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FIFTY-EIGHTH WORLD HEALTH ASSEMBLY  
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## Implementation of resolutions (progress reports)

### Report by the Secretariat

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## A. PREVENTION AND CONTROL OF IODINE DEFICIENCY DISORDERS<sup>1</sup>

1. During the past decade considerable progress has been made towards eliminating iodine deficiency and the number of countries where it is a public health problem has more than halved since 1993 to 54 in 2004. Iodine intake is now adequate or more than adequate in 72 countries,<sup>2</sup> although it is excessive in five of those countries, thereby exposing susceptible groups to a risk of hyperthyroidism. Iodine intake is still insufficient in 54 countries, but data are unavailable in 66 countries (representing only 9% of the world's population). Overall, 2000 million people have insufficient iodine intake, mostly in the South-East Asia, European and Western Pacific regions.

2. The main strategy for prevention and control of iodine deficiency is universal salt iodization. In high-risk communities that are unlikely to have access to iodized salt, iodized oil is recommended. More than 100 countries now have a salt iodization programme compared with only a few in the 1990s, and iodized table salt is consumed by 67% of households worldwide. This proportion is above 90% in 28 countries compared to 19 five years ago.<sup>3</sup> In most countries the use of iodized salt in processed foods is not mandatory or even regulated.

3. Monitoring iodine concentration in salt requires collaboration between the health sector and the salt industry. Intercountry workshops, cosponsored by WHO, UNICEF and The Micronutrient Initiative, have been organized to sensitize and mobilize salt producers.<sup>4</sup> Test kits used to monitor salt iodine levels are being evaluated by WHO and UNICEF with the support of the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America). Because, in many countries with iodine deficiency control programmes, laboratory facilities are often insufficient to monitor iodine status, the International Resource Laboratories for Iodine network was established in 2001 in order to strengthen the capacity of laboratories accurately to measure the iodine content of urine and salt. In each WHO region there is at least one resource laboratory participating in the network, and in which regional training sessions have been organized.<sup>5</sup>

4. In 2002, with the technical support of the International Council for Control of Iodine Deficiency Disorders, WHO and UNICEF began evaluating national programmes to assess achievements of the goal of elimination of iodine deficiency disorders as a public health problem. Thirteen programmes have thus far been reviewed.<sup>6</sup>

5. Collaboration among sectors involved in control of iodine deficiency is crucial for success. By 2000, national intersectoral committees had been established in 81% of countries and in 2002 the

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<sup>1</sup> This report is submitted in accordance with resolution WHA52.24.

<sup>2</sup> Iodine intake, derived from median urinary iodine concentration (UI), may be "adequate" ( $100 \mu\text{g/l} < \text{UI} < 199 \mu\text{g/l}$ ), "more than adequate" ( $200 \mu\text{g/l} < \text{UI} < 299 \mu\text{g/l}$ ) or "excessive" ( $\text{UI} > 300 \mu\text{g/l}$ ); WHO Global Database on Iodine Deficiency, 2004 (<http://whqlib.doc.who.int/publications/2004/9241592001.pdf>).

<sup>3</sup> UNICEF Global Database on Iodized Salt Consumption, 2000-2003 (<http://www.childinfo.org/eddb/idd/database.htm>).

<sup>4</sup> Kenya (Mombasa, 2000), Thailand (Bangkok, 2000), Ukraine (Kiev, 2001), Russian Federation (Moscow, 2002).

<sup>5</sup> Australia, China, Guatemala, India, Islamic Republic of Iran, South Africa.

<sup>6</sup> Bhutan, Cambodia, China, Indonesia, Lao People's Democratic Republic, Malaysia, Mongolia, Panama, Peru, Thailand, The former Yugoslav Republic of Macedonia, Turkmenistan, and Viet Nam.

Network for Sustainable Elimination of Iodine Deficiency<sup>1</sup> was created to support national efforts to accelerate elimination of iodine deficiency disorders by promoting collaboration among public and private sectors, and scientific and civic organizations. Regional conferences<sup>2</sup> were convened to mobilize and strengthen collaboration with major partners.

6. Eliminating iodine deficiency disorders is a key public health goal because of its consequences for social and economic development and achievement of United Nations Millennium Declaration's health-related goals. The challenge is to reinforce salt iodization programmes in the remaining 54 affected countries while ensuring the long-term sustainability of control programmes in the others. The main constraints are related to delivery of iodized salt, especially to the most vulnerable populations, commitment of small salt producers, programme monitoring, and adequacy and enforcement of relevant legislation.

## **B. SCALING UP TREATMENT AND CARE WITHIN A COORDINATED AND COMPREHENSIVE RESPONSE TO HIV/AIDS**

7. In response to requests from Member States, WHO's Secretariat fielded 31 teams to help to expand access to antiretroviral treatment and strengthen prevention programmes. Consistent with the global health-sector strategy for HIV/AIDS, WHO's technical support promotes a comprehensive health-sector response, to ensure that improvements to health infrastructure strengthen health systems overall.

8. Donors have committed 83% of the amount needed for WHO to implement its HIV/AIDS programme in the current biennium. Some 87% of resources have been allocated to activities at country and regional levels, compared with 34% in the previous biennium. Staff have been recruited in more than 40 countries – half in the African region – to help scale up activities.

9. Detailed data and maps of health-service coverage are being generated in selected countries. Support is being provided for improving national HIV/AIDS surveillance systems, including through training and development of tools. WHO's Secretariat also works with the Global HIV Drug Resistance Surveillance Network, linking laboratory technicians, clinicians and epidemiologists in order to monitor and respond to the potential emergence of HIV drug-resistance.

10. The Secretariats of WHO and UNAIDS have established a joint task force to track accurately the number of people receiving antiretroviral treatment, and to disaggregate the data by gender and age in order to determine equity in scaling up treatment. Policy guidelines have been issued for programme managers on issues relating to ethics, equity and accessibility of antiretroviral treatment.<sup>3</sup>

11. Access of developing countries to pharmaceutical and diagnostic products should be improved through the AIDS Medicines and Diagnostics Service, a collaborative undertaking between WHO and

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<sup>1</sup> With representatives from WHO, UNICEF, Centers for Disease Control and Prevention and Emory University (United States of America), International Council for the Control of Iodine Deficiency Disorders, The Micronutrient Initiative, Kiwanis International, EuSalt, the Salt Institute and the Chinese Salt Industry Association.

<sup>2</sup> Cosponsored by WHO, UNICEF, International Council for the Control of Iodine Deficiency Disorders and The Micronutrient Initiative in China (Beijing, 2003), Peru (Lima, 2003) and Senegal (Dakar, 2004).

<sup>3</sup> *Guidance on ethics and equitable access to HIV treatment and care*. Geneva, World Health Organization, 2004.

such partners as UNICEF, World Bank, UNFPA, and the International Dispensary Association. A prequalification project, managed by WHO's Secretariat, provides support for procurement of high-quality medicines for HIV/AIDS treatment. Products are assessed for safety, efficacy and quality, and sites manufacturing active ingredients and finished pharmaceutical products are inspected, as are research organizations contracted to conduct bio-equivalence studies. WHO's Secretariat has begun to issue product assessment reports, and the results of manufacturing-site inspections will soon be available.<sup>1</sup>

12. WHO's Secretariat has set up a new task force on HIV-tuberculosis which aims to provide support for integration of antiretroviral treatment into well-functioning national tuberculosis programmes in several countries, and to document and expand successful approaches.

13. WHO's Secretariat and partners have developed a clinical-care training package for integrating antiretroviral treatment into primary health care at first- and second-level facilities.<sup>2</sup> It should help in the transfer of treatment and care from physicians to nurses and other health-care workers, and to encourage involvement of community members, people living with HIV/AIDS and other laypersons in care. WHO's Secretariat is helping to assure its rapid application and to establish pools of regional experts to collaborate in training.

14. In order to improve coordination and assure consistency with the "Three Ones" principle, the Secretariats of WHO, UNAIDS, and other UNAIDS cosponsors launched a project to demonstrate model, intensified collaboration, initially in 10 of the countries on which "3 by 5" focuses. WHO's Secretariat continues to collaborate with the World Bank's Multi-country HIV/AIDS Program and its Regional HIV/AIDS Treatment Acceleration Project, and to provide technical support for drawing up proposals for, and using financing from, the Global Fund to Fight AIDS, Tuberculosis and Malaria. Special support has been given to increase implementation in poorly performing countries.

15. Several guidelines have been issued, including on antiretroviral treatment for women living with HIV and prevention of HIV infection in their infants, appropriate nutrition for these women, and technology for rapid HIV testing in resource-poor settings.<sup>3</sup>

16. In January 2005, WHO and UNAIDS released the second progress report on the "3 by 5" initiative,<sup>4</sup> which noted that the December 2004 milestone had been met: an estimated 700 000 people in developing countries were receiving antiretroviral treatment at that time. At its 115th session, the Executive Board considered a progress report on implementation of resolution WHA57.14. Members commended the creation of the HIV/AIDS and health systems platform to identify obstacles in health systems to expanding treatment and care and to anticipate or respond to the impact on the rest of the system. They commented on the need for more data for monitoring progress and to strengthen countries' technical capacity.<sup>5</sup>

17. WHO, UNAIDS and the World Bank co-hosted an international consultation in February 2005 to discuss sustainable financing of life-long HIV treatment and care, including the impact of user fees,

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<sup>1</sup> WHO Public Assessment Reports and WHO Public Inspection Reports, respectively.

<sup>2</sup> Integrated guidelines for ART in the context of primary health care. Document WHO/CDS/IMAI 2004.1-2004.5.

<sup>3</sup> Accessible at [www.who.int/3by5/publications](http://www.who.int/3by5/publications).

<sup>4</sup> World Health Organization. "3 by 5" progress report. Geneva, World Health Organization and UNAIDS, 2005.

<sup>5</sup> See document EB115/2005/REC/2, summary record of the twelfth meeting, section 6.

and policies for ensuring long-term programme and system sustainability. Countries are now being supported in drafting long-term financing strategies that ensure that the resources for HIV/AIDS contribute to gains for the health system overall. The HIV/AIDS and health systems platform is instrumental in this support and is also assisting in the formulation of longer-term national human resources strategies for the health sector. WHO's Secretariat has also refined the model approach to HIV/AIDS treatment by defining the minimum package of interventions needed for long-term management of HIV/AIDS, with better integration of prevention into service delivery.

### **C. TRADITIONAL MEDICINE**

18. Resolution WHA56.31 urged Member States to adapt, adopt and implement, as a basis for national programmes, WHO's strategy for traditional medicine including its four main objectives of framing policy; enhancing safety, efficacy and quality; ensuring access; and promoting rational use.<sup>1</sup> It also requested the Director-General to report to the Fifty-eighth World Health Assembly on progress made in implementing the resolution.

#### **Framing policy**

19. In order to obtain baseline information for monitoring progress, the WHO Secretariat conducted a global survey on policies for traditional medicine and complementary/alternative medicine, and regulations on herbal medicines, in 2003. On the basis of the findings,<sup>2</sup> the Secretariat compiled a global database, comprising information provided by 141 Member States, which will be made accessible to national health authorities. Currently, 45 Member States have a relevant national policy; 51 Member States are in the process of formulating one.

#### **Enhancing safety, efficacy and quality**

20. Herbal remedies are the most popularly used therapy in traditional and similar medicine. National regulation is the key to ensuring their quality and safe and effective use. The Secretariat organized, in all regions, seven regional or national training workshops aimed at strengthening national capacity in the regulation of herbal medicines, in which representatives of 85 Member States participated. Subsequently, the African, South-East Asia and Eastern Mediterranean Regions drew up regional minimum requirements on regulation of herbal medicines. Herbal medicines are currently regulated in 92 Member States, and 42 more plan to establish regulations. A harmonized regional or subregional approach to regulation has been further refined in the Region of the Americas, and the South-East Asia, Europe and Western Pacific regions.

21. The Secretariat continues to prepare new guidelines and update existing ones in order to improve the quality of herbal medicines and to monitor their safety.<sup>3</sup> Such material includes guidelines

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<sup>1</sup> WHO traditional medicine strategy 2002-2005. Document WHO/EDM/TRM/2002.1. Available in the meeting room and accessible at <http://www.who.int/medicines/library/trm/strategytrm.shtml>.

<sup>2</sup> Summary report on WHO global survey on national policy on traditional medicine and regulation of herbal medicines (in press).

<sup>3</sup> WHO guidelines on safety monitoring of herbal medicines in pharmacovigilance systems. Geneva, World Health Organization, 2004. Available on request and accessible at [http://www.who.int/medicines/organization/trm/guidelines/herbal\\_medicines\\_summary.shtml](http://www.who.int/medicines/organization/trm/guidelines/herbal_medicines_summary.shtml).

on safety monitoring of herbal medicines in pharmacovigilance systems, and on contaminants and residues; the supplementary guidelines to Good Manufacturing Practices for herbal medicines is being updated.

22. In order to provide guidance to Member States the Secretariat, together with WHO collaborating centres for traditional medicine, other relevant research institutions,<sup>1</sup> and nongovernmental organizations, has initiated the collation of evidence-based information on the efficacy and safety of traditional and similar therapies, including, for example, for the treatment of SARS.<sup>2</sup>

### Ensuring access

23. WHO guidelines on good agriculture and collection practices for medicinal plants were published in collaboration with other organizations of the United Nations system and nongovernmental organizations<sup>3</sup> in 2003. They aim both to promote the conservation and sustainable use of medicinal plants, and to contribute to quality assurance and control of herbal medicines. They are already being used by several Member States as a basis for national guidelines, and by UNCTAD in its training projects. The Secretariat is also preparing similar guidelines on *Artemisia annua* L. in order to support artemisinin-based combination therapies. Guidelines on the conservation of medicinal plants that had been prepared in collaboration with several nongovernmental organizations are being updated.

### Promoting rational use

24. **Rational use by providers.** Several governments have taken steps to ensure the safe practice of traditional medicine. For example, traditional medicine is being included in mandatory undergraduate curriculums in medical schools; WHO's training guidelines serve as a basis for national requirements for physicians to practise acupuncture;<sup>4</sup> and national legislation is being drafted requiring licensed practice of traditional and similar medicine.

25. WHO basic training guidelines are in preparation on chiropractic manual therapies and phytotherapies. Further volumes of WHO monographs on selected medicinal plants are being issued.<sup>5</sup> The Secretariat is supporting the drafting of monographs on commonly used medicinal plants in Newly Independent States.

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<sup>1</sup> Fifty-seven countries have national expert committees on traditional and similar medicines, 37 have a research institute on traditional medicine, and 43 have a research institute on herbal medicines.

<sup>2</sup> *SARS clinical trials on treatment using a combination of traditional Chinese medicine and Western medicine*. Geneva, World Health Organization, 2004. Accessible at [http://whqlibdoc.who.int/publications/2004/9241546433\\_\(1862KB\).pdf](http://whqlibdoc.who.int/publications/2004/9241546433_(1862KB).pdf).

<sup>3</sup> *WHO guidelines on good agricultural and collection practices (GACP) for medicinal plants*. Geneva, World Health Organization, 2003. Available in the meeting room and accessible at <http://www.who.int/medicines/library/trm/medicinalplants/agricultural.shtml>.

<sup>4</sup> Accessible at <http://www.who.int/medicines/library/trm/acupuncture/who-edm-trm-99-1/who-edm-trm-99-1en.shtml>.

<sup>5</sup> Existing monographs are accessible at <http://www.who.int/medicines/library/trm/medicinalplants/monographs.shtml>.

26. **Rational use by consumers.** The Secretariat issued guidelines as support to countries in providing reliable information on traditional and similar medicine to consumers.<sup>1</sup> They are intended to enable consumers to make informed decisions on the use of such medicine.

### **Further action**

27. Despite significant progress on proper use of traditional medicine, the global survey also identified both common problems and country-specific needs. Through the survey a number of Member States have requested the WHO Secretariat to continue providing technical support in line with its strategy on traditional medicine.

## **D. IMPLEMENTING THE RECOMMENDATIONS OF THE *WORLD REPORT ON VIOLENCE AND HEALTH***

28. Resolution WHA56.24 urged Member States to promote the *World report on violence and health*,<sup>2</sup> appoint a focal point in the ministry of health for violence prevention, and prepare a national report on violence and violence prevention. It also requested the Director-General to cooperate with Member States in implementation of measures to prevent violence.

29. A guide has been published which details action steps for carrying out the recommendations made in the report.<sup>3</sup> This and other violence prevention tools have been actively disseminated as part of WHO's Global Campaign for Violence Prevention.

30. Member States in all regions have promoted the report through national launches and violence prevention workshops involving government departments, nongovernmental organizations, research agencies and organizations of the United Nations system. As of February 2005, more than 40 countries had launched the report, more than 50 countries had nominated health ministry focal points; four countries had prepared national reports on violence and health and another 14 had made plans to prepare such reports in 2005-2006.

31. Guidelines have been prepared with WHO's global partners for surveillance and conduct of surveys of violence-related injuries, for the documentation of violence prevention programmes, for implementing the report's recommendations, and for teaching violence and injury prevention to diverse training audiences in different settings. The WHO Secretariat has collaborated with experts in all regions to prepare guidelines for essential trauma care and for medico-legal services for victims of sexual violence. WHO published a report on the economic dimensions of interpersonal violence,<sup>4</sup> and is preparing a manual for estimating the economic burden of violence with the Centers for Disease Control and Prevention in the United States of America.

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<sup>1</sup> Accessible at <http://www.who.int/medicines/library/trm/medicinalplants/consumer.shtml>.

<sup>2</sup> *World report on violence and health*. Geneva, World Health Organization, 2002.

<sup>3</sup> *Preventing violence: a guide to implementing the recommendations of the World report on violence and health*. Geneva, World Health Organization, 2004.

<sup>4</sup> *The economic dimensions of interpersonal violence*. Geneva, World Health Organization, 2004.

32. The Secretariat is collaborating with government departments in several countries to establish violence prevention programmes at national and local level. It has initiated research to support evidence-based approaches to violence prevention and victim services. A project to document violence prevention programmes is under way in several countries, and programmes for preventing armed violence in Brazil and El Salvador are being evaluated by a joint WHO/UNDP project. WHO's multi-country study on violence against women has involved eight countries in four WHO regions. Several countries are conducting situation analyses in order to improve medical and legal services for victims of sexual violence.

33. The Global Interpersonal Violence Prevention Alliance, founded in January 2004 by several Member States and institutions, is integrating a science-based approach to violence prevention in international development cooperation and provides a global network for information sharing and capacity development. An international consortium of groups representing civil and scientific society is establishing an international society for violence and injury prevention. The Secretariat has continued to facilitate collaboration among secretariats of other organizations of the United Nations system working to prevent violence, and in 2004 built a web site to disseminate information about violence-prevention resources in the system.<sup>1</sup> WHO's Secretariat participates with the secretariats of UNICEF and the Office of the High Commissioner for Human Rights in the steering committee of the United Nations Secretary-General's study on violence against children. WHO collaborated with the Council of Europe to draw up a resolution and recommendations for the prevention of violence in everyday life, which were adopted in November 2004. In 2003 the African Union endorsed the recommendations of the report and requested Member States to declare 2005 the African Year of Prevention of Violence.<sup>2</sup> The WHO Secretariat is working with the secretariat of the African Union on initiatives to mark the Year; objectives for the Year include the preparation of a report on violence and health in Africa and a long-term prevention strategy.

34. Although achievements in awareness raising, preparation of guidelines and integration of the recommendations on violence prevention into policy processes have been considerable, these activities need to be strengthened, together with implementation of applied prevention programmes. Member States are encouraged to appoint focal points and to prepare national reports if they have not done so, and to continue to invest in developing the multisectoral systems and services outlined in the report. The WHO Secretariat will continue to provide leadership and technical support through continued drafting of guidelines, provision of technical support to countries, and organization of biennial review meetings, the next of which is scheduled for October 2005 in the United States of America.

## **E. STRATEGIC APPROACH TO INTERNATIONAL CHEMICALS MANAGEMENT**

35. In resolution WHA56.22, Member States were urged to take full account of the health aspects of chemical safety in further development of the strategic approach to international chemicals management. The resolution also asked the Director-General to contribute to the content of that approach and for WHO to participate in preparatory meetings and the final conference. He was also requested to submit both a progress report and the strategic approach, when completed, to the Health Assembly.

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<sup>1</sup> [www.who.int/violence\\_injury\\_prevention/violence/activities/un\\_collaboration](http://www.who.int/violence_injury_prevention/violence/activities/un_collaboration).

<sup>2</sup> Decision EX/CL/Dec.63(III).



36. Manufacture of chemicals accounts for 7% of global income and 9% of international trade. Tens of thousands of chemicals are traded, yet for only a few are even basic toxicity data available. The contribution of chemicals to the global burden of illness, disease and death remains largely unmeasured. The manufacturing base for industrial chemicals is shifting to developing countries, bringing new patterns and levels of exposure to their populations. By 2020, developing countries will account for more than 30% of the global production of chemicals, compared to 20% in 1995.

37. In 1980, WHO, with ILO and UNEP, recognized the need to establish the scientific basis for the safe use of chemicals and to strengthen national capabilities for chemical safety through the establishment of the International Programme on Chemical Safety. The need for an authoritative scientific basis and evidence for the effects of chemicals on human health remains, but now there is an overriding need for effective communication about the risks of chemicals and advocacy for chemical safety in the context of public health. Although WHO has been active in the field of chemical safety through the International Programme, the health sector generally has been somewhat peripheral to the processes of negotiation of international conventions and formal agreements on chemical safety, to which technical assistance for countries is linked. The strategic approach therefore represents a crucial opportunity for WHO and its global health partners to provide support to countries in achieving the goals agreed at the World Summit on Sustainable Development (Johannesburg, South Africa, 25 August – 4 September 2002).

38. Two sessions of the Preparatory Committee for the Development of a Strategic Approach to International Chemicals Management have been held (Bangkok, 9-13 November 2003 and Nairobi, 4-8 October 2004), and attended in total by 146 countries, 13 United Nations bodies and convention secretariats, six intergovernmental organizations and 32 nongovernmental organizations. Participants supported the coordinated health sector input facilitated by WHO.

39. At the second session, it was agreed that the strategic approach should comprise: a high-level declaration, statements of policy and a global programme with concrete actions and targets. The timelines for those actions would extend to 2020, reflecting the target agreed at the World Summit on Sustainable Development for sound management of chemicals. A broad scope is proposed including economic, environmental, health, labour and social aspects of chemical safety. Member States have emphasized the need for health sector participation in implementing the strategic approach and for chemicals management to be integrated into the mainstream of health policies, including those developed in support of the Millennium Development Goals. High-level priorities expressed by the health sector to date (each of which encompasses specific objectives) include:

- actions to improve 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 the effects of chemicals on health, to set priorities for action and to monitor progress in the implementation of the strategic approach
- 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 caused by chemicals.

40. A third session of the Preparatory Committee and a high-level international conference on chemicals management are planned for September 2005 and February 2006, respectively, to finalize the strategic approach, after which it will be submitted to the Health Assembly.

41. This progress report was noted by the Executive Board at its 115th session in January 2005.<sup>1</sup>

## **F. INTERNATIONAL MIGRATION OF HEALTH PERSONNEL: A CHALLENGE FOR HEALTH SYSTEMS IN DEVELOPING COUNTRIES**

42. Monitoring international migration is an integral part of current efforts to improve information systems related to human resources for health. A minimum data set for migration is being compiled. Stronger ties with the International Organization for Migration and ILO have been fostered, and joint activities have been planned in order to monitor the migration of health workers through combined mechanisms. The different multilateral agreements that concern the migration of health personnel were reviewed, including the General Agreement on Trade in Services, as were regional and bilateral agreements. Further work will include better analysis of the effects of international trade in services, including financial flows and remittances, and dissemination of findings.

43. Together with Member States, WHO's Secretariat is developing evidence-based approaches to strengthening production of human resources for health, devising planning and management mechanisms, including for recruitment and retention of health personnel, and exploring the suitability of mid-level workers as an urgent response to personnel shortages. It has also set up mechanisms to establish an education initiative to provide support for the rapid production of new health workers in African countries.

44. Reviews of codes of practice and regional and bilateral trade agreements showed that they have only limited effects on migration of health workers. Ethical guidelines have been drawn up that underscore the roles and responsibilities of both receiving and source countries, and of the individual migrant worker. Wide-ranging consultations on these guidelines will be held with Member States throughout 2005. They should be available in 2006 and should help Member States to negotiate mutually beneficial bilateral agreements.

45. A series of events that brought together key policy-makers, international organizations and WHO's Secretariat has identified actions that can be taken at international, regional and national levels rapidly to address health workforce needs. A seminar on migration and health (Geneva, June 2004), organized jointly with the International Organization for Migration and the Centers for Disease Control and Prevention, included a session on the impact of migration of health workers and the effects of bilateral agreements.<sup>2</sup> Collaborative links with the International Organization for Migration

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<sup>1</sup> See document EB115/2005/REC/2, summary record of the twelfth meeting, section 6.

<sup>2</sup> International Organization for Migration CONFERENCE ROOM PAPER/14, 88th Session of the Council, Geneva, 30 November – 3 December 2004. Health and Migration Seminar. Report of the meeting. Accessible at <http://www.iom.int/DOCUMENTS/GOVERNING/EN/CRP14.pdf>.

are being fostered through an annual protocol for joint work. Mechanisms have been set up for the regular exchange of information between ILO, the International Organization for Migration and WHO. Preparatory work started on a joint conference on migration and health scheduled for 2006; one of the themes will be the movement of health workers.

46. Consultations are under way within WHO to streamline approaches to strengthening human resources in health systems.

47. The development of human resources for health will be the theme of the 2006 World Health Report and World Health Day 2006. It will also be a key area of work in WHO's General Programme of Work 2006-2015.

## **G. PROMOTION OF HEALTHY LIFESTYLES**

48. The Fifty-seventh World Health Assembly considered the report on health promotion and healthy lifestyles.<sup>1</sup> The report drew attention to the major behavioural risk factors, including unhealthy diet, tobacco use, physical inactivity, alcohol misuse and unsafe sex and their underlying determinants, together with the need to strengthen the capability of countries to promote health effectively. Most countries still lack the policies, data and the human and financial resources necessary for sustainable health promotion; a considerable amount of work is needed on integrating health promotion into health systems. The present document reports on progress made in the promotion of healthy lifestyles and provides information concerning future work in accordance with resolution WHA57.16.<sup>2</sup>

49. Intercountry workshops have been held in the WHO South-East Asia and Eastern Mediterranean Regions; draft regional strategies for health promotion and healthy lifestyles have also been developed as part of the current process of strengthening the framework and capacity for effective health promotion in those regions. In the African Region, guidelines on the implementation of the regional health promotion strategy have been developed and training has already been provided in 30 Member States. An initiative that aims to identify and train future leaders in health promotion has been launched in the Western Pacific Region with support from the WHO Centre for Health Development, Kobe, Hyogo, Japan. It is intended to extend the initiative to the African, South-East Asia and Eastern Mediterranean Regions. A focal point for health promotion will be appointed in both the Region of the Americas and the European Region, together with an inter-programme health promotion task force.

50. Preparations are under way for the Sixth Global Conference on Health Promotion, "Policy and partnership for action: addressing the determinants of health". Organized jointly by the Ministry of Public Health Thailand and WHO, the Conference will take place in Bangkok from 7 to 11 August 2005. A major product of the Conference will be the Bangkok Charter for Health Promotion, designed to provide direction and leadership in health promotion in a rapidly changing and globalized world. A further outcome will be the development of a set of objectives, timelines and mechanisms for monitoring progress.

51. A meeting of regional advisers for health promotion was held at the WHO Centre for Health Development and plans were developed for closer collaboration on the following: implementing the

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<sup>1</sup> See documents A57/11 and WHA57/2004/REC/3, summary record of the sixth meeting of Committee A.

<sup>2</sup> See document EB115/37 for details on future work concerning the harmful use of alcohol.

Programme budget 2004-2005; organizing the Sixth Global Conference on Health Promotion, including mapping the capacity for health promotion in all Member States; and extending the base of evidence generated by work on the effectiveness of health promotion.

52. Progress has also been made in the fields of healthy ageing,<sup>1</sup> school health, physical activity and health and oral health promotion. In addition, the evidence base has been expanded, innovative means of financing have been used to broaden the sources of available funding and advances have been made in integrating health promotion into health systems.

### **Future action**

53. The mapping of health promotion in Member States will be carried out through the WHO regional offices and will help to provide a base for identifying areas for action and monitoring progress in building national and local capacity for effective health promotion.

54. A global support group of interested organizations and parties will be established, including the New Partnership for Africa's Development, the European Union, the World Bank and the International Union for Health Promotion and Education. The group will explore issues relating to the organization of future global health promotion conferences, paying particular attention to the possibility of the next conference being held in the African Region.

55. Capacity building for health promotion at national and local levels will continue to be promoted through regional workshops and activities such as the project to develop evidence of the effectiveness of health promotion and the initiative to secure sustainable financing. Further advances will be made by strengthening the capacity of research and academic institutes specializing in public health in low- and middle-income countries and by encouraging joint initiatives with WHO collaborating centres for health promotion.

56. Frameworks and strategies to integrate health promotion into health systems will be developed; the settings approach to health promotion will also continue to be promoted and strengthened.

57. With regard to the issues of healthy ageing, physical activity and health, and oral health, priority will be given to developing country capacity and sustaining cooperation with United Nations organizations and bodies, and other relevant stakeholders.

58. A general framework for health promotion strategy will be developed during the biennium 2006-2007.

### **ACTION BY THE HEALTH ASSEMBLY**

59. The Health Assembly is invited to note the above progress report.

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<sup>1</sup> See document EB115/29.