operational support is essential;

30. We are determined to cooperate fully in an open, inclusive, participatory and transparent manner in the implementation of the Strategic Approach.

Appendix 2

Overarching Policy Strategy

I. Introduction

1. The present Overarching Policy Strategy flows from the commitments expressed in the Dubai Declaration on International Chemicals Management developed in the context of the Rio Declaration, Agenda 21 and the Johannesburg Plan of Implementation. The structure of the strategy is as follows:

- I. Introduction
- II. Scope
- III. Statement of needs
- IV. Objectives
 - A. Risk reduction
 - B. Knowledge and information
 - C. Governance
 - D. Capacity-building and technical cooperation
 - E. Illegal international traffic
- V. Financial considerations
- VI. Principles and approaches
- VII. Implementation and taking stock of progress

2. The involvement of all relevant sectors and stakeholders, including at the local, national, regional and global levels, is seen as key to achieving the objectives of the Strategic Approach, as is a transparent and open implementation process and public participation in decision-making, featuring in particular a strengthened role for women. The main stakeholders in the Strategic Approach are understood to be Governments, regional economic integration organizations, intergovernmental organizations, non-governmental organizations and individuals involved in the management of chemicals throughout their life-cycles from all relevant sectors, including, but not limited to, agriculture, environment, health, industry, relevant economic activity, development cooperation, labour and science. Individual stakeholders include consumers, disposers, employers, farmers, producers, regulators, researchers, suppliers, transporters and workers.

II. Scope

3. The Strategic Approach has a scope that includes:

- (a) Environmental, economic, social, health and labour aspects of chemical safety,

(b) Agricultural and industrial chemicals, with a view to promoting sustainable development and covering chemicals at all stages of their life-cycle, including in products.¹

4. The Strategic Approach should take due account of instruments and processes that have been developed to date and be flexible enough to deal with new ones without duplicating efforts, in particular the efforts of forums dealing with the military uses of chemicals.

III. Statement of needs

5. A major driving force for the establishment of the Strategic Approach has been the recognition of the growing gaps between the capacities of different countries to manage chemicals safely, the need to improve synergies between existing instruments and processes and the growing sense of urgency regarding the need to assess and manage chemicals more effectively to achieve the 2020 goal articulated in paragraph 23 of the Johannesburg Plan of Implementation.² There is also the need for countries to have more effective governance structures to help make the Strategic Approach a lasting success.

6. Since the United Nations Conference on Environment and Development in Rio de Janeiro in 1992, at which the Rio Declaration and Agenda 21 were adopted, much has been done to improve chemicals management. Regulatory systems have been introduced or strengthened; much more information has been made available about chemicals; many chemicals have been assessed at the national level and internationally; a wide range of risk management measures have been introduced; and new tools such as the Globally Harmonized System of Classification and Labelling of Chemicals and pollutant release and transfer registers have been taken up and developed. New international instruments and programmes have been created. Industry has developed and extended its own programmes to contribute to better chemicals management, and there are now in many countries active and well informed public interest movements promoting awareness and good practices with regard to chemicals. It is, however, recognized that:

(a) The existing international policy framework for chemicals is not completely adequate and needs to be further strengthened;

(b) Implementation of established international policies is uneven;

(c) Coherence and synergies between existing institutions and processes are not completely developed and should be further improved;

(d) There is often limited or no information on many chemicals currently in use and often limited or no access to information that already exists;

(e) Many countries lack the capacity to manage chemicals soundly at the national, subregional, regional and global levels;

(f) There are inadequate resources available to address chemical safety issues in many countries, particularly to bridge the widening gap between developed countries on the one hand and developing countries and countries with economies in transition on the other.

¹ The Strategic Approach does not cover products to the extent that the health and environmental aspects of the safety of the chemicals and products are regulated by a domestic food or pharmaceutical authority or arrangement.

² A copy of paragraph 23 is set out in the appendix.

7. Risk reduction (including preventing, reducing, remediating, minimizing and eliminating risks) is a key need in pursuing the sound management of chemicals throughout their entire life-cycle including, where appropriate, products and articles containing chemicals. It is recognized that:

- (a) Risk assessment and management strategies, supported by improved scientific understanding of the role and behaviour of substances, addressing product life-cycles, are central to achieving risk reduction;
- (b) Risk reduction measures, appropriately informed by scientific methods and consideration of social and economic factors, are needed to reduce or eliminate the harmful effects of chemicals and their inappropriate uses;
- (c) Risk reduction measures need to be improved to prevent the adverse effects of chemicals on the health of children, pregnant women, fertile populations, the elderly, the poor, workers and other vulnerable groups and susceptible environments;
- (d) The development of safer alternatives, including alternatives to chemicals of concern, and affordable sustainable technologies should be accelerated;
- (e) Developing countries and countries with economies in transition need better access to affordable, safer technologies and alternatives, which will also assist in reducing illegal traffic in hazardous chemicals.

8. Knowledge, information and public awareness are basic needs for decision-making for the sound management of chemicals, including products and articles containing chemicals. It is recognized that:

- (a) Technological information, the results of hazard and risk assessments, socio-economic methodologies and the tools to develop and apply science-based standards, harmonized risk assessment and management principles are not available to all actors, and the pace of scientific research in these areas needs to be accelerated;
- (b) There is a lack of clear, accessible, timely and appropriate information on chemicals for ready use by local populations.

9. Governance is an important issue that needs to be addressed through a multi-sector and multi-stakeholder approach in pursuing the sound management of chemicals. There is therefore a need to recognize:

- (a) That in many countries some stakeholders, particularly women and indigenous communities, still do not participate in all aspects of decision-making related to the sound management of chemicals, a situation which needs to be addressed;
- (b) That implementation of the present international regime for the sound management of chemicals, including binding instruments and other relevant initiatives, is uneven, a situation which needs to be addressed. There are gaps, overlaps and duplication in chemicals management activities and there is a need in many countries for enhanced coherence, consistency and cooperation to ensure efficient and effective use of available resources at the national, regional, and international levels. Many countries have not ratified or implemented regional and global legally binding instruments and other relevant initiatives, addressed gaps in national chemicals regimes or developed national mechanisms for coordinating chemicals activities;

(c) That the mechanisms used to address the social and economic impacts of chemicals on human health, society and the environment, including liability, compensation and redress, need to be improved in some countries;

(d) That chemicals issues are only sometimes featured in relevant national policy documents, including development assistance plans or strategies, sustainable development strategies and, as appropriate, poverty reduction strategies;

(e) That there is a need to promote the role of all sectors of civil society and the private sector in the implementation of the Strategic Approach.

10. Capacity-building and technical assistance in relation to all aspects of the sound management of chemicals are among the essential elements for the successful implementation of the Strategic Approach:

(a) The widening gap in capacity between developed countries on the one hand and developing countries and countries with economies in transition on the other should be bridged in order to make progress towards the goal articulated in paragraph 23 of the Johannesburg Plan of Implementation. Some developed countries, however, also face capacity issues in striving to meet this goal;

(b) There is a need for enhanced cooperation aimed at strengthening the capacities of developing countries and countries with economies in transition for the sound management of chemicals and hazardous wastes and promoting adequate transfer of cleaner and safer technology to those countries.

11. Illegal international traffic in hazardous substances and dangerous products is a pressing problem for many countries, especially for developing countries and countries with economies in transition.

12. One of the challenges that will be faced by many countries, in particular developing countries and countries with economies in transition, in pursuing the goal articulated in paragraph 23 of the Johannesburg Plan of Implementation is to obtain access to the considerable financial and other resources needed to achieve the sound management of chemicals.

IV. Objectives

13. The overall objective of the Strategic Approach is to achieve the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment. The objective will be achieved, among other ways, through the implementation of activities set out in the Global Plan of Action.

A. Risk reduction

14. The objectives of the Strategic Approach with regard to risk reduction are:

(a) To minimize risks to human health, including that of workers, and to the environment throughout the life-cycle of chemicals;

-
- (b) To ensure that humans and ecosystems and their constituent parts that are especially vulnerable or especially subject to exposure to chemicals that may pose a risk are taken into account and protected in making decisions on chemicals;
- (c) To implement transparent, comprehensive, efficient and effective risk management strategies based on appropriate scientific understanding, including of health and environmental effects, and appropriate social and economic analysis aimed at pollution prevention, risk reduction and risk elimination, including detailed safety information on chemicals, to prevent unsafe and unnecessary exposures to chemicals;
- (d) To ensure, by 2020:
- (i) That chemicals or chemical uses that pose an unreasonable and otherwise unmanageable risk to human health and the environment¹ based on a science-based risk assessment and taking into account the costs and benefits as well as the availability of safer substitutes and their efficacy, are no longer produced or used for such uses;
 - (ii) That risks from unintended releases of chemicals that pose an unreasonable and otherwise unmanageable risk to human health and the environment² based on a science-based risk assessment and taking into account the costs and benefits, are minimized;
- (e) Appropriately to apply the precautionary approach, as set out in Principle 15 of the Rio Declaration on Environment and Development, while aiming to achieve that chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment;
- (f) To give priority consideration to the application of preventive measures such as pollution prevention;
- (g) To ensure that existing, new and emerging issues of global concern are sufficiently addressed by means of appropriate mechanisms;
- (h) To reduce the generation of hazardous waste, both in quantity and toxicity, and to ensure the environmentally sound management of hazardous waste, including its storage, treatment and disposal;
- (i) To promote the environmentally sound recovery and recycling of hazardous materials and waste;
- (j) To promote and support the development and implementation of, and further innovation in, environmentally sound and safer alternatives, including cleaner production, informed substitution of chemicals of particular concern and non-chemical alternatives.

¹ Groups of chemicals that might be prioritized for assessment and related studies include: persistent, bioaccumulative and toxic substances (PBTs); very persistent and very bioaccumulative substances; chemicals that are carcinogens or mutagens or that adversely affect, inter alia, the reproductive, endocrine, immune, or nervous systems; persistent organic pollutants (POPs), mercury and other chemicals of global concern; chemicals produced or used in high volumes; those subject to wide dispersive uses; and other chemicals of concern at the national level.

² *Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3-14 June 1992*, vol. I, *Resolutions Adopted by the Conference* (United Nations publication, Sales No.E.93.I.8 and corrigendum), resolution 1, annex 1.

B. Knowledge and information

15. The objectives of the Strategic Approach with regard to knowledge and information are:
- (a) To ensure that knowledge and information on chemicals and chemicals management are sufficient to enable chemicals to be adequately assessed and managed safely throughout their life-cycle;
 - (b) To ensure, for all stakeholders:
 - (i) That information on chemicals throughout their life-cycle, including, where appropriate, chemicals in products, is available, accessible, user friendly, adequate and appropriate to the needs of all stakeholders. Appropriate types of information include their effects on human health and the environment, their intrinsic properties, their potential uses, their protective measures and regulation;
 - (ii) That such information is disseminated in appropriate languages by making full use of, among other things, the media, hazard communication mechanisms such as the Globally Harmonized System of Classification and Labelling of Chemicals and relevant provisions of international agreements;
 - (c) To ensure that, in making information available in accordance with paragraph 15 (b), confidential commercial and industrial information and knowledge are protected in accordance with national laws or regulations or, in the absence of such laws or and regulations, are protected in accordance with international provisions. In the context of this paragraph, information on chemicals relating to the health and safety of humans and the environment should not be regarded as confidential;
 - (d) To make objective scientific information available for appropriate integration into risk assessments and associated decision-making relating to chemicals policy, including in relation to assessment of chemical hazards and risks to human health, especially vulnerable sub-populations such as children, and to the environment, particularly vulnerable ecosystems;
 - (e) To ensure that science-based standards, risk assessment and management procedures and the results of hazard and risk assessments are available to all actors;
 - (f) To make objective scientific methods and information available to assess the effects of chemicals on people and the environment, particularly through the development and use of indicators;
 - (g) To accelerate the pace of scientific research on identifying and assessing the effects of chemicals on human beings and the environment, including emerging issues, and to ensure that research and development are undertaken in relation to chemical control technologies, development of safer chemicals and cleaner technologies and non-chemical alternatives and technologies;
 - (h) To promote implementation of the common definitions and criteria contained in the Globally Harmonized System of Classification and Labelling of Chemicals;

(i) To make widely available, for consideration and implementation, the range of existing risk reduction and other tools from various participating organizations of the Inter-Organization Programme for the Sound Management of Chemicals (IOMC)¹ such as the Mutual Acceptance of Data system of the Organisation for Economic Co-operation and Development (OECD) and the International Programme on Chemical Safety (IPCS) database on chemical safety information from intergovernmental organizations (INCHEM), in order to promote best practices in chemicals management, harmonization and burden-sharing;

(j) To develop knowledge and information on the estimated current and projected financial and other impacts on sustainable development associated with the unsound management of chemicals of concern on a global basis.

C. Governance

16. The objectives of the Strategic Approach with regard to governance are:

(a) To achieve the sound management of chemicals throughout their life-cycle by means of appropriate national, regional and international mechanisms, as needed, that are multi-sectoral, comprehensive, effective, efficient, transparent, coherent and inclusive and ensure accountability, taking into account the circumstances and needs of countries, especially developing countries and countries with economies in transition;

(b) To promote the sound management of chemicals within each relevant sector and integrated programmes for sound chemicals management across all sectors;

(c) To provide guidance to stakeholders in identifying priorities for chemicals management activities;

(d) To strengthen enforcement and encourage the implementation of national laws and regulations regarding chemicals management, including those that serve to implement international agreements;

(e) To promote relevant codes of conduct, including those relating to corporate environmental and social responsibility;

(f) To promote close international cooperation among concerned institutions, including among customs services, in different countries for the exchange of relevant information aimed at preventing all illegal international traffic in dangerous chemical products;

(g) To promote and support meaningful and active participation by all sectors of civil society, particularly women, workers and indigenous communities, in regulatory and other decision-making processes that relate to chemical safety;

(h) To ensure equal participation of women in decision-making on chemicals policy and management;

¹ The participating organizations of IOMC are the Food and Agriculture Organization of the United Nations, the International Labour Organization, the Organisation for Economic Co-operation and Development, the United Nations Environment Programme, the United Nations Industrial Development Organization, the United Nations Institute for Training and Research and the World Health Organization.

- (i) To ensure that national institutional frameworks address the prevention of illegal international traffic in chemicals;
- (j) To support coordinated assistance activities at the international level in accordance with the implementation of the Strategic Approach;
- (k) To promote mutual supportiveness between trade and environmental policies;
- (l) To provide and support enabling frameworks for businesses to develop and improve products that advance the objectives of the Strategic Approach;
- (m) To enhance synergies between the activities of Governments, international institutions, multilateral organization secretariats and development agencies in pursuit of the sound management of chemicals;
- (n) To enhance cooperation on the sound management of chemicals between Governments, the private sector and civil society at the national, regional and global levels.

D. Capacity-building and technical cooperation

17. The objectives of the Strategic Approach with regard to capacity-building and technical cooperation are:

- (a) To increase the capacity for the sound management of chemicals throughout their life-cycle in all countries as needed, especially in developing countries and countries with economies in transition;
- (b) To narrow the widening gap in capacities between developed countries on the one hand and developing countries and countries with economies in transition on the other hand;
- (c) To establish or strengthen partnerships and mechanisms for technical cooperation and the provision of appropriate and clean technology to and among developing countries and countries with economies in transition, maximizing synergies with the Bali Strategic Plan for Technology Support and Capacity-building;
- (d) To develop and implement sustainable capacity-building strategies in developing countries and countries with economies in transition and to promote cooperation among all countries;
- (e) To promote coordination of and access to information on capacity-building for the sound management of chemicals and to enhance transparency and accountability;
- (f) To include capacity-building for the sound management of chemicals as a priority in social and economic development strategies, including national sustainable development strategies, poverty reduction strategy papers and country assistance strategies, and to make chemicals an important part of national policy;
- (g) To encourage stakeholders to develop and promote programmes on chemical safety and scientific research and analysis and to assist with capacity-building programmes in developing countries and countries with economies in transition;

(h) To encourage and facilitate appropriate use by developing countries and countries with economies in transition of work already done and chemicals management models already established by other countries and international organizations;

(i) To promote the awareness of donors, multilateral organizations and other relevant actors of the relevance of chemical safety for poverty reduction and sustainable development.

E. Illegal international traffic

18. The objectives of the Strategic Approach with regard to illegal international traffic are:

(a) To prevent illegal international traffic in toxic, hazardous, banned and severely restricted chemicals, including products incorporating these chemicals, mixtures and compounds and wastes;

(b) To strengthen mechanisms and domestic and regional implementation supporting existing multilateral agreements that contain provisions relating to the prevention of illegal international traffic;

(c) To promote information sharing and to strengthen the capacity of developing countries and countries with economies in transition at the national and regional levels for the prevention and control of illegal international traffic.

V. Financial considerations

19. The Strategic Approach should reflect national, regional and global efforts to advance the sound management of chemicals recognizing Principle 7 of the Rio Declaration on Environment and Development. The Strategic Approach should call upon existing and new sources of financial support to provide additional resources and should build upon, among other things, the Bali Strategic Plan for Technology Support and Capacity-building. It should also include the mobilization of additional national and international financial resources, including through the Quick Start Programme and other measures set out in this paragraph, to accelerate the strengthening of capabilities and capacities for the implementation of the Strategic Approach objectives. The extent to which developing countries, particularly least developed countries and small-island developing States, and countries with economies in transition can make progress towards reaching the 2020 goal depends, in part, on the availability of financial resources provided by the private sector and bilateral, multilateral and global agencies or donors. Financial arrangements for the Strategic Approach include, among other things:

(a) Actions at the national or sub-national levels to support financing of Strategic Approach objectives, including by:

(i) Integrating Strategic Approach objectives in relevant programmes, plans and/or strategies at various levels;

(ii) Assessing current laws, policies and regulations to identify changes that may be needed to advance implementation of the Strategic Approach objectives, including an assessment of funding needs where appropriate;

(iii) Assessing and where necessary adopting appropriate policies at the national and sub-national levels, which could include economic instruments, that can help to cover the cost of sound chemicals management;

- (iv) Where appropriate, assessing and adopting at the national and sub-national levels economic instruments intended to internalize the external costs of chemicals, bearing in mind that such instruments need careful design, especially in developing countries and countries with economies in transition;
 - (v) Governments and other stakeholders exchanging information on experience and studies in the national use of economic instruments and submitting such information to the United Nations Environment Programme (UNEP) to make it broadly available;
- (b) Enhancing industry partnerships and financial and technical participation in the implementation of Strategic Approach objectives, including by inviting industry:
- (i) To review and strengthen current voluntary industry initiatives to address the considerable challenges associated with the implementation of Strategic Approach objectives;
 - (ii) To develop new initiatives, including in partnership with foundations, academia and non-governmental organizations, for the implementation of Strategic Approach objectives;
 - (iii) To provide resources, including in-kind contributions, for the implementation of Strategic Approach objectives, continuing and building upon its initiatives on good corporate social and environmental responsibility;
- (c) Integration of the Strategic Approach objectives into multilateral and bilateral development assistance cooperation, including by:
- (i) Developing countries and countries with economies in transition, where necessary with the technical support of donors, considering the integration of Strategic Approach objectives into relevant national documents that influence development assistance cooperation;
 - (ii) Donors responding to requests by, and working in partnership with, developing countries and countries with economies in transition by recognizing Strategic Approach objectives as an important element of bilateral aid agency cooperation in support of sustainable development;
 - (iii) Inviting United Nations specialized agencies, funds and programmes and other intergovernmental organizations to include Strategic Approach objectives within their activities, as appropriate;
- (d) Making more effective use of and building upon existing sources of relevant global funding, including by inviting the Global Environment Facility and the Montreal Protocol on Substances that Deplete the Ozone Layer and its Multilateral Fund for the Implementation of the Montreal Protocol within their mandates to consider whether and how they might support implementation of appropriate and relevant Strategic Approach objectives and to report;
- (e) Supporting initial capacity-building activities for the implementation of Strategic Approach objectives by establishing a programme to be called the Quick Start Programme. The Programme will contain a voluntary, time-limited trust fund and may include multilateral, bilateral and other forms of cooperation. The trust fund will be administered by UNEP;

- (f) Inviting Governments and other stakeholders to provide resources to enable the secretariat of the Strategic Approach to fulfil the tasks set out in paragraph 28, including by:
- (i) Inviting UNEP to arrange for the adaptation and reinforcement of the existing voluntary trust fund to support these tasks;
 - (ii) Inviting all countries and regional economic integration organizations to contribute;
 - (iii) Inviting the private sector, including industry, foundations and other non-governmental organizations, to also contribute.

VI. Principles and approaches

20. In developing and implementing the Strategic Approach and the Global Plan of Action, Governments and other stakeholders should be guided by:

- (a) Principles and approaches in the following:
 - (i) Stockholm Declaration on the Human Environment, in particular Principle 22;
 - (ii) Rio Declaration on Environment and Development;
 - (iii) Agenda 21, in particular chapters 6, 8, 19 and 20;
 - (iv) United Nations Millennium Declaration;
 - (v) Bahia Declaration on Chemical Safety;
 - (vi) Johannesburg Plan of Implementation; and
- (b) The following agreements, where applicable to them:
 - (i) Montreal Protocol on Substances that Deplete the Ozone Layer;
 - (ii) Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal;
 - (iii) Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade;
 - (iv) Stockholm Convention on Persistent Organic Pollutants;
 - (v) ILO Convention No. 170 concerning safety in the use of chemicals at work.

VII. Implementation and taking stock of progress

21. Institutional arrangements to support implementation and taking stock of progress on the Strategic Approach will include national coordination and, as appropriate, regional processes and, at the international level, a periodic review process facilitated by a secretariat.

22. Implementation of the Strategic Approach could begin with an enabling phase to build necessary capacity, as appropriate, to develop, with relevant stakeholder participation, a national Strategic Approach implementation plan, taking into consideration, as appropriate, existing elements such as legislation, national profiles, action plans, stakeholder initiatives and gaps, priorities, needs and circumstances. Strategic Approach regional implementation plans may be developed, as appropriate, in a similar fashion. Subsequent implementation phases should focus on implementing specific action plans. In parallel, intergovernmental organizations, international financial institutions and private actors are encouraged to support these activities and to consider the development of their own action plans as appropriate. Partnerships among stakeholders should be pursued in support of implementation.

23. To sustain an integrated approach to managing chemicals, each Government should establish arrangements for implementing the Strategic Approach on an inter-ministerial or inter-institutional basis so that all concerned national departmental and stakeholder interests are represented and all relevant substantive areas are addressed. To facilitate communication, nationally and internationally, each Government should designate a Strategic Approach national focal point to act as an effective conduit for communication on Strategic Approach matters, including invitations to participate in meetings and information dissemination. The Strategic Approach national focal point should be a representative of the country's inter-ministerial or inter-institutional arrangements, where such arrangements exist.

24. The International Conference on Chemicals Management (hereafter referred to as the Conference) will undertake periodic reviews of the Strategic Approach. The functions of the Conference will be:

- (a) To receive reports from all relevant stakeholders on progress in implementation of the Strategic Approach and to disseminate information as appropriate;
- (b) To evaluate the implementation of the Strategic Approach with a view to reviewing progress against the 2020 target and taking strategic decisions, programming, prioritizing and updating the approach as necessary;
- (c) To provide guidance on implementation of the Strategic Approach to stakeholders;
- (d) To report on progress in implementation of the Strategic Approach to stakeholders;
- (e) To promote implementation of existing international instruments and programmes;
- (f) To promote coherence among chemicals management instruments at the international level;
- (g) To promote the strengthening of national chemicals management capacities;
- (h) To work to ensure that the necessary financial and technical resources are available for implementation;
- (i) To evaluate the performance of the financing of the Strategic Approach;
- (j) To focus attention and call for appropriate action on emerging policy issues as they arise and to forge consensus on priorities for cooperative action;
- (k) To promote information exchange and scientific and technical cooperation;

-
- (l) To provide a high-level international forum for multi-stakeholder and multi-sectoral discussion and exchange of experience on chemicals management issues with the participation of non-governmental organizations in accordance with applicable rules of procedure;
- (m) To promote the participation of all stakeholders in the implementation of the Strategic Approach.
25. Where appropriate, sessions of the Conference should be held back-to-back with meetings of the governing bodies of relevant intergovernmental organizations in order to enhance synergies and cost-effectiveness and to promote the Strategic Approach's multi-sectoral nature. Sessions of the Conference should be held in 2009, 2012, 2015 and 2020, unless otherwise decided by the Conference.
26. It will be essential that implementation of the Strategic Approach continue effectively between meetings of the Conference, building on its open, multi-stakeholder and multi-sectoral methods. There will be a number of elements for achieving this:
- (a) Regional meetings have played a significant role in the development of the Strategic Approach and it will be important to build on this commitment and expertise, taking into account the needs of developing countries, in particular the least developed among them, countries with economies in transition and developed countries. Regional meetings will facilitate input on Strategic Approach activities, preparation for future meetings of the Conference and exchange of regional expertise and exchange of information. As with the Conference itself, such meetings could be held back-to-back with relevant regional or global intergovernmental organization meetings, subject to extrabudgetary funding;
- (b) The functions of the regional meetings will include:
- (i) To review progress on implementation of the Strategic Approach within the regions;
- (ii) To provide guidance on implementation to all stakeholders at a regional level;
- (iii) To enable technical and strategic discussions and exchange of information to take place;
- (c) The implementation of the Strategic Approach will depend in significant part on the activities of relevant intergovernmental organizations. In order to help ensure that these activities are coordinated properly, IOMC should continue to perform a coordinating function for intergovernmental organization activities and work programmes.
27. The Conference should have a bureau with functions in accordance with the rules of procedure.
28. The functions to be performed by the secretariat will be:
- (a) To facilitate meetings and intersessional work of the Conference, as well as regional meetings, with maximum multi-stakeholder participation, and to disseminate the reports and recommendations of the Conference;
- (b) To report to the Conference on implementation of the Strategic Approach by all participants;

- (c) To promote the establishment and maintenance of a network of Strategic Approach stakeholders at the national, regional and, in the case of intergovernmental and non-governmental organizations, international levels;
- (d) To facilitate the development and dissemination of guidance materials to support implementation of the Strategic Approach by stakeholders;
- (e) To provide guidance to stakeholders in the initiation of project proposals;
- (f) To provide information clearing-house services such as provision of advice to countries on implementation of the Strategic Approach, referral of requests for information to relevant sources, and facilitation of access to information and expertise in support of specific national actions;
- (g) To ensure that recommendations from the Conference are conveyed to relevant global and regional organizations and institutions;
- (h) To promote the exchange of relevant scientific and technical information;
- (i) To establish and maintain a working relationship with participating organizations of IOMC in order to draw upon their sectoral expertise.

29. The Executive Director of UNEP will be requested to establish the Strategic Approach secretariat. UNEP and the World Health Organization (WHO) will take lead roles in the secretariat in their respective areas of expertise in relation to the Strategic Approach, with UNEP assuming overall administrative responsibility. The Strategic Approach secretariat will be co-located with the UNEP chemicals and waste cluster in Geneva, and take full advantage of existing synergies. In order to reflect the multi-sectoral nature of the Strategic Approach, the secretariat will work in coordination and/or cooperation with the participating organizations of IOMC and UNDP, as well as with other intergovernmental organizations, as appropriate. The secretariat will report to the Conference.

Attachment to the Overarching Policy Strategy

Text of paragraph 23 of the Johannesburg Plan of Implementation

The Johannesburg Plan of Implementation is a key political commitment underlying the SAICM Overarching Policy Strategy. In the Plan, it was agreed that “governments, relevant international organizations, the private sector and all major groups should play an active role in changing unsustainable consumption and production patterns.” This would include the actions at all levels set out in paragraph 23 of the Plan:

“23. Renew the commitment, as advanced in Agenda 21, to sound management of chemicals throughout their life-cycle and of hazardous wastes for sustainable development as well as for the protection of human health and the environment, inter alia, aiming to achieve, by 2020, that chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment, using transparent science-based risk assessment procedures and science-based risk management procedures, taking into account the precautionary approach, as set out in principle 15 of the Rio Declaration on Environment and Development, and support developing countries in strengthening their capacity for the sound management of chemicals and hazardous wastes by providing technical and financial assistance. This would include actions at all levels to:

“(a) Promote the ratification and implementation of relevant international instruments on chemicals and hazardous waste, including the Rotterdam Convention on Prior Informed Consent Procedures for Certain Hazardous Chemicals and Pesticides in International Trade so that it can enter into force by 2003 and the Stockholm Convention on Persistent Organic Pollutants so that it can enter into force by 2004, and encourage and improve coordination as well as supporting developing countries in their implementation;

“(b) Further develop a strategic approach to international chemicals management based on the Bahia Declaration and Priorities for Action beyond 2000 of the Intergovernmental Forum on Chemical Safety by 2005, and urge that the United Nations Environment Programme, the Intergovernmental Forum, other international organizations dealing with chemical management and other relevant international organizations and actors closely cooperate in this regard, as appropriate;

“(c) Encourage countries to implement the new globally harmonized system for the classification and labelling of chemicals as soon as possible with a view to having the system fully operational by 2008;

“(d) Encourage partnerships to promote activities aimed at enhancing environmentally sound management of chemicals and hazardous wastes, implementing multilateral environmental agreements, raising awareness of issues relating to chemicals and hazardous waste and encouraging the collection and use of additional scientific data;

“(e) Promote efforts to prevent international illegal trafficking of hazardous chemicals and hazardous wastes and to prevent damage resulting from the transboundary movement and disposal of hazardous wastes in a manner consistent with obligations under relevant international instruments, such as the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal;

“(f) Encourage development of coherent and integrated information on chemicals, such as through national pollutant release and transfer registers;

“(g) Promote reduction of the risks posed by heavy metals that are harmful to human health and the environment, including through a review of relevant studies, such as the United Nations Environment Programme global assessment of mercury and its compounds.”

Appendix 3

Global Plan of Action

Executive summary

Introduction

1. The Global Plan of Action of the Strategic Approach to International Chemicals Management has been structured into work areas and associated activities that may be undertaken voluntarily by stakeholders in order to pursue the commitments and objectives expressed in the Dubai Declaration on International Chemicals Management and the Overarching Policy Strategy. These reaffirm the commitment expressed at the World Summit on Sustainable Development in the Johannesburg Plan of Implementation that by 2020 chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment.¹ The plan should be regarded as a guidance document to be reviewed, as appropriate, and the activities should be considered and implemented, as appropriate, by stakeholders during the implementation of the Strategic Approach, according to their applicability.

2. The present executive summary aims to give policy-makers a brief overview of the structure of the Global Plan of Action and the list of actions that can be undertaken to achieve the objectives of the Strategic Approach. Within the Global Plan of Action, possible work areas and their associated activities, actors, targets and timeframes, indicators of progress and implementation aspects are grouped according to five categories of objectives contained in the Overarching Policy Strategy of the Strategic Approach, namely, risk reduction, knowledge and information, governance, capacity-building and technical assistance and illegal international traffic. These objectives are discussed in sections A to E of the present executive summary. Cross-cutting measures that appear under more than one objective are discussed in section F, entitled “Improved general practices”.

3. Three tables follow this executive summary. Table A provides a summary list of the work areas and the numbers of the possible activities associated with them. Table B lists the work areas together with the possible activities associated with them and suggested actors, targets and timeframes, indicators of progress and implementation aspects, set out in five separate sections corresponding to the five categories of objectives listed in paragraph 2 above. Although each work area is listed under a single principal category in the summary table A, it may appear under several objectives in the detailed table B. The columns dealing with suggested actors, targets and timeframes, indicators of progress and implementation aspects were not fully discussed and sufficient time was not available to achieve agreement during the process to develop the Strategic Approach. However, stakeholders might find them useful in their implementation of the relevant activities. A table listing acronyms and abbreviations used in table B is appended as well.

4. Participants in the process to develop the Strategic Approach were unable to conclude their discussions on a number of activities, as reflected in table C of document SAICM/ICCM.1/4, which can be found at the website <http://www.chem.unep.ch/saicm>. Bearing in mind that the Global Plan of Action is an evolving tool to assist in achieving the objectives of the Strategic Approach, stakeholders may wish to discuss these items. In the period between the first and second sessions of the

¹Report of the World Summit on Sustainable Development, Johannesburg, South Africa, 26 August–4 September 2002 (United Nations publication, Sales No. E.03.II.A.I. and corrigendum) chap. I, resolution 2, annex.

International Conference on Chemicals Management, activities such as regional meetings could be pursued.

5. The various categories of objectives, together with their corresponding work areas, are closely interconnected. Thus, numerous risk reduction actions are needed to protect human health and the environment from the unsound management of chemicals. A large number of these risk reduction actions will need to be supported by extensive improvements in our knowledge and information on chemicals, governance arrangements (including institutional coordination, regulatory frameworks and public policy) in all sectors involved with chemicals, and general practices associated with the sound management of chemicals throughout their life-cycles. Furthermore, meaningful and timely capacity-building and technical assistance in support of the actions of developing countries and countries with economies in transition are essential to making substantive improvements in reducing the risks to human health and the environment caused by the unsound management of chemicals.

6. The Global Plan of Action also serves as guidance to all stakeholders at the global, regional, national and local levels, including when assessing the current status of their actions in support of the sound management of chemicals and identifying priorities to address gaps in such management. It is emphasized that priorities and timeframes will differ among countries, reflecting, for instance, the current state of chemicals management and the capacity to carry out a given measure in a given country. It is anticipated that Governments and other stakeholders will adopt flexible programmes to build and sustain adequate and comprehensive capabilities for the sound management of chemicals consistent with national circumstances and the Strategic Approach objectives.

7. In general, priority should be given to activities which:

- (a) Focus on narrowing the gap between developed countries on the one hand and developing countries and countries with economies in transition on the other hand in their capacities for the sound management of chemicals;
- (b) Facilitate the implementation of existing agreements and work areas;
- (c) Target issues not currently addressed in existing agreements and work areas;
- (d) Ensure that, by 2020:
 - (i) Chemicals or chemical uses that pose an unreasonable and otherwise unmanageable risk to human health and the environment¹ based on a science-based risk assessment and taking into account the costs and benefits as well as the availability of safer substitutes and their efficacy are no longer produced or used for such uses;
 - (ii) The risks from unintended releases of chemicals that pose an unreasonable and otherwise unmanageable risk to human health and the environment² based on a

¹ Groups of chemicals that might be prioritized for assessment and related studies include: persistent, bioaccumulative and toxic substances (PBTs); very persistent and very bioaccumulative substances; chemicals that are carcinogens or mutagens or that adversely affect, inter alia, the reproductive, endocrine, immune or nervous systems; persistent organic pollutants (POPs); mercury and other chemicals of global concern; chemicals produced or used in high volumes; chemicals subject to wide dispersive uses; and other chemicals of concern at the national level.

² Ibid.

science-based risk assessment and taking into account the costs and benefits are minimized;

- (e) Target chemicals that pose unreasonable and unmanageable risks;
- (f) Promote the generation of adequate science-based knowledge on health and environmental risks of chemicals and make it available to all stakeholders.

8. For many of the work areas, it is important to work in a concerted manner in order to be most effective. It is therefore critical for all stakeholders to take appropriate cooperative action on global priorities. These include, among others:

- (a) Integrating chemicals issues into the broader development agenda, including the development of plans for prioritization of action in consultation with stakeholders, including vulnerable groups;
- (b) Promoting ratification and implementation of relevant existing international conventions on health, safety, occupational health and safety and environment;
- (c) Encouraging implementation of existing internationally recognized standards, tools and approaches for environment and health and protection from chemicals, such as the Globally Harmonized System of Classification and Labelling of Chemicals and pollutant release and transfer registers;
- (d) Promoting reduction of risks from mercury and other chemicals of global concern so that they are minimized;
- (e) Encouraging the reduction of the quantity and toxicity of hazardous wastes;
- (f) Promoting efforts to prevent illegal traffic in chemicals and hazardous waste;
- (g) Promoting greater coordination among regional and national centres and other stakeholders in order to address the whole spectrum of issues regarding chemicals and hazardous waste;
- (h) Promoting alternatives in order to reduce and phase out highly toxic pesticides;
- (i) Promoting capacity-building, education and training and information exchange on sound management of chemicals for all stakeholders;
- (j) Promoting voluntary industry initiatives and product stewardship in all relevant industries;
- (k) Promoting the phase-out of lead in gasoline;
- (l) Promoting the remediation of contaminated areas.

A. Measures to support risk reduction

9. Under the risk reduction objective, work areas aimed at protecting human health and the environment would include the development of action plans to address priority concerns in relation to

groups with specific vulnerabilities. Examples of measures to safeguard the health of women and children are the minimization of chemical exposures before conception and through gestation, infancy, childhood and adolescence. Occupational health and safety for workers would be promoted through measures such as the establishment of national inspection systems and implementation of adequate occupational health and safety standards to minimize workplace hazards from chemicals. Groups of chemicals that might be prioritized for assessment and related studies, such as for the development and use of safe and effective alternatives, include: persistent, bioaccumulative and toxic substances (PBTs); very persistent and very bioaccumulative substances; chemicals that are carcinogens or mutagens or that adversely affect, inter alia, the reproductive, endocrine, immune or nervous systems; persistent organic pollutants (POPs); mercury and other chemicals of global concern; chemicals produced or used in high volumes; chemicals subject to wide dispersive uses; and other chemicals of concern at the national level. Minimization of hazardous wastes would be enhanced by national planning and policies, awareness-raising and protection of handlers, while contaminated sites would be subject to identification and remediation. Pollution prevention measures would include the phasing out of lead in gasoline. Capacities to deal with poisonings and other chemical incidents would be strengthened.

B. Strengthening knowledge and information

10. Measures to strengthen knowledge and information would include improved education, training and awareness-raising activities aimed at those who may be exposed to toxic substances at any stage in the life-cycle of chemicals and the generation and dissemination of data on the hazards of all chemicals in commerce, taking account of legitimate commercial confidentiality needs. Among other measures in this area would be stepped-up monitoring of the impacts of chemicals on health and the environment, harmonized risk assessments, efforts to implement the Globally Harmonized System of the Classification and Labelling of Chemicals, and the development and publication of national pollutant release and transfer registers.

C. Governance: strengthening of institutions, law and policy

11. Central to the Strategic Approach's governance objectives would be measures to review national legislation in order to ratify and implement existing international agreements dealing with chemicals and hazardous wastes, such as the Basel Convention on the Control of the Transboundary Movement of Hazardous Wastes and their Disposal, the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade, the Stockholm Convention on Persistent Organic Pollutants, the International Labour Organization conventions on the protection of workers and measures to improve coordination and synergies with respect to chemical safety policy and activities at the national and international levels. Another core area would be measures to ensure the participation of all stakeholders, including women in particular, in the management of the life-cycle of chemicals. Measures to integrate chemicals management into strategies for development assistance, sustainable development and poverty reduction papers would be important to underpin the more effective direction of resources to chemical safety activities. Other measures under the governance category would include the development of systems for emergency preparedness and response in the case of chemical accidents, the consideration of chemical use in protected areas, training in liability and compensation schemes in relation to damage to human health and the environment caused by the production and use of chemicals and action to prevent and detect illegal trafficking of chemicals and hazardous wastes.

D. Enhancing capacity-building

12. Capacity-building measures include training of personnel in order to provide the necessary skills to support the systematic implementation of the Strategic Approach at the local, national and regional levels in a coordinated way and across the full range of chemical safety needs, including strategic planning, risk assessment and management, testing and research and control of illegal traffic. Use would be made of information-exchange mechanisms on capacity-building in order to ensure coordination.

E. Addressing illegal international traffic

13. Actions at the national, regional and global levels are needed to prevent and detect illegal trafficking of chemicals and hazardous wastes, including efforts towards the more effective application of international conventions relating to transboundary movements of chemicals and hazardous waste.

F. Improved general practices

14. The list of work areas contains a number of activities to improve general chemicals management practices, such as the development and implementation of cleaner production methods in accordance with best available techniques and best environmental practices. Similarly, better agricultural methods, including the use of non-chemical alternatives, would be promoted. Measures associated with improved corporate social and environmental responsibility for the safe production and use of products would include the further development and implementation of voluntary initiatives such as industry's Responsible Care programme and the International Code of Conduct on the Distribution and Use of Pesticides of the Food and Agriculture Organization of the United Nations.

ANNEX 2

Global strategy for the prevention and control of sexually transmitted infections, 2006-2015¹

[A59/11, Annex – 18 May 2006]

CONTENTS

	Page
1. SEXUALLY TRANSMITTED INFECTIONS: A PUBLIC HEALTH PROBLEM	74
1.1 The global burden.....	74
1.2 Why invest in prevention and control of sexually transmitted infections now?	76
1.3 Opportunities for an accelerated response.....	78
2. AIMS AND SCOPE OF THE STRATEGY	83
2.1 Purpose and objectives	83
2.2 Target audience	84
2.3 Guiding principles	84
2.4 Essential elements of the response	85
3. THE TECHNICAL STRATEGY: BUILDING ON SUCCESS IN PREVENTING AND CONTROLLING SEXUALLY TRANSMITTED INFECTIONS	86
3.1 Transmission dynamics	86
3.2 Prevention and control interventions.....	87
3.3 Improving information for policy and programme development.....	95
3.4 Interface with other programmes and partners.....	98
3.5 Strengthening the capacity of health systems for effective service delivery.....	104
3.6 Priority components for immediate action	112
4. THE ADVOCACY STRATEGY: MOBILIZING POLITICAL AND SOCIAL LEADERSHIP AND FINANCIAL RESOURCES	117
4.1 Advocacy.....	117
4.2 Working with the media	119
4.3 Building effective partnerships	119
4.4 Mobilizing financial resources	120

¹ See resolution WHA59.19.

1. SEXUALLY TRANSMITTED INFECTIONS: A PUBLIC HEALTH PROBLEM

1.1 The global burden

More than 30 bacterial, viral and parasitic pathogens are transmissible sexually. While sexually transmitted infections are mostly transmitted through sexual intercourse, transmission can occur also from mother to child during pregnancy and childbirth, and through blood products or tissue transfer, as well as occasionally through other non-sexual means. Including human immunodeficiency virus (HIV) infection that leads to acquired immunodeficiency syndrome (AIDS), they have been recognized as a major public health problem for many years. Some of the commonest sexually transmitted pathogens and the diseases they cause are shown in Table 1.

It is estimated that more than 340 million new cases of curable sexually transmitted infections, namely those due to *Treponema pallidum* (syphilis), *Neisseria gonorrhoeae*, *Chlamydia trachomatis* and *Trichomonas vaginalis*, occur every year throughout the world in men and women aged 15–49 years, with the largest proportion in the region of south and south-east Asia, followed by sub-Saharan Africa, and Latin American and the Caribbean. Millions of viral sexually transmitted infections also occur annually, attributable mainly to HIV, human herpesviruses, human papillomaviruses and hepatitis B virus. Globally, all these infections constitute a huge health and economic burden, especially for developing countries where they account for 17% of economic losses caused by ill-health.

- Herpes simplex virus type 2 infection is the leading cause of genital ulcer disease in developing countries. Data from sub-Saharan Africa show that 30% to 80% of women and 10% to 50% of men are infected. Among women in central and south America, prevalence ranges from 20% to 40%. In the developing Asian countries, its prevalence in the general population ranges from 10% to 30%. In the United States of America, the prevalence of the viral infection among 14–49-year-olds is 19%, and throughout the world, seropositivity rates are uniformly higher in women than in men and increase with age. Herpes simplex virus type 2 infection plays an important role in the transmission of HIV. A study in Mwanza (United Republic of Tanzania), showed that 74% of HIV infections in men and 22% in women could be attributable to the presence of herpes simplex virus type 2.
- Human papillomavirus, another important sexually transmitted viral pathogen, causes about 500 000 cases of cervical cancer annually with 240 000 deaths, mainly in resource-poor countries.
- Hepatitis B virus, which may be transmitted sexually and through needle sharing, blood transfusion and from mother to child, results in an estimated 350 million cases of chronic hepatitis and at least one million deaths each year from liver cirrhosis and liver cancer. A vaccine to prevent hepatitis B virus infection, and thereby reduce the incidence of liver cancer, exists.

Given social, demographic and migratory trends, the population at risk for sexually transmitted infections will continue to grow dramatically. The burden is greatest in the developing world, but industrialized nations can also be expected to experience an increased burden of disease because of the prevalence of non-curable viral infections, trends in sexual behaviour and increased travel. The socioeconomic costs of these infections and their complications are substantial, ranking among the top 10 reasons for health-care visits in most developing countries, and substantially drain both national health budgets and household income. Care for the sequelae accounts for a large proportion of tertiary health-care costs in terms of screening and treatment of cervical cancer, management of liver disease, investigation for infertility, care for perinatal morbidity, childhood blindness, pulmonary disease in

Table 1
Main sexually transmitted pathogens and the diseases they cause

Pathogen	Clinical manifestations and other associated diseases
Bacterial infections	
<i>Neisseria gonorrhoeae</i>	GONORRHOEA Men: urethral discharge (urethritis), epididymitis, orchitis, infertility Women: cervicitis, endometritis, salpingitis, pelvic inflammatory disease, infertility, preterm rupture of membranes, perihepatitis Both sexes: proctitis, pharyngitis, disseminated gonococcal infection Neonates: conjunctivitis, corneal scarring and blindness
<i>Chlamydia trachomatis</i>	CHLAMYDIAL INFECTION Men: urethral discharge (urethritis), epididymitis, orchitis, infertility Women: cervicitis, endometritis, salpingitis, pelvic inflammatory disease, infertility, preterm rupture of membranes, perihepatitis; commonly asymptomatic Both sexes: proctitis, pharyngitis, Reiter's syndrome Neonates: conjunctivitis, pneumonia
<i>Chlamydia trachomatis</i> (strains L1-L3)	LYMPHOGRANULOMA VENEREUM Both sexes: ulcer, inguinal swelling (bubo), proctitis
<i>Treponema pallidum</i>	SYPHILIS Both sexes: primary ulcer (chancre) with local adenopathy, skin rashes, condylomata lata; bone, cardiovascular and neurological damage Women: pregnancy wastage (abortion, stillbirth), premature delivery Neonates: stillbirth, congenital syphilis
<i>Haemophilus ducreyi</i>	CHANCROID Both sexes: painful genital ulcers; may be accompanied by bubo
<i>Klebsiella (Calymmatobacterium) granulomatis</i>	GRANULOMA INGUINALE (DONOVANOSIS) Both sexes: nodular swellings and ulcerative lesions of the inguinal and anogenital areas
<i>Mycoplasma genitalium</i>	Men: urethral discharge (nongonococcal urethritis) Women: bacterial vaginosis, probably pelvic inflammatory disease
<i>Ureaplasma urealyticum</i>	Men: urethral discharge (nongonococcal urethritis) Women: bacterial vaginosis, probably pelvic inflammatory disease
Viral infections	
Human immunodeficiency virus	ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) Both sexes: HIV-related disease, AIDS
Herpes simplex virus type 2	GENITAL HERPES
Herpes simplex virus type 1 (less commonly)	Both sexes: anogenital vesicular lesions and ulcerations Neonates: neonatal herpes (often fatal)
Human papillomavirus	GENITAL WARTS Men: penile and anal warts; carcinoma of the penis Women: vulval, anal and cervical warts, cervical carcinoma, vulval carcinoma, anal carcinoma Neonates: laryngeal papilloma
Hepatitis B virus	VIRAL HEPATITIS Both sexes: acute hepatitis, liver cirrhosis, liver cancer
Cytomegalovirus	CYTOMEGALOVIRUS INFECTION Both sexes: subclinical or nonspecific fever, diffuse lymph node swelling, liver disease, etc.
Molluscum contagiosum virus	MOLLUSCUM CONTAGIOSUM Both sexes: genital or generalized umbilicated, firm skin nodules
Kaposi sarcoma associated herpes virus (human herpes virus type 8)	KAPOSI SARCOMA Both sexes: aggressive type of cancer in immunosuppressed persons
Protozoal infections	
<i>Trichomonas vaginalis</i>	TRICHOMONIASIS Men: urethral discharge (nongonococcal urethritis); often asymptomatic Women: vaginosis with profuse, frothy vaginal discharge; preterm birth, low birth weight babies Neonates: low birth weight
Fungal infections	
<i>Candida albicans</i>	CANDIDIASIS Men: superficial infection of the glans penis Women: vulvo-vaginitis with thick curd-like vaginal discharge, vulval itching or burning
Parasitic infestations	
<i>Phthirus pubis</i>	PUBIC LICE INFESTATION
<i>Sarcoptes scabiei</i>	SCABIES

children and chronic pelvic pain in women. The social costs include conflict between sexual partners and domestic violence. The costs increase further when the cofactor effect of other sexually transmitted infections on HIV transmission is taken into consideration.¹

1.2 Why invest in prevention and control of sexually transmitted infections now?

1.2.1 To reduce related morbidity and mortality

Infections with sexually transmitted pathogens other than HIV impose an enormous burden of morbidity and mortality in both resource-constrained and developed countries, both directly, through their impact on quality of life, reproductive health and child health, and indirectly, through their role in facilitating the sexual transmission of HIV and their impact on national and individual economies.

The spectrum of health consequences ranges from mild acute illness to painful disfiguring lesions and psychological morbidity. For example, infection with *N. gonorrhoeae* causes painful micturition in men, and acute or chronic lower abdominal pain in women. Without treatment, infection with *T. pallidum*, although painless in the early stages, can result in neurological, cardiovascular and bone diseases later in life, and fetal loss in pregnant woman with acute infection. Chancroid causes disabling painful ulcers which can result in extensive tissue destruction if treatment is delayed beyond a few days, particularly in immunocompromised persons. Genital herpes infection causes substantial psychosexual suffering because of its recurrent and painful nature, especially in young people.

In addition, there is a large economic burden and loss of productivity to individuals and nations as a whole. The associated costs include direct costs, both medical and nonmedical, for care and materials, and indirect costs of time spent sick, when an individual is unable to engage in productive activities (travelling to obtain cure, waiting in the health facility for care, and undergoing a procedure such as specimen collection). The magnitude of the global burden of infections with sexually transmitted pathogens other than HIV is such that they should be controlled in their own right as a public health problem.

1.2.2 To prevent HIV infection

Preventing and treating other sexually transmitted infections reduce the risk of sexual transmission of HIV, especially among populations who are most likely to have a high number of sex partners, such as sex workers and their clients. The presence of an untreated inflammatory or ulcerative sexually transmitted disease increases the risk of transmission of HIV during unprotected sex between an infected and an uninfected partner. The cofactor effect of other such infections on HIV transmission seems to be higher with the ulcerative diseases: recent evidence indicates that genital herpes may be responsible for fuelling a large proportion of new HIV infections, and suppressive treatment of herpes simplex virus type 2 infection reduces genital shedding of HIV in women. Genital ulcers or a history of such diseases have been estimated to increase the risk of transmission of HIV 50–300-fold per episode of unprotected sexual intercourse.

¹ Globally, the predominant mode of transmission of HIV is sexual, which makes it a sexually transmitted infection, even though there are other modes through which the virus can be transmitted. Over the years, numerous epidemiological and biological studies have provided evidence that other sexually transmitted infections, if present in a person, act as cofactors for HIV acquisition or transmission, which has led to the common statement “sexually transmitted infections facilitate the transmission of HIV”. This can give the impression that HIV is itself not a sexually transmitted infection. In this document, whenever the phrase “sexually transmitted infections facilitate HIV transmission” is used, it should be understood that these are sexually transmitted infections other than HIV. Where more clarity is needed, the phrases “other sexually transmitted infections” or “sexually transmitted infections other than HIV” are used. In general, strategies and interventions that prevent the transmission of HIV work equally as well for the other sexually transmitted infections.

Services providing care for sexually transmitted infections are one of the key entry points for HIV prevention. Patients seeking such care are a key target population for prevention counselling and voluntary and confidential testing for HIV, and may be in need of care for HIV and AIDS. Patients attending health clinics for care for sexually transmitted infections may have primary HIV infection at the same time, and they usually have high HIV viral load. HIV shedding in semen increased six-fold in men with gonococcal urethritis in Malawi. Following treatment for the urethritis, the seminal viral load was reduced to levels similar to those of HIV-infected men without urethritis. A recent study in the United States of America of 52 HIV-infected men with primary or secondary syphilis, 58% of whom were receiving antiretroviral therapy, showed that syphilis is associated with significant increases in plasma viral load and significant decreases in the CD4⁺ cell count. Syphilis treatment restored immunity to pre-infection levels, findings that underscore the importance of preventing and promptly treating syphilis in HIV-infected individuals both as a prevention strategy and to improve quality of care for persons living with HIV. Effective prevention messages, treatment for other sexually transmitted infections, and promotion of condoms in such a population could have a substantial impact on HIV transmission.

The Millennium Development Goal 6, target 7 calls on nations to have halted and begun to reverse the spread of HIV/AIDS by 2015. In the United Republic of Tanzania, scientifically rigorous methods demonstrated that treatment of sexually transmitted infections could reduce the sexual transmission of HIV in a highly cost-effective manner: improved syndromic management of such infections reduced HIV incidence by 38% in a community intervention trial in Mwanza. Results of that trial can probably be generalized to other populations where the HIV epidemic is concentrated, most HIV infections are acquired from casual partners, and the prevalence of treatable sexually transmitted infections is high. Their treatment is, therefore, one of the interventions that feasibly and cost-effectively contribute towards the attainment of target 7.

1.2.3 To prevent serious complications in women

Sexually transmitted infections are the main preventable cause of infertility, particularly in women. Between 10% and 40% of women with untreated chlamydial infection develop symptomatic pelvic inflammatory disease. Post-infection tubal damage is responsible for 30% to 40% of cases of female infertility. Furthermore, women who have had pelvic inflammatory disease are 6 to 10 times more likely to develop an ectopic (tubal) pregnancy than those who have not, and 40% to 50% of ectopic pregnancies can be attributed to previous pelvic inflammatory disease.

Millennium Development Goal 5, target 6 seeks to reduce maternal mortality by three quarters by 2015. Prevention of pelvic inflammatory disease will contribute to this goal by preventing the death toll related to ectopic pregnancy. Prevention of human papillomavirus infection will reduce the number of women who die from cervical cancer, the second most common cancer in women after breast cancer.

1.2.4 To prevent adverse pregnancy outcome

Untreated sexually transmitted infections are associated with congenital and perinatal infections in neonates, particularly in the areas where rates of infection remain high.

In pregnant women with untreated early syphilis, 25% of pregnancies result in stillbirth and 14% in neonatal death – an overall perinatal mortality of about 40%. Syphilis prevalence in pregnant women in Africa, for example, ranges from 4% to 15%. Up to 35% of pregnancies among women with untreated gonococcal infection result in spontaneous abortions and premature deliveries, and up to 10% in perinatal deaths. In the absence of prophylaxis, 30% to 50% of infants born to mothers with untreated gonorrhoea and up to 30% of infants born to mothers with untreated chlamydial infection

will develop ophthalmia neonatorum, which can lead to blindness; worldwide, between 1000 and 4000 newborn babies become blind every year because of this condition.

Universal institution of an effective intervention to prevent congenital syphilis should prevent an estimated 492 000 stillbirths and perinatal deaths per year in Africa alone. In terms of cost-effectiveness, in Mwanza (United Republic of Tanzania), where the prevalence of active syphilis is 8% in pregnant women, the cost of the intervention is estimated to be US\$ 1.44 per woman screened, US\$ 20 per woman treated, and US\$ 10.56 per disability-adjusted life year saved. The cost per disability-adjusted life year saved from all syphilis-screening studies ranges from US\$ 4 to US\$ 19.

1.3 Opportunities for an accelerated response

1.3.1 A cost-effective intervention for HIV prevention

Improved case management of sexually transmitted infections is one of the interventions scientifically proven to reduce the incidence of HIV infection in the general population. If the interventions are targeted to a particular population group with a high likelihood of transmission, the cost-effectiveness becomes even more pronounced.

1.3.2 New partnerships

There is a renewed global resolve to fight the AIDS epidemic that includes a commitment to control sexually transmitted infections as a primary prevention strategy. The United Nations Declaration of Commitment on HIV/AIDS (June 2001) states that, while care, support and treatment are fundamental elements of an effective response, prevention must be the mainstay of responses to the AIDS pandemic, including early and effective treatment of those infections. New partners and sources of funding have emerged on the international development scene. These include powerful advocates, influential networks, communities, partners in non-health sectors, the commercial sector and philanthropic organizations. Funds can be mobilized through these new sources of funding, as well as through existing ones, to ensure an intensified response to all sexually transmitted infections.¹

A diverse range of interventions and the successful results from resource-limited settings as different as Thailand and Uganda, and from other countries such as Denmark, Sweden and the United Kingdom of Great Britain and Northern Ireland, indicate that sexually transmitted infections can be controlled, provided that sufficient political will and resources are mobilized in order to achieve and maintain activities at a necessary level. Collaboration between countries, and partnerships with interested agencies, facilitate the sharing of information and scaling up of successful lessons.

Interventions to prevent mother-to-child transmission of HIV can be linked with efforts to prevent congenital syphilis in order to avert the tragedy of babies who avoid HIV but die of syphilis, as was the case in Haiti. In addition, this linkage enhances the cost-effectiveness of the interventions.

¹ Some mechanisms available include the Global Fund to Fight AIDS, Tuberculosis and Malaria at national level, strategies and initiatives for expanding access to antiretroviral agents, the United States of America's President's Emergency Plan for AIDS Relief (providing US\$ 15 000 million, including US\$ 9000 million in new funding, to fight the HIV/AIDS pandemic over five years, with a focus on 15 of the hardest hit countries), and the World Bank multisectoral HIV/AIDS and sexually transmitted infection prevention projects.

1.3.3 New technologies for a strengthened response

Opportunities for innovative methods for the prevention, care and surveillance of sexually transmitted infections will result from technological advances in diagnostics, treatment, vaccines, and barrier methods.

Rapid diagnostic tests

- New point-of-care rapid treponemal tests enable screening for syphilis at the peripheral health post, and thus provision of treatment without delay.
- Nucleic acid amplification tests can be used to monitor infection trends and guide the adaptation of treatment protocols. Some tests can be used on easy-to-collect specimens, such as urine and self-administered vaginal swabs.
- A new generation of cheap, rapid diagnostic tests for chlamydial infection is under development.

Therapeutics

- Some medicines, for example, ciprofloxacin (where effective) and acyclovir, are becoming more affordable. Others, such as azithromycin and cefixime, which have the added advantage of single-dose administration, will become cheaper as their patents expire and procurement strategies for bulk purchasing are put in place. Penicillins have remained effective for the treatment of early syphilis and can be given as single-dose treatments, albeit by injection.

Vaccines

- Preventive vaccines against oncogenic types of human papillomavirus show great promise and will soon be available. The international community should work together with countries to plan and develop strategies for implementing and promoting their use in national immunization programmes in order to guarantee high coverage, especially in adolescents, so that people can be protected before they become sexually active.
- An effective vaccine against herpes simplex virus type 2 infection is not yet available. One vaccine, however, has shown promise in women with no prior exposure to type 1 or 2 of the virus. More field trials are needed to evaluate its utility in a variety of epidemiological settings. Given the high prevalence of herpes simplex virus type 2 infection and its importance in enhancing HIV transmission, a vaccine to prevent the spread of herpes simplex virus type 2 at an early age offers the most compelling hope. The international community, scientists, funding agencies and governments should join forces to plan and rapidly progress towards the development of effective vaccines against herpes simplex virus type 2 infection.
- A preventive vaccine against hepatitis B virus has been available since 1982. Countries should put in place plans for the prevention of hepatitis B and scale up the inclusion of the existing vaccine in immunization programmes in order to ensure that all children in all countries are immunized, and that all sexually active adults at high risk of hepatitis B virus infection have access to the vaccine.

1.3.4 A public health approach to prevention and control of sexually transmitted infections

Effective prevention and care can be achieved by use of a combination of responses. Services for prevention and for care of people with sexually transmitted infections should be expanded and embrace a public health package that includes the following elements:

- promotion of safer sexual behaviour
- promotion of early health-care-seeking behaviour
- introduction of prevention and care activities across all primary health-care programmes, including sexual and reproductive health and HIV programmes. Successful and cost-effective integrated programmes for sexually transmitted infection, HIV and tuberculosis control have been documented in several countries. The care is usually given by the same providers at the primary health centre level as those already delivering the primary health care. Such an approach is both attractive and cost-saving for client and health system alike.
- a comprehensive approach to case management that encompasses:
 - identification of the sexually transmitted infections syndrome;
 - appropriate antimicrobial treatment for the syndrome;
 - education and counselling on ways to avoid or reduce risk of infection with sexually transmitted pathogens, including HIV;
 - promotion of the correct and consistent use of condoms;
 - partner notification (see section 3.2.3 for more details).

To the extent possible, interventions and strategies should be evidence-based. By implementing and carefully evaluating innovative interventions, however, new evidence can be gathered to inform policies, programmes and scaling up. It is, therefore, important to apply the following concept: plan, do, assess and then (if successful) scale up. Innovative approaches in such a process include:

- periodic presumptive treatment: this short-term strategy has been shown to control certain sexually transmitted infections when targeted at specific population groups in appropriate settings
- social marketing of commodities for infection control: social marketing of pre-packed medicines or condoms (along with training in their correct and consistent use) for treatment and prevention has improved access to care for sexually transmitted infections in some places
- provision of user-friendly services for adolescents: experience has shown how to make services more responsive and acceptable to adolescents – countries should use this knowledge and experience to scale up appropriately-adapted interventions to suit each country or setting, and to reach as many adolescents as are in need
- male involvement and motivation, and services for men: pilot projects targeting men have been successful; the experience gained should be adapted to local conditions and activities should be scaled up

- second-generation HIV surveillance to cover also behaviour and sexually transmitted infections: such an approach will provide programmes with information on appropriate interventions to control all sexually transmitted infections.

1.3.5 Condom promotion to populations engaged in high-risk behaviours and to the general population

There has been sufficient evidence to show that condoms, when used correctly and consistently, are effective in protecting against the transmission of HIV to women and men. They also reduce the risk of men becoming infected with gonorrhoea from their sexual partners. Correct and consistent condom use is associated not only with reduced transmission of HIV and with reduced acquisition of urethral infection among men, but also with the reduced acquisition of the following:

- genital infection with herpes simplex virus type 2 by men and women;
- syphilis by men and women;
- chlamydial infection by men and women;
- gonococcal infection by women;
- possibly *Trichomonas vaginalis* infection by women.

Condom use has also resulted in accelerated regression of cervical and penile human papillomavirus-associated lesions and accelerated clearance of genital human papillomavirus infection by women.

Given this evidence, it is important to assess the magnitude of HIV and other sexually transmitted infection rates in the general population and in high-risk populations. In countries where these rates are high in both the general population and high-risk populations, safer sex strategies must be delivered as a package to both population groups. Such strategies include: promoting the correct use of male and female condoms, and their distribution, and sexual abstinence, delaying sexual debut and reducing the number of sexual partners. In settings where the infections are concentrated in high-risk populations, targeted interventions should be a priority, but not to the exclusion of education and other prevention and care services for the general population.

1.3.6 Obstacles to provision of services for control of sexually transmitted infections

Over the past five years, interest and resources for the prevention and control of sexually transmitted infections other than HIV have declined despite their importance as cofactors in the transmission of HIV and as direct agents of significant morbidity and mortality in the world. Advocacy and support have focused on antiretroviral therapy and testing and counselling policies for HIV.

In spite of the Programme of Action of the United Nations International Conference on Population and Development (Cairo, 1994) and the outcome of the Fourth World Conference on Women (Beijing, 1995), advocates for sexual and reproductive health have not been particularly enthusiastic about integrating prevention and care activities for sexually transmitted infections (including HIV) into their work. Integration of those activities into sexual and reproductive health programmes in order to improve coverage has proved to be more complex than expected. Experience with integration has been mixed; not enough is known about how integrated interventions can best be configured and what effect they have on prevention of infections and unwanted pregnancy.

In addition, syndromic management of women who present with vaginal discharge has proven problematic as a tool for the detection and management of cervical infections, particularly in areas of low prevalence of sexually transmitted infections. As a result, affordable, rapid diagnostic tests are needed. Such tests have been slow to be developed and, where available, they are still too expensive for governments to incorporate into national care programmes.

Several other difficulties have been encountered in attempts to promote prevention interventions. The determinants of the epidemiology of sexually transmitted infections are multifaceted (including gender inequities, poverty and other socioeconomic disparities), and intervention efforts to prevent infection have failed to take into consideration the full range of the underlying determinants. At the care level, it is crucial to ensure consistent supplies of medicines and condoms, a challenge that has not been successfully tackled by health systems. Counselling on risk reduction is also usually lacking. In the control of these infections, a broader participation of partners from different sectors, disciplines and communities (including from nongovernmental and faith-based organizations) is necessary, but this broader involvement remains a challenge, especially in the area of community participation.

In addition to these shortcomings, the following underlying factors have also contributed to failure to control sexually transmitted infections:

- ignorance and lack of information perpetuate wrong conceptions of these diseases and associated stigmatization
- many of the infections tend to be asymptomatic or otherwise unrecognized until complications and sequelae develop, especially in women
- the stigmatization associated with infection (and clinics that provide services) constitutes an ongoing and powerful barrier to the implementation of prevention and care interventions.

At the individual and community levels, stigmatization results in:

- reluctance of patients to seek early treatment;
- preference to seek treatment in the private sector, whether provided by medically qualified personnel, pharmacists, traditional practitioners or other types of providers, who are perceived to offer greater accessibility, confidentiality, and to be less stigmatizing than public-sector facilities;
- difficulty in notifying and treating infections in sexual partners.

At the policy and decision-making levels, the following factors operate:

- Policy-makers and planners give low priority to control of sexually transmitted infections. This situation is potentially aggravated by the stigmatization and prejudice associated with the infections and ignorance of the importance of their impact on health and economic development.
- Donors are increasingly using sector-wide approaches to allocate aid to the whole health sector rather than to specific projects, such as sexually transmitted infection control. Although this allows health ministries to determine national priorities, it also means that countries that have traditionally accorded little importance to these infections in their health budgets because of stigmatization can continue to do so.

- There is a failure to provide suitable education and services to populations identified as being particularly vulnerable to sexually transmitted infections, such as young people and adolescents, sex workers (both male and female) and their clients, men who have sex with men, transgendered people, substance users, prisoners, mobile populations (for work or recreation), children and young people on the street, and people affected by conflict and civil unrest.

2. AIMS AND SCOPE OF THE STRATEGY

2.1 Purpose and objectives

The purpose of the global strategy is to provide a framework to guide an accelerated global response for the prevention and control of sexually transmitted infections, towards the attainment of international development goals. In particular, the strategy will focus on achievement of the following objectives:

- to increase the commitment of national governments and national and international development partners for prevention and control
- to promote mobilization of funds and reallocation of resources, taking into account national prioritized results-oriented interventions that ensure aid effectiveness, ownership, harmonization, results and accountability¹
- to ensure that policies, laws and initiatives related to provision of care are non-stigmatizing and gender-sensitive within the prevailing sociocultural context
- to harness the strengths and capacities of all partners and institutions in order to scale up and sustain interventions for prevention and control.

The global response will be guided by two strategic components.

Technical component: a global technical strategy adaptable at the country and regional levels, including ways to package and deliver the key programmatic elements of prevention and control in a sustainable manner. The strategy will draw on lessons learnt and on clearly successful actions that need to be scaled up. It will identify shortcomings in such key areas as:

- availability or suitability of health-care services for priority target populations (e.g. adolescents and sex workers);
- diagnosis and treatment of asymptomatic infections;
- the syndromic approach for the management of abnormal vaginal discharge;
- management of sexually transmitted infections in sexual partners;

¹ Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability. Paris, March 2005.

- attitudes of health-care providers;
- availability and reliability of data for planning purposes.

It will also identify appropriate opportunities for interfacing and integrating with HIV/AIDS and sexual and reproductive health programmes, and for involvement of the private sector.

Advocacy component: a global advocacy campaign to raise awareness and mobilize resources worldwide. This campaign will run alongside other initiatives such as campaigns for the elimination of congenital syphilis, the control and eradication of curable genital ulcer diseases, and the control of genital herpes and genital human papillomavirus infections.

2.2 Target audience

The strategy outlines the essential elements of an effective response to the burden of infection and provides information on key issues. It does not attempt to provide guidelines on how to develop or implement activities.

Its target audiences are the following: managers of national programmes on HIV/AIDS/sexually transmitted infections and sexual and reproductive health; health-sector stakeholders including public-sector and private-sector health-care providers; health ministers, policy-makers and other decision-makers in the health sector; international agencies and nongovernmental partners; other governmental departments and agencies; and donors.

2.3 Guiding principles

The strategy is underpinned by internationally agreed frameworks of ethics and human rights, which recognize the right of all persons to the highest attainable standards of health, including sexual and reproductive health. It conforms with the legal framework governing the reproductive health needs of children and adolescents, in particular the right to be free of coercion or abuse, including sexual abuse.

The strategy is also based on the following guiding principles:

1. Gender inequalities must be addressed through interventions that influence political will as well as societal norms and attitudes concerning sexual behaviour and the status of women. Active promotion of male responsibility and the empowerment of women in the prevention and control of sexually transmitted infections are crucial elements of an effective gender-sensitive response.
2. There should be a seamless continuum between prevention interventions and care. The balance and variety of activities will depend on the local determinants of epidemiology, patterns of infections and resources available. In each setting, the availability of and access to condoms and medicines for treatment of sexually transmitted infections will constitute elements of a fully effective response.
3. Interventions should form an integral part of a range of comprehensive sexual and reproductive health services. Close cooperation with sexual and reproductive health programmes, within the framework of WHO's strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, is crucial for the implementation of strategies on both sexually transmitted infections and reproductive health.
4. Cooperation between prevention and care programmes for sexually transmitted infections and those for HIV is vital for the response, as not only are the risk behaviours that lead to infection with

HIV and other sexually transmitted pathogens the same, but also prevention and care of other sexually transmitted infections remain key elements of the primary prevention of HIV, especially in settings and populations with low HIV prevalence. Combining the strengths of the two programmes creates synergies for the fight against both HIV and other sexually transmitted infections. WHO's global health-sector strategy for HIV/AIDS 2003-2007 and the WHO/UNAIDS strategies for coming as close as possible to the goal of universal access to prevention, care and treatment will be instrumental frameworks for this collaboration.

5. Building partnerships is critical for improved prevention and care of sexually transmitted infections. The multisectoral approach should include the ministries of health, education, sports, tourism and transport, and the military and other uniformed forces, as well as the private and informal sectors.

6. Engagement of communities (including nongovernmental and faith-based organizations) and vulnerable populations as partners in the design, implementation and evaluation of interventions and services enriches the process, ensures ownership and culture-sensitiveness of the process and output, and mobilizes commitment for implementation.

7. Reducing stigmatization and discrimination at both individual and societal levels is a key component to improve health-care seeking behaviour and provision of health-care services in relation to prevention and control.

2.4 Essential elements of the response

The key strategic elements of a control programme for sexually transmitted infections at the national and regional levels are well-established and include the following:

- reviewing relevant policies, laws and regulations to ensure that they are non-punitive and non-coercive and contribute towards the aims of the prevention and control programmes and services
- promoting healthy behaviours: safer sexual and health-seeking behaviours, compliance with therapy, and responsible notification and management of infections in sexual partners
- delivering care including antenatal case-finding programmes for syphilis and other sexually transmitted infections, ophthalmic prophylaxis at birth for neonates, and immunization against hepatitis B
- ensuring a reliable supply of safe, effective, high-quality and affordable medicines and commodities for prevention and control, including male and female condoms and other effective barrier methods
- strengthening support components, including the adaptation of normative guidelines, training, information networks, commodities logistics, laboratory support, surveillance and research.

Innovative ways of packaging and delivering these core elements must be explored. The challenge is to determine how best:

- to use existing and new tools and technologies so as to benefit the people who need them most;

- to improve clinic environments to make them more accessible, user-friendly and client-centred so that they respond to clients’ needs;
- to communicate clear health messages in local languages so that they are more memorable and effective;
- to develop strong relations with the media and recruit advocates for prevention and control across social networks that are difficult to penetrate;
- to promote a multisectoral response that works in sectors other than health, such as the legal and education sectors, the tourism industry and the private sector;
- to develop public-private partnerships for prevention and control;
- to rally international agencies, national governments, private philanthropic organizations and commercial interests around a set of priority interventions and initiatives;
- to move beyond the search for “magic bullets” to multifaceted interventions that work in concert across multiple components and levels, and are sustainable at the local level.

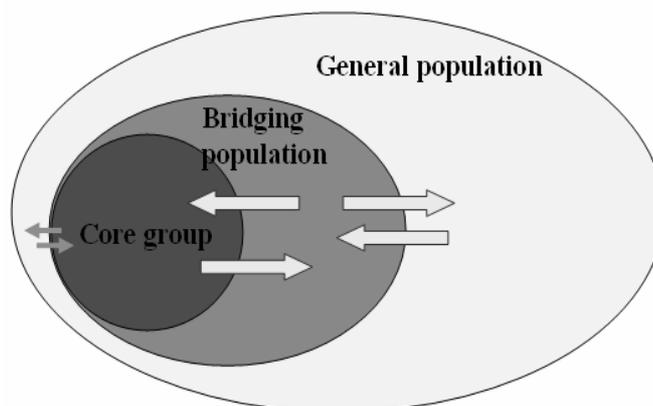
3. THE TECHNICAL STRATEGY: BUILDING ON SUCCESS IN PREVENTING AND CONTROLLING SEXUALLY TRANSMITTED INFECTIONS

3.1 Transmission dynamics

In the past 20 years, knowledge about the transmission dynamics of sexually transmitted infections has grown, as a consequence of the pandemic of HIV and increased efforts to control the other infections. Mathematical modelling and research have shown the importance of sexual networks in determining the spread of all these infections. This improved understanding of the transmission dynamics has implications for the design of strategic prevention and control interventions.

Within a given population the distribution of such infections is not static. Over time, epidemics evolve through different phases characterized by changing patterns in the distribution and transmission of the sexually transmitted pathogens within and between subpopulations. Generally, early in an epidemic or in some geographical settings, sexually transmitted pathogens are likely to be transmitted within and from high-risk persons with high rates of infection and frequent changes of sexual partner (*core groups*). As the epidemic progresses, the pathogens spread into lower-risk populations (*bridging populations*) who may be an important sexual link between the core groups and the general population. Social or economic conditions of certain population groups can increase their vulnerabilities for acquiring or transmitting an infection and bring them into this bridging category. Sexual networks vary from setting to setting but, in general, sexual partners of individuals with high rates of infection (i.e. bridging populations), in turn, infect other sexual partners, such as their spouses or other regular sexual partners within the general population. Figure 1 is a simplified representation of the population transmission dynamics for sexually transmitted infections.

Figure 1.
Transmission dynamics of sexually transmitted infections at the population level



The situation is further complicated by the different interaction dynamics between host and pathogen which are governed by a threshold parameter, R_0 , the basic reproductive number. R_0 represents the expected number of secondary cases produced by a single index case in a population of susceptible persons. R_0 is a product of three variables, represented as $R_0 = \beta \times D \times C$, where β is the transmission efficiency of the pathogen per single sexual contact (infectiousness), D is the duration of infectiousness and C is the rate of change of sexual partners. Some pathogens (e.g. *Haemophilus ducreyi*) are highly infectious but the period during which an infected person is infectious is of short duration, while others such as HIV and herpes simplex virus type 2 are of relatively low infectiousness but infected people are infectious for a long period. *Neisseria gonorrhoeae*, *Chlamydia trachomatis* and *Treponema pallidum*, on the other hand, are of intermediate infectiousness and duration. Thus, the pattern by which an epidemic will evolve will differ for different types of population-pathogen interactions. All these factors need to be taken into consideration, where possible, when planning an effective programme for the prevention and control of these infections.

Risk factors for sexually transmitted infections, including HIV infection, vary by sex, and women and their infants are disproportionately affected. Differences in vulnerability and sequelae are attributable to biological susceptibility and to gender differentials such as power inequalities, and behavioural factors including sexual practices, health-care seeking behaviour, and in some settings, poor access to care and low levels of education.

3.2 Prevention and control interventions

Given the transmission dynamics summarized above, strategies for prevention and control need to be appropriate in order to maximize the impact and gains. Programmes need to have an understanding of the following:

- which populations are at greatest risk;
- what behaviours or circumstances put these populations at risk;
- what are the best approaches and interventions to break the chain of transmission;
- how to prioritize, scale up and sustain the interventions.

In some geographical settings and countries rates of sexually transmitted infections in the general population are high, while in others high rates are confined to specific population groups. Exercises that map infection levels, sexual behaviours (e.g. number of sexual partners and rates of partner change), preventive behaviours (e.g. correct and consistent condom use), and health-related behaviours (e.g. treatment-seeking behaviours) in population groups with high rates of infection and in vulnerable groups, as well as in the general population, provide valuable information on the transmission dynamics and help to determine which interventions for control would be most successful. Targeted interventions should be prioritized according to the needs, feasibility and availability of resources.

The populations whose behaviours and vulnerabilities need to be analysed for possible targeted interventions vary between regions and among countries. Those frequently observed to be in need of targeted interventions include:

- sex workers (female, male and transgendered) and their clients who also might have sex with their regular partners;
- mobile populations such as long-distance truck drivers, fishermen, seafarers and migrant workers, who are at increased risk of infection primarily because of their mobility and high-risk sexual contacts;
- men who have sex with men who have multiple sexual partners and engage in unprotected anal intercourse;
- men who have sex with men and who also have sex with women (i.e. bisexual men);
- substance users, especially those who also sell or exchange sex to support their habit or who have sex with non-users;
- incarcerated persons, especially juveniles;
- external and internal refugees and displaced persons;
- members of the uniformed services, including military and police;
- tourists, especially recreational sex tourists;
- women or men who experience sexual and gender-based violence;
- children and young people on the street, and those who are abused or are orphans.

Adolescents are at special risk of infection with sexually transmitted pathogens, including HIV, because they might not have the information, skills, health care and support they need while going through sexual development. Their sexual relations tend to be unplanned and sporadic, and in many cases result from pressure or force or take place in exchange for acceptance or financial gain. Adolescent women in particular are more vulnerable than men for biological, social and economic reasons. In some cultures where adolescents, especially girls, marry at a young age, national programmes need to recognize that the young girls may be at increased risk because the social and biological factors referred to above still apply to them even though they will be regarded as adults by virtue of being married. The prevention and care of these infections, including HIV infection, among young people will require a range of age-appropriate interventions from a variety of different sectors. The health sector itself will be responsible for a number of such interventions, through a range of health-system partners. Some of these areas of activity for adolescents are discussed in section 3.4.1.

All targeted interventions, however, must be provided in the context of effective services for people with sexually transmitted infections and other health needs for the general populations as well as the populations being targeted.

3.2.1 Promoting healthy sexual behaviour

An effective response to the spread of sexually transmitted infections starts with prevention by providing accurate and explicit information on safer sex, including correct and consistent use of male and female condoms, as well as abstinence, delay in onset of sexual activity, keeping to one sexual partner or reducing the number of sexual partners. In addition to prevention interventions, health-care services must be available to provide early and effective treatment.

Communication about sexual behavioural change is part of an integrated, multilevel, interactive process with communities, aimed at developing tailored messages and approaches using a variety of channels. It should be an integral component of prevention efforts and incorporated into care and support activities. It can increase knowledge; stimulate dialogue within the community; promote essential changes in attitude; reduce stigmatization and discrimination; create demand for information and health-care services; advocate appropriate policies and laws; promote interventions for prevention, care and support; and improve skills and self-esteem.

When choosing the communication channels for sexual behavioural-change messages it is important to know which ones can most effectively reach the target population. One successful channel for targeted interventions is through peer educators and opinion leaders. Health talks through institutional or interpersonal networks, group discussions or other one-to-one approaches have also proved effective. Age-appropriate schools-based programmes help in reaching young people who are attending school, but for the out-of-school population other channels, such as peer education, are necessary.

Whatever channel of communication is selected, it is important to use language that is well understood locally. Care should be taken that the messages are sensitive to gender and culture and that they do not reinforce any existing norms that could be driving the spread of sexually transmitted infections. Prevention activities should be designed for the particular population for whom they are intended, by taking into consideration people's situations, vulnerabilities and specific needs.

Innovative strategies for raising demand for high quality services should be used, for example market-oriented methods for raising consumer awareness on what is the correct, high-quality treatment that they should expect from the care providers. This approach relies on the premise that increasing demand affects supply of health-care services. Creating high expectations that are not met can be detrimental to success.

Health education about sexually transmitted infections, and counselling of both infected and uninfected people, including voluntary counselling and confidential HIV testing, should be an integral part of any health service for those infections, as the counselling process creates motivation to change sexual behaviour in both infected and uninfected individuals. Education and counselling messages should also highlight the need for sexual partners to be informed and managed properly for any such infection in order to avoid repeated infections.

3.2.2 Providing condoms and other barrier methods

The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted pathogens. Although the female condom is effective and safe, it has not achieved its full potential in national programmes because of its relatively high cost. Male and female condoms are a key component of comprehensive prevention strategies, and both should be made readily and consistently available to all those who need them in order to reduce risks of sexual exposure to pathogens including HIV.

Tests are currently under way to assess the effectiveness of diaphragms to protect the cervix against HIV and other sexually transmitted infections. Together, microbicides and the diaphragm offer the best promise of prevention tools that women can control. Currently, several new microbicides are undergoing field trials. Should any of these new methods of prevention prove effective, strategies will need to be developed to facilitate their introduction in different geographical and population settings.

Planning is essential to ensure that national needs are met on a consistent basis. Once procured, condoms should be promoted and distributed through both the public and private sectors, in clinical and non-clinical settings. Maternal and child health and family planning clinics are good additional outlets for condoms, making them accessible to women who could be at risk of sexually transmitted infections. Social marketing programmes have been shown to be particularly effective in ensuring that high-quality, affordable condoms are available where and when they are needed, in both traditional and non-traditional outlets. Condom distribution can also be supplemented by community-based distribution and outreach services to target populations.

3.2.3 Delivering prevention and care

The aim of delivering care services for people with sexually transmitted infections is to prevent the development of long-term complications and sequelae in people already infected and to prevent the spread of infection to uninfected sexual partners, the fetus or the newborn.

Strategic options for prevention and care

In any particular population there will be individuals infected and those not infected with sexually transmitted pathogens. A proportion from each of these groups will seek care either for symptoms perceived to be related to a sexually transmitted infection, or for ailments other than such infections. At the same time, within the community there will be a number of symptomatic people with sexually transmitted infections who do not seek care for one reason or another, and others who will be asymptomatic but infected. Strategies need to be identified and put in place to cope with this variety of presentations both at the community and health-centre levels.

Figure 2 presents a diagrammatic representation of such a scenario. The left side represents people with an established sexually transmitted infection and the right side represents those without an infection; the top half represents symptomatic persons (with or without a sexually transmitted infection) and the bottom half represents the asymptomatic group. The upper-left quadrant, therefore, represents persons with true symptomatic infections, while the lower-left quadrant concerns those without symptoms of infection. The challenge is how to detect the infection in these people who are infected but without symptoms. The upper-right quadrant represents people who are not infected but presenting with symptoms suggestive of infection. This group does not require treatment for sexually transmitted infections, but needs information and reassurance, along with treatment for the ailment that could be responsible for the symptoms. In this group, the challenge is how to exclude infection. The lower-right quadrant relates to people without infection and free of any symptoms. This is a healthy population that needs information and knowledge to remain free of infection. Such information can be provided either within the community or when these people come into contact with a health centre. Options and commodities necessary to provide a comprehensive prevention and care programme are discussed below, in terms of the transmission dynamics and the different categories of persons presenting at health-care facilities.

Sexually transmitted infections programmes should promote accessible, acceptable and effective interventions that offer comprehensive case management of infected persons to prevent further infections and their many complications and long-term sequelae. The components of such management are the following:

- correct diagnosis by syndrome or laboratory diagnosis;

- provision of effective treatment;
- reduction in or prevention of further risk-taking behaviour through age-appropriate education and counselling;
- promotion and provision of condoms, with clear messages for correct and consistent use;
- notification and treatment of sexually transmitted infections in sexual partners, where applicable.

Figure 2.
Diagrammatic representation of clinical presentations of sexually transmitted or reproductive tract infections and service needs

		General population				
		People with sexually transmitted infections (infected)	People without sexually transmitted infections (uninfected)			
		INFECTED AND SYMPTOMATIC	UNINFECTED BUT SYMPTOMATIC			
		Do not seek treatment	Seek treatment	Do not seek treatment		
		Treatment necessary	Avoid unnecessary treatment			
Clinical presentation	Interventions	Standardized case management Health education and counselling Behavioural change communication to raise awareness of symptoms of sexually transmitted infections and improve health-care seeking behaviour	Behavioural change communication to raise awareness and education on reproductive health and personal hygiene		SYMPTOMATIC	
		Prevention messages against sexually transmitted infections, including HIV	Prevention messages against sexually transmitted infections, including HIV			
		INFECTED BUT ASYMPTOMATIC	UNINFECTED AND ASYMPTOMATIC			
ASYMPTOMATIC	Interventions	Do not seek care	Attend health facility for reasons other than sexually transmitted infections	Do not seek care	ASYMPTOMATIC	
		Treatment necessary	No treatment needed			
		Case-finding and screening Incorporation of rapid diagnostic tests for sexually transmitted infections Periodic presumptive treatment Awareness campaigns	Behavioural change communication to raise awareness and education on reproductive health and personal hygiene			
		Prevention messages against sexually transmitted infections, including HIV	Prevention messages against sexually transmitted infections, including HIV			

Whenever an infection is diagnosed or suspected, effective treatment should be provided promptly to avoid complications and to break the chain of transmission. The client should receive education and counselling on: adherence to treatment; notification and treatment of infections in sexual partners; risk reduction; and correct and consistent condom use. Referral for existing complications or sequelae should be provided, whenever needed.

Syndromic management

Traditionally, a presumed sexually transmitted infection has been diagnosed by either clinical appearance alone (which is often inaccurate) or a laboratory-based test, which can be complicated and expensive and commonly delays treatment while test results are awaited. Even if desirable, laboratory-based diagnosis is often limited, especially in resource-constrained settings, owing to the cost of maintaining a laboratory and a consistent supply of test kits as well as ensuring quality control. For these reasons WHO recommends the syndromic management of sexually transmitted infections in patients presenting with consistently recognized signs and symptoms shown in simple flowcharts that can be used at the primary health-clinic level.¹

Syndromic management is based on the identification of a group of symptoms and easily recognized signs associated with infection with well-defined pathogens. Treatment for each syndrome is directed against the main organisms within that geographical setting responsible for the syndrome. The syndromic approach has been shown to be highly effective for the management of urethritis and epididymitis in men and genital ulcers in both men and women, and works well in the management of infants with ophthalmia neonatorum. It should be noted that the syndrome of vaginal discharge is neither specific nor sensitive for predicting gonococcal, chlamydial or other cervical infections; however, if the primary objective is to treat vaginitis – attributable, for example, to bacterial vaginosis or trichomoniasis – the approach is of benefit and becomes cost effective in all settings.

Sexually transmitted infections often exist without symptoms, particularly in women. Different strategies are required for the detection and management of these asymptomatic infections. Some of the strategies are case-finding or screening, with enhanced interventions for reaching sexual partners in order to provide case management for a presumptive sexually transmitted infection, and increasing knowledge and awareness of individual risk. Case-finding refers to testing in individuals who seek health care for reasons other than a sexually transmitted infection. A very important application of case-finding is the provision of care for such infections in antenatal clinics and in maternal and child-health and family planning clinics. A common example of case-finding is the routine testing of pregnant women for syphilis at antenatal clinics.

Screening refers to testing of individuals who are not directly seeking any health care. For example, testing of blood donors for syphilis, HIV infection and markers of hepatitis B virus infection is an important application of screening. Community-based screening, when feasible and acceptable and done with due regard to confidentiality and human rights, can be an effective means of detecting and treating people with asymptomatic infections. Targeting screening to those at higher risk of infection will improve the cost-effectiveness of screening programmes.

Strategies for case-finding and screening for sexually transmitted infections require more than the development of rapid diagnostic tests but will be more feasible when these become available. In all cases, careful attention should be paid to patient confidentiality, counselling and treatment.

¹ WHO has developed protocols for seven syndromes: vaginal discharge, urethral discharge, genital ulcer, lower abdominal pain, scrotal swelling, inguinal bubo, and neonatal conjunctivitis.

Strategies for notification of sexual partners

Partner notification, which is an integral part of case management, is a process whereby the sexual partners of patients diagnosed with sexually transmitted infections are informed of their exposure to infection so that they may seek consultative screening and treatment. Partner notification aims to prevent reinfection of the index patient and reduce the spread of infections. Three main approaches have been followed:

- use of third parties (usually health-care personnel) to notify sexual partners
- index patients notify their sexual partners, or the patients are supplied with medications to deliver to their sexual partners
- index patients agree to notify their sexual partners, with the understanding that health-care personnel will notify those partners who do not present for treatment within a given time.

Epidemiological treatment (treatment for the same infection or syndrome as in the index patient) should be given to all recent sexual partners. Management of such partners for infections is one of the most difficult interventions to achieve, but it is an important component of control of sexually transmitted infections. It offers a significant opportunity for identifying and treating asymptomatic persons, particularly women, at an early stage and before the development of complications. This intervention should not be coercive, however, and special care needs to be taken to observe confidentiality and to take gender into account, in view of the fact that the implications for partners will differ according to their sex and their sexual and social norms.

There is no strong or consistent evidence for the relative effects of the three approaches or patient choice among strategies. Patient referral incurs fewer costs and can be more effective with appropriate education and counselling. More operational research, especially in developing countries, is needed to evaluate the different approaches in terms of acceptability, the number of sex partners that present for medical evaluation, the impact on index patient reinfection rates, and incidence of sexually transmitted infections. In addition, whatever approach of partner notification is implemented, costs and potential harm related to the process need to be monitored and documented.

3.2.4 Access to medicines and appropriate technology

Medicines

Consistent availability of appropriate medicines is essential for a successful sexually transmitted infection control programme. Prompt and effective treatment breaks the chain of transmission and prevents the development of complications and long-term sequelae. Most of these medicines are inexpensive, and cost should not be a barrier to their availability. Some of the newer and improved formulations are, however, expensive and require procurement mechanisms that would make them affordable to governments and clients. Factors related to affordability can include national, regional and international features such as patents, limited volume, limited competition, import duties and tariffs, and local taxes and mark-ups for wholesaling, distribution and dispensing.

A medicine that is appropriate for treatment of a sexually transmitted infection is one that is highly efficacious, that has acceptable toxicity, for which microbial resistance is either unlikely or will be delayed, that is administered orally and preferably as a single dose, and that is not contraindicated for pregnant or breast-feeding women. A two-tier medicines policy, with the provision of less effective medicines at the peripheral health-care level and the most effective (usually more expensive) ones

only at a referral level, can result in an unacceptable rate of treatment failures, complications and referrals, bring about drug resistance more rapidly and erode confidence in health services.

To ensure a consistent supply of safe and effective medicines, countries need to have a sustainable procurement strategy that ensures a 60-day reserve stock at a minimum. Procurement strategies are discussed in section 3.5.6.

Diagnostic tests

Some 80% to 90% of the global burden of sexually transmitted infections occurs in the developing world where there is limited or no access to appropriate diagnostics. There is a need for the development of rapid diagnostic tests in order to improve the quality of care and diagnosis for patients in resource-limited settings. There is a particularly urgent need for improved diagnostics for these infections in HIV-endemic areas, as some of them are important cofactors in the transmission of HIV.

Vaccines

As immunization of populations at risk is, in general, a highly effective method of controlling infectious diseases, the arguments for searching for effective vaccines against sexually transmitted infection, including HIV infection, are compelling. Such vaccines would be an important addition to the existing armamentarium of prevention technologies. Currently, hepatitis B vaccine is the only effective vaccine available against a sexually transmitted pathogen.

Preventive vaccination against the oncogenic human papillomavirus types will soon become available, as was shown by a recent trial which demonstrated a vaccine efficacious in prevention of incident and persistent cervical infections with types 16 and 18. Discussions have been held, under the auspices of WHO, to determine appropriate endpoint measures for human papillomavirus vaccines and encourage recognition of human papillomavirus infection as a public health problem. WHO is encouraging countries to consider the benefits of introducing these vaccines in their programmes as well as to explore issues of acceptability and feasibility when it comes to implementation of such vaccination programmes.

Clinical trials found that a vaccine against herpes simplex virus type 2 was highly effective compared with a placebo, but effectiveness was only in women, and only in women who had not been previously infected with herpes simplex virus type 1. As more research and clinical trials continue, country programme managers should engage in discussions on conducting herpes simplex virus type 2 vaccine trials in different epidemiological settings to evaluate utility, acceptability and feasibility, while at the same time building capacity for research and implementation.

For a successful implementation of any vaccination strategy, the target population must be carefully defined and the acceptability of the vaccine must be assured, especially within a population that may not perceive itself as at risk for sexually transmitted infections. Once the population has been defined and mobilized to accept the vaccine, it will be important to provide that population – reliably and consistently – with a potent vaccine to ensure the success of an immunization strategy. Lessons may be taken from some vaccination programmes against infectious diseases and, indeed, from the lack of widespread use of an existing vaccine against hepatitis B.

3.2.5 Scaling up

Small-scale and pilot programmes to prevent and control sexually transmitted diseases provide only limited geographical and population coverage and cannot be expected to have a meaningful impact on disease burden. Many programmes tend to implement interventions on a small pilot scale,

which, though producing good results, do not reach a wider population for a greater impact. To achieve greater impact, prevention and care interventions must be evaluated for their technical elements and those found to be effective must be scaled up. The objectives of scaling up are to ensure that an effective intervention reaches the populations in need of the service. This means increasing geographical coverage and the number of people served within a particular target population, extending a programme to reach additional target populations, and broadening the scope of interventions provided by a programme.

Scaling up such programmes will have the greatest impact when it is focused on priority target populations (i.e. those that affect the dynamics of the spread of sexually transmitted infections most) and reaches as many individuals as possible within those populations. Scaling up also requires a special focus on:

- quality of services, as there is a risk of trading off quality against intensity of efforts to reach more people;
- absorptive capacity, i.e. ensuring sufficient resources are available to support the scaling up;
- sustainability: before scaling up, mechanisms for sustained provision of care should be established.

3.3 Improving information for policy and programme development

3.3.1 Surveillance

Surveillance of sexually transmitted infections at the national, regional and global levels needs to be enhanced for the purposes of advocacy, programme design, monitoring and evaluation, and patient care. The basic components of surveillance that need to be enhanced include the following:

- case-reporting that disaggregates by age and sex (syndromic or etiological reports depending on the availability of diagnostic tests; universal or sentinel-site reports depending on whether a functional national reporting system for notifiable infectious diseases exists as well as on how services for prevention and control of sexually transmitted infections are delivered and organized)
- prevalence assessment and monitoring to identify and track the burden of infection (symptomatic and asymptomatic) in defined populations
- assessment of etiology of infection
- antimicrobial resistance monitoring
- special studies, for example assessment of quality of care using mystery clients.

The above components are complementary activities, and the ways in which each one of them is performed will depend on the existing surveillance infrastructure and on the systems that are already in place for reporting as part of integrated disease surveillance. The state of the HIV epidemic in a particular country also has implications for activities and priorities for surveillance of sexually transmitted infections.

Second-generation HIV surveillance

Surveillance of sexually transmitted infections is closely linked to and has a special role in second-generation HIV surveillance; the latter includes, in addition to HIV surveillance and AIDS case reporting, behavioural surveillance in order to monitor trends in risk behaviour over time and surveillance of sexually transmitted infections in order to monitor the spread of other such infections in populations at risk for HIV. For example, findings of studies on herpes simplex virus type 2 infections can be used as markers for HIV vulnerability. Strengthening of surveillance of sexually transmitted infections is, therefore, an important component of second-generation HIV surveillance.

Surveillance of sexually transmitted infections should be closely linked to behavioural surveys, especially to surveys on sexual behaviours, determinants of the epidemiology of such infections and health-care seeking behaviours and their relationship to underdetection and underreporting of these infections. Surveillance is also important in assessing which population groups should receive targeted interventions.

Periodically, there is a need to perform special studies to focus on other surveillance issues that are not part of the routine case reporting or prevalence assessment. These studies can include investigations for outbreaks of particular infections, such as syphilis, lymphogranuloma venereum and chancroid in certain populations and geographical settings.

The private sector, to the greatest extent possible, should be included in the reporting system, despite the reluctance often encountered to report sexually transmitted infections to public health authorities because of concerns about privacy and stigmatization, apathy, or a perception that little is to be gained from the notification process. In many countries patients with such infections seek to obtain medication directly from pharmacies or the informal private sector, without first seeking diagnosis from a clinician. This practice can be a source of a substantial amount of underreporting, and special studies could be necessary to determine its extent and the magnitude of underreporting. Incentives to encourage reporting should be considered. Some of these could include accreditation or franchising.

Current surveillance systems need to be strengthened through improving laboratory facilities, materials and personnel, and enforcing reporting mechanisms, especially when diagnostic facilities are in place. As current surveillance systems are further limited by underestimation of the burden attributable to asymptomatic sexually transmitted infections, accompanying strategies for screening and case-finding need to be put in place.

Data for advocacy

The timely collection of reliable data is required to estimate the burden of sexually transmitted infections, including their complications and their economic impact. In turn, this information provides the rationale for enhanced policy attention and resource allocation to control such infections at the national, regional and global levels.

Data for programme design and monitoring

Timely and reliable data are also required to support programme management. Prevalence studies in various populations help to assess the distribution of sexually transmitted infections, identify priority target populations and estimate the burden of asymptomatic infections in a community. Trend data are useful to evaluate the effectiveness and impact of control programmes and interventions, and also serve as biological markers of trends in unsafe sexual practices.

Data for patient care

Antimicrobial resistance to commonly used medicines that took decades to develop continues to diminish their effectiveness. Resistance develops largely because medicines are misused through indiscriminate use and over-prescribing. Medicines are misused by patients who do not complete prescribed courses either because of non-adherence or poverty; poverty often forces both health-care providers and their patients to opt for lower doses of prescribed medications or cheaper, less effective alternatives in order to save money. Ironically, far more expensive medicines must replace cheaper ones once the latter lose their effectiveness.

It is essential that health authorities regularly monitor and detect the relative prevalence of pathogens responsible for the clinical presentations in the local settings and the emergence of resistance, so that treatment guidelines and national lists of essential medicines can be kept up to date. Sexually transmitted organisms that particularly warrant monitoring include *Neisseria gonorrhoeae* and *Haemophilus ducreyi* among the bacteria and herpes simplex virus type 2 among the viruses.

As levels of resistance vary widely from one country to another, WHO does not recommend any one single first-line treatment for gonorrhoea. Instead, each country must make decisions according to its own resistance patterns – a quandary, given that many cannot afford surveillance and have to rely on proxy data gathered by neighbouring countries or use regional estimates.

3.3.2 Monitoring and evaluation

Progress of programme implementation needs to be monitored in order to ensure that activities are performed as planned, on time and within budgeted resources, and determine whether the activities are producing the expected outcome or impact. There is a lack of data at the implementation level that makes it difficult to measure accurately the effectiveness and cost-effectiveness of various interventions. Such information is important for priority setting, strategic planning and resource allocation. A data collection and analysis process should be established to monitor the following:

- service delivery (e.g. numbers of clients served, pregnant women screened and treated for syphilis, condoms distributed, and individuals referred for voluntary counselling and testing);
- quality of care provided (e.g. proportion of clients treated according to national guidelines using standard indicators);
- adequacy of staffing patterns (e.g. patient load);
- client response and satisfaction (e.g. total number of clients served, initial versus repeat or return visits, and proportion using facilities as first treatment option);
- capital and recurrent programme costs to assess efficiency and cost-effectiveness.

Further, it is important that the results of such monitoring, which could be limited to operational research, are linked in a meaningful way with programme implementation. The results should be used to evaluate and improve the ongoing programmes and in the design of new ones. More operational research is needed to examine which interventions work best in particular settings, and research on issues related to women's sexual and reproductive health should be conducted in order to guide the formulation of gender-sensitive strategies and interventions.

3.4 Interface with other programmes and partners

3.4.1 Public sector health programmes

Sexually transmitted infections are implicated in programmes concerned with adolescent health, family planning, women's health, safe motherhood, immunization, child survival and HIV prevention. These programmes are interdependent and strategically should be integrated or have interfaces. These interfaces are indispensable for broadening the coverage of interventions for clients, and reducing missed opportunities for the prevention, detection and treatment of sexually transmitted infections. It should also strengthen the collaboration between the public and private health sectors for better quality and wider coverage. However, such interfacing or integration is made difficult by the need to accommodate additional tasks in existing programmes, particularly when the health goals of the new tasks are different from those of the existing services. Additional supervision, and financial and managerial support, might be required. Until these are in place, integration cannot be assumed to have been established. Although interfacing and integration facilitate increased coverage for clients, access to health care and management planning, they are not easy to achieve or cheaper in the first instance. Benefits are felt and appreciated only after initial difficulties and costs.

HIV/AIDS

The predominant mode of transmission of HIV and other sexually transmitted infections is sexual. Other routes of transmission for both include injecting drug use, transfusion of blood and blood products, transplantation of donated organs or tissue, and vertical transmission from a mother to her fetus or newborn infant. Many of the measures for preventing the sexual transmission of HIV and other pathogens are the same, as are the target audiences and populations for the interventions.

Some sexually transmitted infections, when present, facilitate the transmission of HIV. Some studies have demonstrated that ulcerative infections are implicated to varying degrees, with relative risks ranging from 1.5 to 8.5 (see Table 2). The increase in transmission probability for HIV infection per single sexual act is probably much higher than the relative risks observed in cohort studies, because participants are not continuously affected by a sexually transmitted infection during the follow-up period. Although the cofactor effect seems to be higher for ulcerative diseases, non-ulcerative infections could be more important in some populations because of their frequency and prevalence. More recently, intervention studies have added information and weight to the sexually transmitted infection/HIV cofactor effect.

The community-based randomized control trial in the Mwanza district of the United Republic of Tanzania showed that strengthened case management of symptomatic patients, by using syndromic management provided through the existing primary health-care clinics, reduced HIV incidence by 38%. A study conducted in Malawi among HIV-1 seropositive men showed that men with urethritis had HIV-1 RNA concentrations in seminal plasma eight times higher than those in seropositive men without urethritis. Gonorrhoea was associated with the greatest concentration of HIV-1 in semen. After the urethritis patients received antimicrobial therapy directed against sexually transmitted infections, the concentration of HIV-1 RNA in semen decreased significantly at two weeks. Blood plasma viral RNA concentrations did not change. There was no significant change in seminal plasma HIV-1 RNA concentrations during the two-week period in the control group. These results suggest that treating urethritis decreases the infectiousness of men with HIV-1 infection, and give further evidence that HIV/AIDS control programmes that include detection and treatment of other sexually transmitted infections in patients already infected with HIV-1 could help to curb the epidemic.

Treatment of sexually transmitted infections is a cost-effective option for countries to invest in, both as a means of reducing the serious morbidity caused by such infections and as an intervention to

Table 2.
Studies on sexually transmitted infection as risk factor for HIV transmission

Reference	Study population	Sexually transmitted infection studied	Relative risk	Odds ratio
Plummer, 1991	Female sex workers, Kenya	Chlamydia		3.6
Laga, 1993	Female sex workers, Democratic Republic of the Congo	Chlamydia Gonorrhoea Trichomoniasis		3.6 4.8 1.9
Kassler, 1994	Heterosexual cohort, United States of America	Gonorrhoea		2.5
Craib, 1995	Cohort of MSM, Canada	Rectal gonorrhoea		3.18
Cameron, 1989	Heterosexual men, Kenya	Mainly chancroid	4.7	
Telzak, 1993	Heterosexual men, United States of America	GUD, chancroid	3.0	
Limpakarnjanarat, 1999	Female sex workers, Thailand	Syphilis GUD and herpes		3.7 2.0-2.4
Mbizvo, 1996	Antenatal care women, Zimbabwe	GUD + PID		5.8
Bollinger, 1997	Sexually transmitted infection clinic attendees, India	GUD		4.2
Stamm, 1988	MSM, United States of America	Herpes, syphilis	3.3-8.5	
Holmberg, 1988	MSM, United States of America	Herpes	4.4	
Darrow, 1987	MSM, United States of America	Syphilis	1.5-2.2	

MSM, men who have sex with men; GUD, genital ulcer disease; PID, pelvic inflammatory disease.

prevent HIV. Therefore, programmes on all such infections should establish and maintain strong linkages and complement each other's efforts, given the synergistic interactions between HIV and other sexually transmitted infections and the common elements for prevention of both. Already, in many regions and countries of the world, programmes on sexually transmitted infections and HIV are fully or partially integrated or coordinated through joint planning.

Areas of collaboration between these programmes include advocacy, policy formulation, training, programme planning and evaluation, surveillance and research. The two sets of programmes should not only collaborate but also share their resources for planning and implementing these activities. They can work together to:

- educate clients on risk behaviours and prevention methods at the health-centre level and in the community, involving the public and private sectors alike
- offer counselling and confidential, voluntary testing for HIV to enable individuals to know their HIV status and be appropriately evaluated for antiretroviral treatment
- offer effective treatment for other established sexually transmitted infections to improve the quality of life of persons living with HIV and to reduce infectivity
- develop and implement strategies in order to improve access to appropriate, safe and effective medicines and condoms of high quality at affordable prices
- ensure that national investments in health systems infrastructure and commodity distribution systems contribute to improving the quality and accessibility of care for sexually transmitted infections, including HIV
- ensure a comprehensive prenatal care package that includes screening for infections such as HIV infection and syphilis.

Sexual and reproductive health

The interface between services for sexually transmitted infections and sexual and reproductive health is extensive. Both seek to improve the quality of life and, in particular, the sexual and reproductive life of women and men. The two sets of services engage in the following key areas of activity.

- Improving access to services for prevention and control of sexually transmitted infection. As antenatal, maternal and child health, and family planning clinics serve many women of reproductive age, they constitute a network of health facilities that have the potential to expand the reach and coverage for care of sexually transmitted infections to a significant segment of the general female population that would otherwise not be reached through specialized clinics and general curative medical services. Age-appropriate health education and counselling for these infections and their risk factors can be provided and help in further prevention of infection. Through the establishment of systematic screening programmes, women with asymptomatic infections could be detected and treated, and many adverse pregnancy outcomes of untreated infections avoided.
- Improving women's health. Sexually transmitted infections and reproductive tract infections contribute significantly to a woman's ill-health by increasing her risk of infertility, ectopic pregnancy, cervical cancer, spontaneous abortion and HIV infection. Prevention, detection and early treatment of sexually transmitted infections, therefore, constitute key elements in women's health services.
- Ensuring contraceptive choice and safety. As the presence of some sexually transmitted or reproductive tract infections restricts a woman's access to the full range of contraceptives, and since the contraceptive user may attribute the symptoms of such an infection to a side-effect of a particular contraceptive method (leading to decreased acceptance and discontinuation of contraceptive methods), screening and treatment of sexually transmitted infections, together with counselling on dual protection, are important elements in ensuring contraceptive choice and safety.
- Dealing with sexual and gender-based violence. Violence against women can have serious consequences for women's reproductive health, including the acquisition of sexually transmitted infections. Treatment of those infections and post-exposure prophylaxis for HIV after rape need to be offered. Gender-sensitive methods for partner notification in the case of a sexually transmitted infection need to be explored in order to avoid violence. There is a need to identify successful case studies of partner notification in different cultural settings, and at the same time to initiate operational research to learn how to conduct partner notification in a more acceptable manner across different sociocultural and religious settings.
- Screening and treatment for sexually transmitted infections. Screening and treatment can improve health outcomes following abortion, as the presence of an infection in the lower reproductive tract at the time of abortion is a risk factor for post-procedural complications. Therefore, pre-abortion management of these infections is an important step in preventing post-procedural infections.
- Incorporating gender-sensitive approaches. Services for sexually transmitted infections and sexual and reproductive health both face similar challenges of incorporating gender-sensitive approaches, in particular involving men, reaching marginalized or otherwise neglected populations (such as sex workers, substance users, the poor people in urban and rural areas,

migrant populations, displaced persons and refugees) and responding to adolescents' special needs.

- Preventing reproductive tract infections. These infections, other than those that are sexually transmitted, usually present with symptoms that can be mistaken for a sexually transmitted infection. The endogenous reproductive tract infections, e.g. bacterial vaginosis and candidiasis, result from alterations in the balance of normal, protective bacterial flora in a woman's reproductive tract. Bacterial vaginosis is the most prevalent reproductive tract infection in the world, and it is the most prevalent cause of vaginal discharge in developing countries. Up to 50% of pregnant women have been found to have bacterial vaginosis in sub-Saharan Africa. Bacterial vaginosis has been implicated as a cause of preterm birth, low birth weight, preterm pre-rupture of membranes, postpartum sepsis and spontaneous miscarriage. Bacterial vaginosis has also been implicated in the transmission of HIV infection. Education for the prevention of reproductive tract infections and their complications requires a common approach with services for control of sexually transmitted infections within reproductive health-care settings.
- Promotion of safe transcervical procedures. For example, clients should be checked or treated for endogenous or sexually transmitted infections before insertion of the contraceptive intrauterine device or termination of pregnancy, in order to avoid ascending bacterial contamination of the upper genital tract. Alternatively, women who select to use the intrauterine device should be encouraged to choose a different form of contraception if they consider themselves at risk of exposure to a sexually transmitted infection.
- Scaling up provision of existing and potential vaccines to prevent genital and liver cancers and some sexually transmitted infections. Collaboration and joint planning between programmes against sexually transmitted infections and those for sexual and reproductive health, within national immunization programmes, will facilitate the roll-out of existing and potential vaccines such as hepatitis B and human papillomavirus vaccines, and provide a ready channel for the introduction of any new vaccines.

In addition, sexual and reproductive health services are best positioned to ensure the health of women, neonates and children in collaboration with sexually transmitted infection programmes. Thus, sexual and reproductive health services should ensure the following:

- Health education to prevent HIV and other sexually transmitted infections, including their long-term sequelae such as pelvic inflammatory disease, infertility, ectopic pregnancy and genital cancers. Gender inequalities, culturally constructed roles and biological factors all contribute to women's and young people's vulnerability to infections. Recognizing the influence of ethnicity, culture, sexual orientation, geographical location (urban, rural or inaccessible remote locations), age and different life-skills is essential for better targeting and tailoring responses to the burden of sexually transmitted infections and their complications and long-term sequelae.
- Prevention of congenital syphilis. Effective prevention of congenital syphilis depends first on prevention of syphilis in pregnant women. If that fails, then secondary prevention involves screening for syphilis during pregnancy and providing adequate treatment for both the woman and her sexual partner. Given the high social and economic costs of congenital syphilis and the possibility of changes in the epidemiology of syphilis, prenatal syphilis screening followed by treatment of seroreactive women is a highly cost-effective intervention for the prevention of congenital syphilis and the complications of untreated syphilis in the parents, even in settings with prevalence rates of below 1%. Services should take the following actions:
 - Pregnant women should routinely be screened during their first prenatal visit, ideally before 28 weeks of gestation. In communities where the risk for congenital syphilis is high, a

policy to institute a second screening test at 36 weeks or at delivery should be considered. Clear national guidelines will need to be developed on clinical and serological follow-up for both mother and child.

- Discussion concerning treatment of sexually transmitted infections in sexual partners should be held and an assessment of the risk of reinfection should be made and appropriate action taken.
- As with other sexually transmitted infections, pregnant women found to have syphilis should be offered voluntary counselling and confidential testing for HIV. In high HIV prevalence settings, voluntary counselling and testing should be offered to all pregnant women.
- Prevention of neonatal blindness. Prophylaxis against ophthalmia neonatorum among neonates has been shown to be highly cost effective where the prevalence of gonorrhoea among pregnant women is 1% or more.
- Assessment and management of sexually exploited and abused children. Sexual exploitation and abuse of children and adolescents have come to be recognized as serious social problems that require the attention of policy-makers, educators, and a variety of professionals who deliver social and health care and basic social services when sexual exploitation or abuse is suspected. Screening and exclusion of a sexually transmissible agent, including HIV, should be performed by a trained child clinician following locally defined procedures and guidelines. A standardized approach to the management of sexually transmitted infections in children and adolescents who are suspected of having been sexually abused is important because the infection could be asymptomatic. Psychological and social support should be included for complete management of these young patients.

Adolescent health services

Sexually transmitted infections are a major health risk to all sexually active adolescents¹. Every year, one in 20 adolescents contracts sexually a bacterial infection, and the age at which infections are acquired is becoming younger. Most projects to improve sexual and reproductive health for adolescents have focused on sexual health counselling and family planning but have neglected care for sexually transmitted infections among their service-delivery objectives. Involving parents and young people at the appropriate age of maturity in the planning and implementation of interventions for them is crucial in making an impact on their behaviour. Programmes, including sexual and reproductive health services as part of primary health care, should, at a minimum, institute and provide the following basic interventions.

- Strengthening surveillance of sexually transmitted infections among adolescents and young people. Data need to be stratified by age and sex to enable an appropriate programme assessment and response to meet the needs of adolescents.
- Improving the awareness and knowledge of adolescents about sexually transmitted infections and their complications, and how to prevent them. Appropriate sexual education and consistent access to male and female condoms, with clear messages about correct and consistent use,

¹ WHO has defined adolescents as persons in the 10–19 years age group, while youth has been defined as the 15–24 years age group. “Young people” is a combination of these two overlapping groups, covering the range 10–24 years.

should be available to all who need them. This will lead to the common goal of improving the sexual health and well-being of adolescents.

- Improving adolescents' access to services. It is unlikely that one model for the delivery of care for sexually transmitted infections will suffice to meet the needs of all adolescents. Services can build on those that already exist, including: adult health clinics made youth-friendly through special training of health-care providers; sexual and reproductive health clinics dedicated to adolescents; "one-stop shops" where all health-care services for young people can be obtained; multi-purpose youth health centres; and age-appropriate school-based or linked services. However, new innovative formats such as mobile clinics might be required to reach the most vulnerable youth, including sex workers and street children, particularly during main festivals and events.

3.4.2 The private sector

Although free public-sector services are available even in most resource-poor countries, they might not always be acceptable to the clients or have appropriate health personnel or the necessary medicines available. The private sector or traditional healers and informal providers are frequently the first port of call for patients with sexually transmitted infections, even for those who believe that government health clinics are technically superior. Private providers, whether medically qualified or not, are more acceptable to many people because they are perceived to offer better access and confidentiality, and often have the reputation of being less stigmatizing than public sector facilities. Self-medication, following direct over-the-counter purchases from pharmacists, druggists and vendors, is also common.

Given this scenario, public policy and interventions should necessarily involve the private and informal sectors, and public-private partnerships should be established in the provision of care for sexually transmitted infections. Effective and appropriate regulatory measures should be taken by governments to ensure technical quality and accountability in the private sector services. Strategies for collaboration and quality control should be examined at the country level; these can include training of pharmacists and private practitioners on case management and national guidelines. Governments should explore how to establish formal relations for the promotion of appropriate care with pharmacists' unions, traditional healers' associations and other providers, depending on the setting and prevailing policies, laws and regulations. This should be done in collaboration with the communities themselves.

3.4.3 Community involvement

The involvement of the community in decisions that affect their health is important, and programmes to control sexually transmitted infections need to devise mechanisms for obtaining input from the whole community through appropriate representatives of civil society. This can best be achieved by forming partnerships with nongovernmental organizations, faith-based organizations, community-based organizations and the private sector. Communities should be educated about the availability, advantages and disadvantages of the different types of providers of care. Consumer advocacy groups can be established, and well-informed and discerning patients can also help to improve care. Consumers can be encouraged to use providers who adhere to predefined, agreed and well-publicized quality standards. Strategies to engage the community include the following activities:

- providing information in order to increase community awareness of the problem and increase community demand for interventions and services;
- holding ongoing consultations with the community;

- involving the community in the design and implementation of interventions;
- sharing accountability and responsibility with the community for programme outcomes;
- involving local political leaders and opinion-makers, including traditional and faith leaders, in advocacy for prevention and care of sexually transmitted infections.

Religious and faith-based organizations are often instrumental in shaping opinions, attitudes and behaviour of the followers of the faith and the community in general. In many places they are uniquely placed to provide health education on HIV and other sexually transmitted infections through their extensive networks that reach even the most remote villages and communities. These community-based organizations can be vital partners in promoting prevention, counselling, home care, clinical care and even advanced treatment as well as reducing stigmatization and discrimination. They should, therefore, be engaged in discussions on sexuality, gender and sexually transmitted infections, including HIV, in order to facilitate and enhance an environment for open discussion of these issues. Strengthening collaboration with, and capacity of, these organizations is important to ensure that they work more effectively in partnership with governments and others in the prevention and control of sexually transmitted infections.

3.4.4 Other partners

There are several other partners and stakeholders who should be included in the response to sexually transmitted infections, depending on the setting. These can include other government departments such as education and labour, sports and cultural authorities, police and border control officials, and private companies such as the transport and tourism industries, among others. Different strategies for prevention and control can be explored with them, including prevention and care in the education sector and the workplace. Mechanisms should be developed to encourage organizations to be accountable for such care. In some settings there is a need for cross-border collaboration to establish interventions among cross-border traders, temporary or permanent migrants, displaced persons and persons whose occupation puts them in a different place at one time or another in the course of their work.

3.5 Strengthening the capacity of health systems for effective service delivery

Health systems, broadly defined as comprising all the organizations, institutions and resources devoted to producing health actions, are a prerequisite to the establishment, delivery and monitoring of programmes on sexually transmitted diseases and the success of their outcomes. The capacity of each country's health system will largely determine the extent to which national programmes are able to provide high quality care with the largest geographical spread, reaching disadvantaged and targeted populations in order to achieve a measurable impact on reducing the burden of sexually transmitted and other reproductive tract infections, while preventing new infections. The ability to provide services in an equitable manner is an important consideration, particularly given the stigmatization that surrounds the primary prevention and treatment of sexually transmitted infections. In many resource-limited settings, health systems are overstretched, inadequately funded and ill-equipped to cope with the present and future demands for care. In strengthening health systems, a special focus must be placed on financing to ensure sustainability (including resource mobilization, pooling, allocation and payment), stewardship and regulatory guardianship (to ensure quality and equity) and public-private partnerships to extend the reach of the programme to the largest coverage possible.

In countries where health system reform is under way, efforts should be undertaken to ensure that services for people with sexually transmitted infections are considered in the process. Priority-

setting processes that are used to select an essential package of health interventions for primary care should reflect the significant contribution of these infections to the burden of reproductive ill-health. The goals of reform (improving quality, equity and client responsiveness – as well as sustainability and efficiency) must also take into consideration providers of health care for those with such infections. In particular, financing by the private sector and the effective engagement of the private sector should be used to expand access to care.

The health system response must be based on an analysis of the epidemiology of sexually transmitted infections, sexual risk behaviours and vulnerabilities, patterns of health-seeking behaviour and the skills and attitudes of health-care providers. Based on the findings of the analysis, a comprehensive programme for prevention and control should be developed to cover all the population groups for which interventions are required. Care-delivery strategies should be tailored to the needs of the particular population groups for whom they are intended. The programme should include a continuum of all aspects of prevention and control of sexually transmitted infections, including health promotion, curative services, linkages to family planning, sexual and reproductive health, immunization, HIV/AIDS and other services. It should expand the collaboration among its different partners, in both the public and private sectors, for a multisectoral response.

The programme should also include a plan for monitoring the impact of the implementation of the interventions. The provision of timely data on programme performance and impact will assist in securing resources for additional activities, and provide an evidence base for future programme directions.

3.5.1 Access to services

In most countries, patients with sexually transmitted infections have a choice of settings from which to seek care. Public providers compete with many different types of qualified and unqualified private providers and traditional practitioners. In both the public and private sectors, potential sources of care include specialized clinics, hospital outpatient departments of other specialties such as obstetrics and gynaecology, dermatology or urology, dispensaries and primary health-care centres, and family planning, maternal and child health and antenatal care clinics. The extent to which services are offered through primary care centres or specialized clinics will depend on the epidemiological, organizational and resource circumstances and should take into account the health-care seeking behaviours and preferences of the different subpopulations.

In many settings, the problem is one of an unmet need for good quality care for people with sexually transmitted infections. Providing a supply of care in the public sector does not necessarily lead to better coverage for priority populations, even when such services are of a technically superior quality and are offered free of charge. Additional factors need to be taken into account in order to achieve access to care, and a client-oriented approach should be adopted in all settings. Particular attention should be given to gender equity, adolescents, and poor and marginalized groups when planning the services. Services should be made more user-friendly by improving factors such as distance to residence, professionalism of health-care staff, privacy, confidentiality and reduction of waiting time. The private sector, including pharmacists and other dispensers of medicines, needs to be engaged and committed to providing good quality services, including measures for regulatory supervision and control. Communities and consumers should be educated on health matters in general and sexually transmitted infections in particular, by stressing the importance of having these infections diagnosed and treated by a trained health professional. The price or availability of medicines and condoms can be a barrier to access for some populations. Policies may need to be changed in order to improve the availability of medicines and options such as subsidies for poor people, widespread condom provision for all population subgroups, coverage of diagnostic expenses in health insurance schemes, and referral mechanisms for higher-level care may need to be considered. Outreach may improve access to care for hard-to-reach populations, where needed.

3.5.2 Quality assurance

Decentralization and privatization of the medical sector are two of the components of health sector reform embarked upon by governments. A key challenge for governments is ensuring quality in the large and rapidly growing private sector, about whose role and practices there is little information. Governments must fulfil the core public function of stewardship and put in place processes that ensure good quality of care for the population, both in the public and private sectors.

National guidelines for case management of sexually transmitted infections

In order to promote good-quality case management, guidelines based on identified patterns of infection and disease should be developed and disseminated to all providers of care related to sexually transmitted infections. The processes of elaborating, adopting and disseminating guidelines should involve representatives of both the public and private sectors. Training on the content and use of national guidelines should be imparted to both public sector health workers and private sector health-care providers.

A syndromic approach to management of sexually transmitted infections overcomes many obstacles to the provision of good-quality and efficient management, particularly (but not only) in resource-limited settings. Although desirable, etiological diagnosis for these infections is not feasible in many resource-constrained settings. National experts and committees should be consulted on the most appropriate strategy for management of sexually transmitted infections that will benefit all sectors of the population in need of care. A carefully planned and implemented mixture of protocols may be devised based on the financial, human and technical resources available and the burden of disease.

Licensing, certification and accreditation

Licensing of professionals and certification of facilities help to maintain the quality, safety and geographical distribution of health-care services. Licensing and certification not only apply to the health-service industry but also to the pharmaceutical and health-insurance industries. Effective government stewardship functions through these enforcement mechanisms, which are best established through strong ties with, and broad participation of, the private sector. Professional associations and other self-regulatory bodies that function outside of or in partnership with government are an essential element of regulatory and quality control.

Accreditation is a process of certifying that a facility meets certain standards, and is often linked to coverage of procedures by health insurance schemes. Provider licensing and certification supported by professional associations, as well as community-based consumer educational campaigns in local languages, can help to ensure standards for quality of care. There is an important role for accrediting pre-service and in-service training programmes in helping to ensure quality (including the monitoring of training curricula and requirements for continuing medical education).

Where the capacity to monitor and enforce regulations is limited or non-existent, as is the case in many resource-limited settings, national and local policy-makers should find incentives for rewarding good practice. Accreditation or other forms of recognition linked to payment modalities of private providers (including health insurance coverage) who provide comprehensive high-quality and reasonably-priced care for people with sexually transmitted infections is one possible incentive. Incentive payments can be linked to the obligation to provide data to health authorities on a regular basis, participation in continuing medical education, and willingness to have practices audited. Other incentives not linked to payments but of a financial nature could include access to subsidized medicines or other commodities (e.g. a condom social marketing programme), preferential access to

diagnostic and referral services, and options to participate in schemes which franchise or contract out service provision, such as vouchers or other forms of pre-payment given to the clients directly. Adherence to regulations can be enhanced by provision of adequate resources to regulatory bodies, a clear distinction of roles between regulators and those being regulated, and the establishment of consumer advocacy groups.

Peer review and self-regulation

Settings that have effective regulatory mechanisms in place are characterized by frequent dialogue in a range of different venues between government and professional associations in the private sector. Professional associations and provider networks can be called upon to exert peer pressure and promote self-regulation in partnership with government. For example, they can promote a high quality of service provision by their members through the introduction of professional points (or continuing education credits) for attending sessions and workshops that educate and update participants. However, several randomized controlled trials have found that continuing medical education programmes that are not linked to financial incentives or access to better working conditions have limited success in improving practice.

Supportive supervision and monitoring

Regular supervisory and monitoring visits to health facilities are an important component of ensuring the continued provision of good quality care and sustaining provider morale and motivation, as also demonstrated in the trial in Mwanza (United Republic of Tanzania). Such supervisory visits need not be confined to the public sector. They can be adapted to the private sector to maintain quality, provide continuing education and serve as a means of collaboration between the private and the public sectors. Supervisory visits need to adopt a facilitation process in order not to be a threat to the health-care providers, but rather a source of encouragement, and a means of updating health-care providers and constantly improving quality of care. Training of supervisors is important, so that they can reorient their skills to being supportive rather than judgemental and fault-finding.

Referral centres

Establishment of national and regional centres for referral of complicated cases and confirmatory diagnosis improves quality control. Referral protocols, specifying when and where to refer, should be part of the standard management protocols developed for all health workers involved in care for people with sexually transmitted infections. High drop-out rates among referred patients are common. Care should be taken not to send patients on long and expensive journeys to centres that have nothing extra to offer.

Active supervision and continuing medical education through feedback on cases and formal in-service training sessions help to build the links between the centres. Consultations and communication between health centre and referral centre by means of visits or radio link also facilitate the development of professional trust and confidence.

Most important, however, is the establishment of a programme at the district level with agreed goals and objectives, standard protocols, performance targets and annual or semi-annual review sessions. The link with the referral centre then becomes more comprehensive and interactive, which thereby establishes a more meaningful and motivational relationship among staff.

3.5.3 Financing services

Financing and payment are central functions for any health-care system, and involve four distinct functions: resource mobilization, resource pooling, resource allocation, and payment and purchasing. Although every health system carries out these functions, each will organize them differently, reflecting variation in institutional structures, societal expectations and systems of governance. Health system financing has a strong impact on programme coverage, equity and health outcomes.

Resource mobilization for activities for prevention and control of sexually transmitted infections is necessarily linked to that for HIV/AIDS programmes. Ensuring that adequate funds are devoted to prevention and control of other infections within the overall HIV/AIDS funding envelope is an essential aspect of both international and national fund-raising decisions, particularly given the need to scale up existing interventions for control of sexually transmitted infections. Given that prevention and control of those infections are part and parcel of HIV funding, policies relating to user fees for care of those with HIV and other sexually transmitted infections should be the same.

Shifting the responsibility of resource mobilization to the point of service delivery, through the introduction of user fees, must necessarily include exemption schemes for poor people. Universal coverage will be achieved if pre-payment systems such as health insurance or social health insurance are developed rather than relying on user fees. As countries move towards the creation or expansion of health insurance systems (public-provided, employment-based or privately purchased schemes and community-based pooling schemes), sexually transmitted infection programmes will need to ensure that their medical procedures are included in the benefit packages. In many resource-constrained countries, the cost of medicines is the largest portion of out-of-pocket expenses (those met by patients themselves rather than the health system or a health insurance) for an individual or household. Out-of-pocket expenditure for all medicines can be as high as 65% of total cost of medicines in sub-Saharan Africa and 81% in Asia. In industrialized countries it rarely exceeds 20%.

Adequate or reasonably adequate financial flows at every level of the system improve the responsiveness and effectiveness of service provision. In countries where such decisions are decentralized, financial allocations are often made at the local level, requiring the sexually transmitted infection programme manager to have effective lobbying presence and skills in elaborating and implementing a business plan. In general, public health-care clinics in resource-constrained countries are often poorly equipped and inadequately financed, resulting in low staff morale. Flexibility in designing and implementing different payment and purchasing options that respond to local conditions should be encouraged. Options from both the demand side (e.g. vouchers) and the supply side (e.g. incentive payments as salary supplements) need to be tried.

As many governments and donor agencies move towards sector-wide approaches to channel aid to the health sector, sexually transmitted infection programmes will be challenged to ensure that treatment and preventive activities are valued in the definition of the sector's goals and objectives. Through sector-wide approaches, funds are given to the entire health sector rather than to specific health projects, and ministries of health determine the priorities within the health sector. While this is intended to improve efficiency, there is a risk that funding for services for people with sexually transmitted infections, historically accorded a low priority in developing country health budgets, will be further curtailed.

3.5.4 Human resources development

Discussions about training in leadership, management and strategic planning, advocacy, commodity management, health information systems and other functional areas relevant to the

management of national programmes on sexually transmitted and reproductive tract infections are beyond the scope of this strategy, and should take place in the context of a broader development strategy for human capacity in the health sector. This section focuses on training health personnel in the delivery of care for people with sexually transmitted infections.

Projected personnel requirements for such services can be satisfied, to some extent, through the retention and retraining of existing health personnel and, in part, through recruitment and training of additional staff. Members of the programme team should be trained for their respective roles in management of different components of the programme. Health personnel should be trained according to their respective functional areas. For example, if health-care providers in antenatal care and family planning clinics are expected to provide care to people with sexually transmitted infections, their training should reflect this. Similarly, if physicians are expected to provide patient education and counselling, their training should be broadened to include these skills.

Medical schools and other tertiary educational institutions need to play a greater role in comprehensive training on sexually transmitted infections, including all the aspects of prevention, care and counselling, for physicians, nurses, laboratory workers, pharmacists and public health staff during their basic training. Training in syndromic approaches, their application to sexually transmitted infections, scientific basis and advantages and shortcomings should be incorporated in the respective curricula. A component on sexually transmitted infections should also be an essential feature of postgraduate medical training curricula in public health.

In-service training should be provided to all members of the health-care team, including clinicians, pharmacists and front-line workers such as clerks and receptionists. Training should not be limited to the biomedical aspects of case management but must also address provider attitudes and beliefs. Innovative approaches such as distance and computer-assisted learning should be explored.

Professional associations can play an important role in providing continuing medical education and skills updating, particularly to private sector providers, through training sessions, conferences, journal articles and mailings in the form of newsletters and self-instruction manuals.

Continuing retraining (refresher training) of staff should be based on the results of monitoring and evaluation of control of sexually transmitted infections and programmes for staff development. Skills for prevention and control should be enhanced in other sectors as well as within communities through strengthening capacities and building awareness. The role of community health workers in the management of sexually transmitted infections should be explored in settings where this cadre exists.

Albeit frequently neglected because of resource constraints, follow-up and supervision are crucial aspects of training and of ensuring quality of care.

3.5.5 Laboratory support for programme management

In many communities cost and inconsistent availability of supplies, test kits and expertise severely limit the practicality and availability of laboratory investigations of sexually transmitted infections. Even when such resources are available, the large numbers of cases of sexually transmitted infections and the degree of difficulty in identifying some of the organisms responsible, as well as frequent coinfections, make individual laboratory-based case management impractical and unreliable in many settings. Also, most laboratory tests take a considerable length of time to process, resulting in delays in treatment or loss to follow-up. Reliability of laboratory results compounds the problem further, as test kits for the same organism differ from one manufacturer to another, and performance of the same test can be subject to the experience of the technician and the specimen collection technique, as well as the storage and transport capacity of the health system. On account of these limitations,

laboratory support should be confined to situations where it is essential for programmatic or clinical decisions.

Good-quality laboratory systems should be established wherever laboratory-based diagnoses of sexually transmitted infections are made, either for the diagnosis of individual infections or for providing support for syndromic management. Appropriate training should be provided for all laboratory personnel, and clear guidelines should be given regarding which tests should be used by the laboratory, the interpretation of results obtained and expected turn-around times. Internal quality-control guidelines should be established and adhered to, and participation in external quality-assurance programmes encouraged.

Adequate laboratory support is important for an effective control strategy; clear guidelines should be defined, stipulating where laboratory facilities need to be strengthened and for what purpose. Laboratories should be established and strengthened at national and regional levels and, where feasible, laboratory support can be established at a local level. Such a network of laboratories can work together to strengthen services. To be cost effective, the network can identify clear roles and areas of responsibility, as recommended below:

National level

- conducting epidemiological, sentinel and etiological surveys to monitor disease trends and effectiveness of interventions
- validating and adapting flowcharts for recommendations and guidelines for syndromic management
- establishing national proficiency and quality control systems for the laboratory diagnosis of sexually transmitted infections
- providing training workshops for laboratory diagnosis of sexually transmitted infections
- evaluating performance and cost-effectiveness of new diagnostic tests
- collating data on antimicrobial susceptibility patterns and making recommendations
- at referral centres, establishing diagnosis in those cases that fail syndromic case management and those for medico-legal purposes (e.g. rape or sexual abuse)
- initiating or strengthening screening programmes, where feasible, for asymptomatic gonococcal and chlamydial infections, especially among target populations such as sexually active young women and men

Regional level

- conducting etiological surveys to monitor disease trends and effectiveness of interventions
- monitoring patterns of antimicrobial susceptibility
- supporting regional proficiency and quality control systems for the laboratory diagnosis of sexually transmitted infections
- providing training workshops for laboratory diagnosis of sexually transmitted infections

Local level

- supporting sentinel surveys
- providing routine serological testing for syphilis in pregnant women.

3.5.6 Procurement and logistics management

In order to function effectively, health personnel should have access to medicines, supplies (e.g. gloves, syringes and laboratory supplies), condoms and medical equipment (e.g. examination tables, examination light, screens for privacy, specula for vaginal examinations and sterilization equipment). Thus, the four basic elements of the logistics cycle to be considered are the following:

- selection of supplies to be stocked (requiring coordination with the national government's essential medicines programme in order to ensure that the required medicines and commodities are licensed by the country's national regulatory authorities and included in the country's essential medicines and commodities lists)
- a procurement strategy that seeks to ensure that supplies are purchased at competitive and affordable prices in an open and transparent process
- a distribution system that ensures that supplies reach the sites where they are needed on a regular basis (recognizing that most medicines used in treating sexually transmitted infections are commonly used to treat other infections)
- commodity management that ensures timely procurement, disbursement and replenishment of supplies.

Access to medicines for sexually transmitted infections is poor in many developing countries, affected by factors such as affordability, sustainable financing and erratic procurement, which lead to frequent shortages. Most medicines are generic and not prohibitively expensive, yet the cost is a significant contributor to the level of access in most developing countries. In fact, most of the medicines used in the treatment are not specifically for sexually transmitted infections but are used to treat other diseases. An analysis needs to be performed to identify the reasons for, and resolve the problem of, inconsistent supply of medicines for management of these infections. Strategies to expand access to the full range of such medicines can include using safe high-quality generic medicines, bulk purchasing to obtain the lowest price, differential pricing, financing strategies, and rationalizing the prescription of medicines (e.g. through the introduction of standardized protocols for management).

Other accompanying support mechanisms to promote access to medicines can be looked at and considered from region to region and country to country, and could involve policy formulation, innovation and regulatory mechanisms. Aspects to be considered could include:

- instituting a mandated multidisciplinary national body to coordinate medicine use policies and introduce appropriate and enforced regulations;
- establishment of medicines and therapeutic committees in districts and hospitals;
- problem-based training in pharmacotherapy in undergraduate curricula;
- continuing in-service medical education as a licensing requirement;

- public education in local languages about medicines;
- provision of independent medicine information for prescribers, other than that obtained solely from the pharmaceutical industry;
- supervision, audit and feedback of prescribers;
- sufficient government expenditure to ensure availability of medicines and staff;
- avoidance of financial incentives from industry to prescribers who use certain medicines.

3.6 Priority components for immediate action

As a priority, countries must implement or scale up the provision of care for those with sexually transmitted infections through key activities for which there is sufficient knowledge and evidence for impact and feasibility (Table 3, Priority 1 activities). These interventions have been implemented in many places with modest additional human and financial resources, but they have not been sufficiently scaled up for maximum impact at national level. Some components may be implemented within the “plan, do, assess and scale up” concept in order to gather more information, gain more knowledge and collect data, while providing service at the same time. For interventions that may require substantial additional human and financial resources, plans should be made to implement them in a stepwise manner as resources become available (Table 3, Priority 2 activities). Each component needs to take into account the transmission dynamics, sexual networks, vulnerable populations and service provision, while appreciating that a person with a sexually transmitted infection may present with or without symptoms at any of the many health facilities that exist in the country.

3.6.1 Good-quality case management

Comprehensive case management of sexually transmitted infections must have, as a minimum, the following components:

- correct diagnosis;
- effective treatment;
- health education and counselling for risk avoidance and risk reduction for sexually transmitted infections, including HIV infection;
- promotion and provision of condoms, and information on their correct and consistent use;
- notification and treatment of sexual partners.

There is enough evidence that syndromic management is effective and has had an impact on the epidemic of sexually transmitted infections in many care settings. For example, declines in incidence rates have been observed following introduction of control strategies based on the syndromic approach in several countries, including interventions among sex workers in Côte d’Ivoire, Senegal and South Africa, and in clinics for sexually transmitted infections in Burkina Faso and Kenya. At community level, impact has been demonstrated by studies in Uganda (Masaka) and the United Republic of Tanzania (Mwanza). This approach is particularly effective for urethral discharge in men and genital ulcer disease in both men and women.

Table 3.
Summary of actionable interventions for immediate implementation

Priority 1 activities	Indicators	National-level targets
<p>1. Build on success. Scale up of services for diagnosis and treatment of sexually transmitted infections (Use syndromic management where diagnostic resources are limited.)</p> <p>2. Control congenital syphilis as a step towards elimination.</p> <p>3. Scale up sexually transmitted infection prevention strategies and programmes for HIV-positive persons.</p> <p>4. Upgrade surveillance of sexually transmitted infections within the context of second-generation HIV surveillance.</p> <p>5. Control bacterial genital ulcer disease.</p>	<p>1(a). Proportion of primary point-of-care sites providing comprehensive case management for symptomatic infections.</p> <p>1(b). Proportion of patients with sexually transmitted infections at selected health facilities who are appropriately diagnosed, treated and counselled according to national guidelines.</p> <p>2. Proportion of pregnant women aged 15–24 years attending antenatal clinics with a positive serology for syphilis.</p> <p>3. Proportion of HIV-positive patients with sexually transmitted infections who are given comprehensive care including advice on condom use and partner notification.</p> <p>4(a). Number of prevalence studies regularly conducted (at sentinel sites or in sentinel populations) every three to five years.</p> <p>4(b). Annual incidence of reported sexually transmitted infections (syndromic or etiological reporting).</p> <p>5(a). Proportion of confirmed cases of bacterial genital ulcer disease among patients with genital ulcerative diseases.</p> <p>5(b). Percentage of pregnant women aged 15–24 years attending antenatal clinics with a positive serology for syphilis.</p>	<p>1(a). 90% of primary point-of-care sites provide comprehensive care for people with sexually transmitted infections by 2015.</p> <p>1(b). By 2015, 90% of women and men with sexually transmitted infections at health-care facilities are appropriately diagnosed, treated and counselled.</p> <p>2(a). More than 90% of first-time antenatal clinic attendees aged 15–24 years screened for syphilis.</p> <p>2(b). More than 90% of women seropositive for syphilis treated adequately by 2015.</p> <p>3(a). Strategies and guidelines on interventions for HIV-positive patients with sexually transmitted infections in place by 2010.</p> <p>3(b). 90% of primary point-of-care sites provide effective care to HIV-infected patients with sexually transmitted infections.</p> <p>4(a). At least two rounds of prevalence surveys conducted by 2015.</p> <p>4(b). Routine reporting of sexually transmitted infections established and sustained over at least five consecutive years by 2015.</p> <p>5(a). Zero cases of chancroid identified in patients with genital ulcer disease by 2015.</p> <p>5(b). Less than 2% of positive syphilis serology among antenatal clinic attendees aged 15–24 years.</p>

(Table 3, continued)

Priority 1 activities	Indicators	National-level targets
6. Build on success. Implemented targeted interventions in high-risk and vulnerable populations.	6(a). Health needs identified and national plans for control of sexually transmitted infections, including HIV, for key high-risk and vulnerable populations developed and implemented.	6(a). By 2010, health needs, policies, legislation and regulations reviewed; plans in place and appropriately selected country-specific targeted interventions implemented.
7. Implement age-appropriate comprehensive sexual health education and services.	6(b). Proportion of young people (aged 15–24 years) with infections that were detected during diagnostic testing for sexually transmitted infections.	6(b). At least two rounds of prevalence surveys conducted among groups with high-risk behaviour and among young people by 2015.
7. Implement age-appropriate comprehensive sexual health education and services.	7. Percentage of schools with at least one teacher who can provide life-skills-based education about prevention of HIV and other sexually transmitted infections.	7(a). Review of policies and development of age-appropriate training and information materials for schools completed by 2007.
8. Promote partner treatment and prevention of reinfection.	8(a). Proportion of patients with sexually transmitted infections whose partner(s) are referred for treatment.	7(b). Increased number of teachers trained in participatory life-skills-based HIV education that includes other sexually transmitted infections by 2015.
8. Promote partner treatment and prevention of reinfection.	8(a). Proportion of patients with sexually transmitted infections whose partner(s) are referred for treatment.	8(a). Plans and support materials for partner notification developed, and health-care provider training in place by 2010.
9. Support roll-out of effective vaccines (against hepatitis B and human papillomavirus and, potentially, herpes simplex virus type 2 infections).	9(a). Policy and plans for universal vaccination against hepatitis B.	8(b). The proportion of patients who bring in, or provide treatment to, their partner(s) doubled by 2010.
9. Support roll-out of effective vaccines (against hepatitis B and human papillomavirus and, potentially, herpes simplex virus type 2 infections).	9(b). Plans and policy reviews and strategies for use of human papillomavirus and potential herpes simplex virus type 2 vaccines.	9(a). Plans in place regarding vaccination against hepatitis B and human papillomavirus infection by 2008.
10. Facilitate development and implementation of universal opt-out voluntary counselling and testing for HIV among patients with sexually transmitted infections.	10. Proportion of patients assessed for sexually transmitted infections who are routinely counselled and offered confidential testing for HIV.	9(b). Pilot vaccination programmes initiated and scaling up in progress by 2010.
10. Facilitate development and implementation of universal opt-out voluntary counselling and testing for HIV among patients with sexually transmitted infections.	10. Proportion of patients assessed for sexually transmitted infections who are routinely counselled and offered confidential testing for HIV.	10(a). HIV testing and counselling available in all settings providing care for people with sexually transmitted infections by 2015. 10(b). The proportion of patients with sexually transmitted infections who receive voluntary counselling and testing for HIV doubled.

Syndromic management for urethral discharge and genital ulcer disease can be scaled up to cover at least 90% of relevant primary point-of-care sites and patients presenting with such conditions. The following are important in implementation:

- medicines logistics systems;
- training of health personnel;
- confidentiality;
- periodic validation of flowcharts in order to adapt them to the epidemiological patterns of sexually transmitted infections in a given setting;
- strategies for partner notification that include: notification of sexual partners by health-care providers; patient-delivered therapy, where applicable; use of the Internet, where applicable; and presumptive treatment of infections in sexual partners, especially those of symptomatic men.

3.6.2 Access to essential commodities and medicines

Access to an essential package of medicines and commodities is crucial for management, prevention and care, and should be maintained and improved. Every health-care facility that provides a service for control of sexually transmitted infections should have available, as a minimum, a 60-day reserve stock of the necessary commodities.

3.6.3 Interventions for high-risk and vulnerable populations

Interventions should be put in place and scaled up to increase access to care, depending on locally determined criteria and sensitive to local cultural values, for high-risk and vulnerable populations, including young people, sex workers, men who have sex with men, and injecting drug users, among others. A recent comparison of evidence-based HIV prevention activities ranked interventions targeted at female sex workers first in terms of efficiency ratio and effect and lowest in terms of cost and dependence on the health system. Given existing knowledge of what works best and with allowance for innovative approaches in some areas, priority areas for action for countries are proposed as follows:

- information about and interventions against sexually transmitted infections to reach at least 90% of persons identified as sex workers, male or female, and other locally determined priority vulnerable groups
- age-appropriate comprehensive sexual education in schools, including review, development and provision of evidence-based and skills-based prevention education for HIV and other sexually transmitted infections
- development and implementation of age-appropriate media-based educational interventions (e.g. information and education on sex and relationships, sexuality and correct and consistent condom use) in order to reach all young people and communities (through, for instance, Internet online chat rooms, mass media, advertisements, posters and postage stamps, and theatre with a focus on improved sexual behaviours)

- ensuring the availability of age-appropriate client-friendly health-care services, particularly for adolescents, through retraining of health-care providers and the implementation of client-centred policies for the provision of health care
- endorsement and support of efforts to control bacterial genital ulcer diseases and eliminate congenital syphilis through an integrated syphilis and genital ulcer disease control strategy, bearing in mind that:
 - elimination of congenital syphilis is becoming increasingly easy to implement at national level;
 - prevalence of chancroid is already decreasing in many countries, but more data and increased effort are needed for the areas where the disease remains endemic;
 - reducing genital ulcer disease prevalence involves many of the interventions that are important in HIV transmission
- targeted health education and counselling to prevent further transmission of HIV and other sexually transmitted infections, including:
 - counselling for patients with HIV, and voluntary HIV counselling and testing of patients with other sexually transmitted infections;
 - linking programmes on mother-to-child transmission of HIV with syphilis screening, and screening of other sexually transmitted infections where feasible, in order to ensure that the potential for congenital syphilis is detected and treatment is given concurrently with HIV care in order to reduce child mortality (Millennium Development Goal 4, target 5)
- facilitating, supporting and promoting universal vaccination against hepatitis B, especially in people with sexually transmitted infections and high-risk persons, and development of strategies for up and coming vaccines such as those against human papillomavirus and herpes simplex virus type 2 infections
- building partnerships for implementing this strategy, and implementing interventions horizontally in sexually transmitted infection/HIV, sexual and reproductive health, and other primary health care services, including developing policy and operational frameworks for horizontal implementation
- seeking additional technical and financial assistance from international and national organizations in order to meet targets and maintain quality of care.

3.6.4 Surveillance and data collection

Countries need to have at their disposal strategic information obtained through an assessment of the epidemiology of sexually transmitted infections and the response to the burden and needs. Accurate data enable strategic planning and provide information for advocacy and prioritization of interventions. As second-generation surveillance for HIV and other such infections has become increasingly feasible, countries should put in place a surveillance system that includes risk behaviour. Information and data should be collected from various population groups, including adolescents in and out of school and uniformed corps, such as the military and the police force.

3.6.5 An integrated approach to implementation: shared responsibilities

In order to accelerate accessibility of services to the population, a collaborative implementation of activities by different health disciplines at various levels of the health system is necessary. Table 4 summarizes key activities that can be undertaken collaboratively among programmes against HIV and other sexually transmitted infections and for sexual and reproductive health and ministries of education and labour. At national level some health implementers can be recruited into this collaborative approach to preventing and controlling sexually transmitted infections, with appropriate local adaptation. These may include women's groups, clubs, community associations and religious institutions.

4. THE ADVOCACY STRATEGY: MOBILIZING POLITICAL AND SOCIAL LEADERSHIP AND FINANCIAL RESOURCES

4.1 Advocacy

However good the technologies and interventions that are available, they are of no benefit to the population without the political will and resources to sustain their implementation. The stigmatization associated with sexually transmitted infections prevents public discussion and community involvement around the issue of their prevention and care. Having such an infection is still considered socially unacceptable, and there are limited patient-based constituent groups who advocate publicly or lobby for programmes related to sexually transmitted infections. Advocacy needs to occur at both the country and global levels to put control of these infections high on the health agenda. Furthermore, strong leadership (with support from civil society), a clear vision and clear messages, strategies and interventions (with a solid science base) are required to inspire action. Advocacy will be enhanced by:

- documenting the situation strategically and packaging the messages;
- identifying key constituencies that can influence policies and resource allocation;
- creating multidisciplinary and multisectoral coalitions and networks to influence decision-makers.

At the country level, advocacy should promote enabling policies and legislation. Existing regulations and legislation should be reviewed to assess their utility and contribution to prevention and care policy, goals and objectives relating to sexually transmitted infections. Consideration should be given to reforming policies and legislation that obstruct the goals of prevention and care according to sound scientific evidence.

Advocacy efforts can build on the experience and lessons learnt from other successful advocacy campaigns such as those for immunization programmes, poliomyelitis eradication, Stop TB, Roll Back Malaria, and tobacco control.

Table 4.
A guide to collaborative implementation of interventions for prevention and control of sexually transmitted infections

Programme	Primary, prioritized core activities	Collaborative activities
HIV/AIDS	<ul style="list-style-type: none"> • HIV/sexually transmitted infection prevention and care • Condom promotion • Positive prevention • Voluntary HIV counselling and testing • Second-generation surveillance with indicators for sexually transmitted infections • Monitoring and evaluation • Operational research 	<ul style="list-style-type: none"> • Sexual health • Targeted interventions for HIV and sexually transmitted infection prevention and care • Promotion of syndromic management of sexually transmitted infections
Sexually transmitted infections	<ul style="list-style-type: none"> • Guidelines, curriculum development and integration, training, quality assurance • Syndromic management in sexually transmitted infection clinics • Partner treatment guide and plan • Condom promotion • Surveillance for sexually transmitted infections • Targeted interventions for prevention and control of sexually transmitted infections • Monitoring and evaluation • Operational research and cycle of “plan, do, assess and scale up” 	<ul style="list-style-type: none"> • Sexually transmitted infection prevention among persons with HIV • Antenatal syphilis screening • Second-generation surveillance • Voluntary HIV counselling and testing in sexually transmitted infection services
Sexual and reproductive health	<ul style="list-style-type: none"> • Antenatal syphilis prevention and care • Condom promotion for dual protection against sexually transmitted infections and pregnancy • Age-appropriate sexual health guidelines • Treatment for sexually transmitted infections in reproductive health settings • Monitoring and evaluation • Operational research and cycle of “plan, do, assess and scale up” 	<ul style="list-style-type: none"> • Second-generation surveillance
Ministerial (education and youth)	<ul style="list-style-type: none"> • Age-appropriate comprehensive sexual health education and services, including production of information materials in local languages 	<ul style="list-style-type: none"> • School health centres, where feasible
Ministerial (labour, tourism, and other)	<ul style="list-style-type: none"> • Workplace interventions with peer education and information • Screening for and treatment of sexually transmitted infections 	<ul style="list-style-type: none"> • Health clinics with capacity to screen for and treat sexually transmitted infections

4.2 Working with the media

Public health has become news, and the media are now covering health issues and disease threats in an unprecedented fashion. The field of sexually transmitted infections needs to attract more positive media coverage and more proactive work needs to be done with the media. Success stories that emphasize positive achievements are a key component of strong communication. Partnerships with key media representatives should be built in order to promote the goals of the global strategy, and include:

- building the capacity of media personnel to develop and promulgate supportive messages;
- improving the public's perception of prevention, control and care related to sexually transmitted infections;
- helping to mobilize political will;
- helping to diminish stigmatization in society and communities;
- communicating prevention messages and raising awareness about the devastating consequences of sexually transmitted and other reproductive tract infections.

4.3 Building effective partnerships

A broad-based approach that engages multiple partners and sectors should be adopted because the goals of prevention and control of sexually transmitted infections can be achieved only by joining forces. It is therefore crucial to create strategic alliances and coalitions between the private and public sectors, multilateral and bilateral aid agencies, organizations in the United Nations system, the pharmaceutical industry, the media, professional and civil society organizations, and academic and other institutions. Partnerships can increase the visibility, momentum and effectiveness of prevention and care efforts by uniting diverse elements, working synergistically and reducing unnecessary duplication of efforts.

Specific areas and issues for partners to rally around include:

- the control of specific sexually transmitted infections and their complications, such as the elimination of congenital syphilis and the control and elimination of chancroid;
- expanding access to, and the range of, appropriate technologies for prevention and care, such as rapid diagnostic tests for and vaccines against sexually transmitted infections, and female-controlled barrier methods, including microbicides;
- ensuring access to safe and effective, high-quality medicines for treatment of sexually transmitted infections and other essential commodities at affordable prices;
- complementary interventions, such as the prevention of mother-to-child transmission of HIV and syphilis in order to ensure that babies are born free of both infections.

The development of interregional collaboration, regional networks of expertise and experience, provision of regional assistance and the development and strengthening of regional “centres of excellence” are all important and relevant strategies to strengthen national programmes.

4.4 Mobilizing financial resources

In order to implement the strategy there needs to be a mechanism to mobilize additional resources. For developing or resource-limited countries, various sources can be explored. For example, there are resources linked to the Global Fund to Fight AIDS, Tuberculosis and Malaria; countries should take the opportunity to develop proposals for the Global Fund that include strategies to control sexually transmitted infections. At the global level, international agencies should intensify discussion to facilitate provision of funds for sexually transmitted infection control through such mechanisms. There are also other opportunities, such as foundations that have an interest in sexually transmitted infection control in general or for specific populations or interventions. At the national level, wherever sector-wide approaches are an approved funding mechanism, advocacy strategies for adequate resource allocation for programming for the prevention and control of sexually transmitted infections should be developed.
