



WORLD HEALTH ORGANIZATION

**FIFTY-EIGHTH
WORLD HEALTH ASSEMBLY**

GENEVA, 16-25 MAY 2005

**RESOLUTIONS AND DECISIONS
ANNEX**

GENEVA
2005



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2005

สิ่งพิมพ์รัฐบาล
สมบัติของสมุทรรัฐสภา

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	PAHO	– Pan American Health Organization
ASEAN	– Association of South-East 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-eighth World Health Assembly was held at the Palais des Nations, Geneva, from 16 to 25 May 2005, in accordance with the decision of the Executive Board at its 114th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annex – document WHA58/2005/REC/1

Verbatim records of plenary meetings, list of participants – document WHA58/2005/REC/2

Summary records of committees, reports of committees – document WHA58/2005/REC/3

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¹ Adopted at the second plenary meeting.

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¹ Including election of Vice-Chairmen and Rapporteur.

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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Ms E. SALGADO (Spain)

Vice-Presidents

Mr S. MEKY (Eritrea)

Dr M. FERNÁNDEZ GALEANO

(Uruguay)

Dr M. FIKRI (United Arab Emirates)

Professor SUCHAI

CHAROENRATANAKUL (Thailand)

Ms A. KING (New Zealand)

Secretary

Dr LEE Jong-wook, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Algeria, Benin, Bhutan, Chad, Czech Republic, Honduras, Kiribati, Morocco, Peru, Serbia and Montenegro, Slovakia and Yemen.

Chairman: Dr T. KIENENE (Kiribati)

Vice-Chairman: Dr D. YEVIDE (Benin)

Rapporteur: Dr A. AL-RABI (Yemen)

Secretary: Mr G.L. BURCI, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bahamas, Bolivia, Bosnia and Herzegovina, Cameroon, China, Comoros, France, Gambia, Guatemala, Guyana, India, Kuwait, Lithuania, Palau, Paraguay, Russian Federation, Senegal, Seychelles, Timor-Leste, Togo, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Viet Nam and Mr Muhammad Nasir Khan, Pakistan (President, Fifty-seventh World Health Assembly, ex officio).

Chairman: Mr Muhammad Nasir KHAN
(Pakistan)

Secretary: Dr LEE Jong-wook, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bhutan, Brazil, China, Congo, Cuba, Equatorial Guinea, Ethiopia, France, Latvia, Lebanon, Luxembourg, Malawi, Mongolia, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United States of America and Zimbabwe.

Chairman: Ms E. SALGADO (Spain)

Secretary: Dr LEE Jong-wook, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

Vice-Chairmen: Dr H. NTABA (Malawi) and
PEHIN DATO ABU BAKAR APONG
(Brunei Darussalam)

Rapporteur: Dr R. BUSUTTIL (Malta)

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

Committee B

Chairman: Dr J. WALCOTT (Barbados)
Vice-Chairmen: Professor J. PEREIRA
MIGUEL (Portugal) and
Dr M.A. RAHMAN KHAN (Bangladesh)

Rapporteur: Mr YEE Ping Yi (Singapore)
Secretary: Dr M. YOUNES, Director, Office
of the Assistant Director-General,
Sustainable Development and Healthy
Environments

RESOLUTIONS

WHA58.1 Health action in relation to crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004

The Fifty-eighth World Health Assembly,

Having considered the reports on health action in relation to crises and disasters;¹

Regretting the profound human consequences of the earthquakes and tsunamis that on 26 December 2004 struck many countries, from south-east Asia to east Africa, causing an estimated 280 000 deaths, with thousands more still missing, injuring as many as half a million people, and making at least five million people homeless and/or deprived of adequate access to safe drinking-water, sanitation, food or health services;

Noting that citizens of more than 30 countries were affected by the disaster, and that those who died included many health professionals;

Acknowledging that most relief assistance has initially been, and will continue to be, provided from within affected communities and through local authorities, supported through intense international cooperation, and expecting that these communities will continue to experience serious difficulties as a result of the loss of their means of livelihood, overloading of health and social services, and both immediate and long-term psychological trauma;

Recognizing that action to address the public health aspects of crises should at all times strengthen the ingenuity and resilience of communities, the capacities of local authorities, the preparedness of health systems, and the ability of national authorities and civil society to provide prompt and coordinated back-up geared to the survival of those immediately affected;

Appreciating the generous assistance provided to the affected nations by governments, nongovernmental groups, individuals, and national public-health institutions, including through the Global Outbreak Alert and Response Network;

Acknowledging the difficulties faced by under-resourced local health systems in locating missing persons, identifying those who have died, and managing the bodies of the deceased;

Recognizing the challenges faced by overwhelmed local authorities as they coordinate the relief effort, including personnel and goods generously made available as a result of both national and international solidarity;

Noting that the effectiveness with which affected nations respond to sudden events of this scale reflects their preparedness and readiness for focused and concerted action, particularly in relation to saving life and sustaining survival;

¹ Documents A58/6 and A58/6 Add.1.

Recalling that more than 30 countries worldwide are currently facing major, often long-standing, crises, with as many as 500 million persons at risk because they face a variety of avoidable threats to their survival and well-being, and that around 20 other countries are at high risk of serious natural or man-made events, increasing the number of persons at risk to between 2000 million and 3000 million;

Appreciating that analyses of health needs and performance of health systems, within the context of national policies and internationally agreed development goals, including those contained in the United Nations Millennium Declaration, are essential for the proper rehabilitation and recovery of equitable individual and public health services, and that this task is best undertaken if there are clear synergies between preparedness and response;

Reaffirming the need to build local capacity to assess risks, and to prepare for, and respond to, any future catastrophe, including by providing continuous public education, dispelling myths about health consequences of disasters, and reducing the risk of disaster damage in critical health facilities;

Recognizing that improvement of social and economic circumstances of the most disadvantaged countries is a preventive action that reduces the risk of crises and disasters and their consequences;

Taking into account the outcomes of the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18 to 22 January 2005),

1. CALLS UPON the international community to continue, in response to countries' requests, its strong and long-term support to areas affected by the tsunamis of 26 December 2004, and to give similar attention to the needs of people affected by other humanitarian crises;
2. URGES Member States:
 - (1) to provide adequate backing to tsunami-affected countries and all other Member States affected by crises and disasters for the sustainable recovery of their health and social systems;
 - (2) to pay particular attention to mental health needs and establishment of service-delivery models in their health and social systems;
 - (3) to make their best efforts to engage actively in the collective measures to establish global and regional preparedness plans that integrate risk-reduction planning into the health sector and build up capacity to respond to health-related crises;
 - (4) to formulate, on the basis of risk mapping, national emergency-preparedness plans that give due attention to public health, including health infrastructure, and to the roles of the health sector in crises, in order to improve the effectiveness of responses to crises and of contributions to the recovery of health systems;
 - (5) to ensure that women and men have equal access to both formal and informal education on emergency preparedness and disaster reduction through early warning systems that empower women, as well as men, to react in timely and appropriate ways, and that appropriate education and response options are also made available to all children;
 - (6) to pay particular attention to gender-based violence as an increasing concern during crises, and to provide appropriate support to those affected;
 - (7) to ensure that – in times of crisis – all affected populations, including displaced persons, have equitable access to essential health care, focusing on saving those whose lives are endangered and sustaining the lives of those who have survived, and paying particular attention

to the specific needs of women and children, older people, and persons with acute physical and psychological trauma, communicable diseases, chronic illnesses, or disability;

(8) to provide support for a review, within the Proposed programme budget 2006-2007, of WHO's actions in relation to crises and disasters, in order to allow for immediate, timely, adequate, sufficient and sustained interventions, and to consider increasing contributions in order to ensure adequate financing of significant WHO actions and interventions before, during and after crises;

(9) to protect national and international personnel involved in improving the health of crisis-affected communities, and to ensure that they receive the necessary back-up to undertake urgent and necessary humanitarian action and relief of suffering – to the greatest possible extent – when lives are endangered;

(10) to strengthen information systems and to improve collaboration with national and international media in order to ensure the availability of accurate and up-to-date information;

(11) to enhance international solidarity and to identify mechanisms for joint cooperation in the development of emergency preparedness and response strategies;

(12) to consider improving existing intergovernmental mechanisms for humanitarian assistance and possible additional mechanisms and modalities for the rapid availability of resources in the event of disasters, so as to allow for prompt and effective response;

3. REQUESTS the Director-General:

(1) to intensify WHO support for tsunami-affected Member States and all other Member States affected by crises and disasters as they focus on effective disease-surveillance systems, and improved access to clean water, sanitation, safe foodstuffs, good-quality essential medicines and health care, particularly for mental health, providing necessary technical guidance, including that on management of bodies of the deceased and avoidance of communicable diseases, and ensuring prompt and accurate communication of information;

(2) actively, and in a timely manner, to provide accurate information to international and local media to counter rumours in order to prevent public panic, conflicts, and other social and economic impacts;

(3) to pay particular attention to providing support to Member States for establishment of service-delivery models in their health and social systems;

(4) to encourage cooperation of WHO's field activities with those of other international organizations, with the support of donor agencies, so as to help governments of countries affected by the tsunamis to coordinate responses to public health challenges, under the aegis of the United Nations Office for the Coordination of Humanitarian Affairs, and to plan and implement the rapid and sustainable rehabilitation of health systems and services, and to report to the Health Assembly on the progress of such cooperation;

(5) to assist in the design of health aspects of programmes that provide support to persons whose lives and livelihoods have been affected by the tsunamis, and of the services needed to address their physical and mental trauma;

(6) to adapt, redesign where necessary, and secure adequate resources for effective work in the area of emergency preparedness and response, and other areas of work involved in the Organization-wide response to crises;

- (7) to enhance WHO's capacity to provide support, within the coordination mechanisms of the United Nations system and of other institutions, particularly the International Red Cross and Red Crescent Movement, for formulating, testing and implementing health-related emergency preparedness plans, responding to the critical health needs of people in crisis conditions, and planning and implementing sustainable recovery after a crisis;
- (8) to establish clear lines of command within WHO in order to facilitate rapid and effective responses in the initial stages of an emergency, and to communicate those arrangements clearly to Member States and other partners in the United Nations system;
- (9) to mobilize WHO's own health expertise, to increase its ability to locate outside expertise, to facilitate effective collaboration between local and international expertise, to ensure that knowledge and skills are updated and relevant, and to make this expertise available in order to provide prompt and appropriate technical support to both international and national health disaster preparedness, response, mitigation and risk-reduction programmes;
- (10) to foster WHO's continued and active cooperation with the International Strategy for Disaster Reduction, thereby ensuring adequate emphasis on health-related concerns in the implementation of the outcomes of the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005);
- (11) to ensure that WHO helps all relevant groups concerned with preparation for, response to, and recovery after, disasters and crises through timely and reliable assessments of suffering and threats to survival, using morbidity and mortality data; coordination of health-related action in ways that reflect these assessments; identification of, and action to, fill gaps that threaten health outcomes; and building of local and national capacities, including transfer of expertise, experience and technologies, among Member States, with adequate attention to the links between relief and reconstruction;
- (12) to strengthen existing logistics services within WHO's mandate, in close coordination with other humanitarian agencies, so that the necessary operational capacity may be available for Member States to receive prompt and timely assistance when faced with public health crises;
- (13) to develop models and guidelines for rapid health-impact assessments after crises, in order to assure appropriate, timely and effective response to affected communities;
- (14) to inform the Fifty-ninth World Health Assembly, through the Executive Board, of progress made in the fulfilment of this resolution.

(Seventh plenary meeting, 20 May 2005 –
Committee A, first report)

WHA58.2 Malaria control

The Fifty-eighth World Health Assembly,

Having considered the report on malaria;¹

¹ Document A58/8.

Concerned that malaria continues to cause more than one million preventable deaths a year, especially in Africa among young children and other vulnerable groups, and that the disease continues to threaten the lives of millions of people in the Americas, Asia and the Pacific;

Recalling that the period 2001-2010 has been proclaimed the Decade to Roll Back Malaria in Developing Countries, Particularly in Africa, by the United Nations General Assembly,¹ and that combating HIV/AIDS, malaria and other diseases is included in the internationally agreed development goals, including those contained in the United Nations Millennium Declaration;

Recalling further United Nations General Assembly resolution 59/256 entitled “2001-2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa”;

Mindful that the global burden of malaria needs to be decreased in order to reduce child mortality by two thirds by 2015 and to help achieve the other internationally agreed development goals, including those contained in the United Nations Millennium Declaration, of improving maternal health and eradicating extreme poverty;

Recognizing that the Global Fund to Fight AIDS, Tuberculosis and Malaria has committed 31% of its grants, or US\$ 921 million, over two years, to projects to control malaria in 80 countries,

1. URGES Member States:

- (1) to establish national policies and operational plans to ensure that at least 80% of those at risk of, or suffering from, malaria benefit from major preventive and curative interventions by 2010 in accordance with WHO technical recommendations, so as to ensure a reduction in the burden of malaria of at least 50% by 2010 and 75% by 2015;
- (2) to assess and respond to the need for integrated human resources at all levels of the health system in order to achieve the targets on the Abuja Declaration on Roll Back Malaria in Africa and the internationally agreed development goals of the United Nations Millennium Declaration, and to take the necessary steps to ensure the recruitment, training and retention of health personnel;
- (3) to further enhance financial support and development assistance to malaria activities in order to achieve the above targets and goals, and to encourage and facilitate the development of new tools to increase effectiveness of malaria control, especially by providing support to the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases;
- (4) to ensure financial sustainability and to increase, in countries endemic for malaria, domestic resource allocation to malaria control and to create favourable conditions for working with the private sector in order to improve access to good-quality malaria services;
- (5) to pursue a rapid scale-up of prevention by applying expeditious and cost-effective approaches, including targeted free, or highly subsidized, distribution of materials and medicines to vulnerable groups, with the aim of assuring that at least 60% of pregnant women receive intermittent preventive treatment and at least 60% of those at risk use insecticide-treated nets, wherever that is the vector-control method of choice;

¹ Resolution 55/284.

- (6) to support indoor residual insecticide spraying, where this intervention is indicated by local conditions;
- (7) to achieve community participation and multisectoral collaboration in vector-control and other preventive actions;
- (8) to develop or strengthen intercountry cooperation to control the spread of malaria across shared borders and migratory routes;
- (9) to encourage intersectoral collaboration, both public and private, at all levels, especially in education;
- (10) to support expanded access to artemisinin-based combination therapy, including the commitment of new funds, innovative mechanisms for the financing and national procurement of artemisinin-based combination therapy, and the scaling up of artemisinin production to meet the increased need;
- (11) to support the development of new medicines to prevent and treat malaria, especially for children and pregnant women; of sensitive and specific diagnostic tests; of effective vaccine(s); and of new insecticides and delivery modes in order to enhance effectiveness and delay the onset of resistance, including through existing global partnerships;
- (12) to support coordinated efforts to improve surveillance, monitoring and evaluation systems so as better to track and report changes in the coverage of recommended “Roll Back Malaria” interventions and subsequent reductions in the burden of malaria;

2. REQUESTS the Director-General:

- (1) to reinforce and expand the Secretariat’s work to improve existing national capabilities, and to cooperate with Member States, in collaboration with Roll Back Malaria partners, in order to ensure the full and cost-effective use of increased financial resources for achieving international goals and targets, including the internationally agreed development goals related to malaria contained in the United Nations Millennium Declaration;
- (2) to collaborate with malaria-affected countries, with Roll Back Malaria partners, and with malaria-free countries facing a real risk of re-emergence, so as to ensure that countries receive full support for necessary monitoring and evaluation, including the development and implementation of appropriate pharmacovigilance systems;
- (3) to collaborate with Roll Back Malaria partners, industry, and development agencies in order to ensure that sufficient quantities of insecticide-treated mosquito nets and effective antimalarial medicines are made available, especially those required for combination therapies, for example by studying the possibility of WHO undertaking bulk purchases on behalf of Member States which so desire, noting the need for strictly controlled distribution systems for antimalarial medicines;
- (4) to provide evidence-based advice to Member States on the appropriate use of indoor residual insecticide spraying, taking into account recent experiences around the world;
- (5) to strengthen collaboration with partners in industry and academia for development of affordable high-quality products for malaria control, including rapid, easy-to-use, sensitive and specific diagnostic tests; an effective malaria vaccine; novel, effective and safe antimalarial

medicines; and new and environmentally friendly insecticides and delivery modes to enhance effectiveness and delay the onset of resistance;

(6) to provide support for intercountry collaboration to control malaria, in particular where there is a risk of spread across shared borders;

(7) to further promote cooperation and partnership between countries supporting malaria control programmes in order to ensure that funds available to combat the disease are used efficiently and effectively.

(Eighth plenary meeting, 23 May 2005 –
Committee A, second report)

WHA58.3 Revision of the International Health Regulations

The Fifty-eighth World Health Assembly,

Having considered the draft revised International Health Regulations;¹

Having regard to articles 2(*k*), 21(*a*) and 22 of the Constitution of WHO;

Recalling references to the need for revising and updating the International Health Regulations in resolutions WHA48.7 on revision and updating of the International Health Regulations, WHA54.14 on global health security: epidemic alert and response, WHA55.16 on global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health, WHA56.28 on revision of the International Health Regulations, and WHA56.29 on severe acute respiratory syndrome (SARS), with a view to responding to the need to ensure global public health;

Welcoming resolution 58/3 of the United Nations General Assembly on enhancing capacity building in global public health, which underscores the importance of the International Health Regulations and urges that high priority should be given to their revision;

Affirming the continuing importance of WHO's role in global outbreak alert and response to public health events, in accordance with its mandate;

Underscoring the continued importance of the International Health Regulations as the key global instrument for protection against the international spread of disease;

Commending the successful conclusion of the work of the Intergovernmental Working Group on Revision of the International Health Regulations,

1. ADOPTS the revised International Health Regulations attached to this resolution, to be referred to as the "International Health Regulations (2005)";

2. CALLS UPON Member States and the Director-General to implement fully the International Health Regulations (2005), in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3;

¹ See document A58/4.

3. DECIDES, for the purposes of paragraph 1 of Article 54 of the International Health Regulations (2005), that States Parties and the Director-General shall submit their first report to the Sixty-first World Health Assembly, and that the Health Assembly shall on that occasion consider the schedule for the submission of further such reports and the first review on the functioning of the Regulations pursuant to paragraph 2 of Article 54;

4. FURTHER DECIDES that, for the purposes of paragraph 1 of Article 14 of the International Health Regulations (2005), the other competent intergovernmental organizations or international bodies with which WHO is expected to cooperate and coordinate its activities, as appropriate, include the following: United Nations, International Labour Organization, Food and Agriculture Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, International Shipping Federation, and *Office International des Epizooties*;

5. URGES Member States:

(1) to build, strengthen and maintain the capacities required under the International Health Regulations (2005), and to mobilize the resources necessary for that purpose;

(2) to collaborate actively with each other and WHO in accordance with the relevant provisions of the International Health Regulations (2005), so as to ensure their effective implementation;

(3) to provide support to developing countries and countries with economies in transition if they so request in the building, strengthening and maintenance of the public health capacities required under the International Health Regulations (2005);

(4) to take all appropriate measures for furthering the purpose and eventual implementation of the International Health Regulations (2005) pending their entry into force, including development of the necessary public health capacities and legal and administrative provisions, and, in particular, to initiate the process for introducing use of the decision instrument contained in Annex 2;

6. REQUESTS the Director-General:

(1) to give prompt notification of adoption of the International Health Regulations (2005) in accordance with paragraph 1 of Article 65 thereof;

(2) to inform other competent intergovernmental organizations or international bodies of adoption of the International Health Regulations (2005) and, as appropriate, to cooperate with them in the updating of their norms and standards and to coordinate with them the activities of WHO under the International Health Regulations (2005) with a view to ensuring application of adequate measures for the protection of public health and strengthening of the global public-health response to the international spread of disease;

(3) to transmit to the International Civil Aviation Organization (ICAO) the recommended changes to the Health Part of the Aircraft General Declaration,¹ and, after completion by ICAO of its revision of the Aircraft General Declaration, to inform the Health Assembly and replace

¹ Document A58/41 Add.2.

Annex 9 of the International Health Regulations (2005) with the Health Part of the Aircraft General Declaration as revised by ICAO;

(4) to build and strengthen the capacities of WHO to perform fully and effectively the functions entrusted to it under the International Health Regulations (2005), in particular through strategic health operations that provide support to countries in detection and assessment of, and response to, public health emergencies;

(5) to collaborate with States Parties to the International Health Regulations (2005), as appropriate, including through the provision or facilitation of technical cooperation and logistical support;

(6) to collaborate with States Parties to the extent possible in the mobilization of financial resources to provide support to developing countries in building, strengthening and maintaining the capacities required under the International Health Regulations (2005);

(7) to draw up, in consultation with Member States, guidelines for the application of health measures at ground crossings in accordance with Article 29 of the International Health Regulations (2005);

(8) to establish the Review Committee of the International Health Regulations (2005) in accordance with Article 50 of the Regulations;

(9) to take steps immediately to prepare guidelines for implementation and evaluation of the decision instrument contained in the International Health Regulations (2005), including elaboration of a procedure for review of its functioning, which shall be submitted to the Health Assembly for its consideration pursuant to paragraph 3 of Article 54 of the Regulations;

(10) to take steps to establish an IHR Roster of Experts and to invite proposals for its membership, pursuant to Article 47 of the International Health Regulations (2005).

INTERNATIONAL HEALTH REGULATIONS (2005)**PART I – DEFINITIONS, PURPOSE AND SCOPE, PRINCIPLES AND RESPONSIBLE AUTHORITIES***Article 1 Definitions*

1. For the purposes of the International Health Regulations (hereinafter the “IHR” or “Regulations”):

“affected” means persons, baggage, cargo, containers, conveyances, goods, postal parcels or human remains that are infected or contaminated, or carry sources of infection or contamination, so as to constitute a public health risk;

“affected area” means a geographical location specifically for which health measures have been recommended by WHO under these Regulations;

“aircraft” means an aircraft making an international voyage;

“airport” means any airport where international flights arrive or depart;

“arrival” of a conveyance means:

- (a) in the case of a seagoing vessel, arrival or anchoring in the defined area of a port;
- (b) in the case of an aircraft, arrival at an airport;
- (c) in the case of an inland navigation vessel on an international voyage, arrival at a point of entry;
- (d) in the case of a train or road vehicle, arrival at a point of entry;

“baggage” means the personal effects of a traveller;

“cargo” means goods carried on a conveyance or in a container;

“competent authority” means an authority responsible for the implementation and application of health measures under these Regulations;

“container” means an article of transport equipment:

- (a) of a permanent character and accordingly strong enough to be suitable for repeated use;
- (b) specially designed to facilitate the carriage of goods by one or more modes of transport, without intermediate reloading;
- (c) fitted with devices permitting its ready handling, particularly its transfer from one mode of transport to another; and
- (d) specially designed as to be easy to fill and empty;

“container loading area” means a place or facility set aside for containers used in international traffic;

“contamination” means the presence of an infectious or toxic agent or matter on a human or animal body surface, in or on a product prepared for consumption or on other inanimate objects, including conveyances, that may constitute a public health risk;

“conveyance” means an aircraft, ship, train, road vehicle or other means of transport on an international voyage;

“conveyance operator” means a natural or legal person in charge of a conveyance or their agent;

“crew” means persons on board a conveyance who are not passengers;

“decontamination” means a procedure whereby health measures are taken to eliminate an infectious or toxic agent or matter on a human or animal body surface, in or on a product prepared for consumption or on other inanimate objects, including conveyances, that may constitute a public health risk;

“departure” means, for persons, baggage, cargo, conveyances or goods, the act of leaving a territory;

“deratting” means the procedure whereby health measures are taken to control or kill rodent vectors of human disease present in baggage, cargo, containers, conveyances, facilities, goods and postal parcels at the point of entry;

“Director-General” means the Director-General of the World Health Organization;

“disease” means an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans;

“disinfection” means the procedure whereby health measures are taken to control or kill infectious agents on a human or animal body surface or in or on baggage, cargo, containers, conveyances, goods and postal parcels by direct exposure to chemical or physical agents;

“disinsection” means the procedure whereby health measures are taken to control or kill the insect vectors of human diseases present in baggage, cargo, containers, conveyances, goods and postal parcels;

“event” means a manifestation of disease or an occurrence that creates a potential for disease;

“*free pratique*” means permission for a ship to enter a port, embark or disembark, discharge or load cargo or stores; permission for an aircraft, after landing, to embark or disembark, discharge or load cargo or stores; and permission for a ground transport vehicle, upon arrival, to embark or disembark, discharge or load cargo or stores;

“goods” mean tangible products, including animals and plants, transported on an international voyage, including for utilization on board a conveyance;

“ground crossing” means a point of land entry in a State Party, including one utilized by road vehicles and trains;

“ground transport vehicle” means a motorized conveyance for overland transport on an international voyage, including trains, coaches, lorries and automobiles;

“health measure” means procedures applied to prevent the spread of disease or contamination; a health measure does not include law enforcement or security measures;

“ill person” means an individual suffering from or affected with a physical ailment that may pose a public health risk;

“infection” means the entry and development or multiplication of an infectious agent in the body of humans and animals that may constitute a public health risk;

“inspection” means the examination, by the competent authority or under its supervision, of areas, baggage, containers, conveyances, facilities, goods or postal parcels, including relevant data and documentation, to determine if a public health risk exists;

“international traffic” means the movement of persons, baggage, cargo, containers, conveyances, goods or postal parcels across an international border, including international trade;

“international voyage” means:

(a) in the case of a conveyance, a voyage between points of entry in the territories of more than one State, or a voyage between points of entry in the territory or territories of the same State if the conveyance has contacts with the territory of any other State on its voyage but only as regards those contacts;

(b) in the case of a traveller, a voyage involving entry into the territory of a State other than the territory of the State in which that traveller commences the voyage;

“intrusive” means possibly provoking discomfort through close or intimate contact or questioning;

“invasive” means the puncture or incision of the skin or insertion of an instrument or foreign material into the body or the examination of a body cavity. For the purposes of these Regulations, medical examination of the ear, nose and mouth, temperature assessment using an ear, oral or cutaneous thermometer, or thermal imaging; medical inspection; auscultation; external palpation; retinoscopy; external collection of urine, faeces or saliva samples; external measurement of blood pressure; and electrocardiography shall be considered to be non-invasive;

“isolation” means separation of ill or contaminated persons or affected baggage, containers, conveyances, goods or postal parcels from others in such a manner as to prevent the spread of infection or contamination;

“medical examination” means the preliminary assessment of a person by an authorized health worker or by a person under the direct supervision of the competent authority, to determine the person’s health status and potential public health risk to others, and may include the scrutiny of health documents, and a physical examination when justified by the circumstances of the individual case;

“National IHR Focal Point” means the national centre, designated by each State Party, which shall be accessible at all times for communications with WHO IHR Contact Points under these Regulations;

“Organization” or “WHO” means the World Health Organization;

“permanent residence” has the meaning as determined in the national law of the State Party concerned;

“personal data” means any information relating to an identified or identifiable natural person;

“point of entry” means a passage for international entry or exit of travellers, baggage, cargo, containers, conveyances, goods and postal parcels as well as agencies and areas providing services to them on entry or exit;

“port” means a seaport or a port on an inland body of water where ships on an international voyage arrive or depart;

“postal parcel” means an addressed article or package carried internationally by postal or courier services;

“public health emergency of international concern” means an extraordinary event which is determined, as provided in these Regulations:

- (i) to constitute a public health risk to other States through the international spread of disease and
- (ii) to potentially require a coordinated international response;

“public health observation” means the monitoring of the health status of a traveller over time for the purpose of determining the risk of disease transmission;

“public health risk” means a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger;

“quarantine” means the restriction of activities and/or separation from others of suspect persons who are not ill or of suspect baggage, containers, conveyances or goods in such a manner as to prevent the possible spread of infection or contamination;

“recommendation” and “recommended” refer to temporary or standing recommendations issued under these Regulations;

“reservoir” means an animal, plant or substance in which an infectious agent normally lives and whose presence may constitute a public health risk;

“road vehicle” means a ground transport vehicle other than a train;

“scientific evidence” means information furnishing a level of proof based on the established and accepted methods of science;

“scientific principles” means the accepted fundamental laws and facts of nature known through the methods of science;

“ship” means a seagoing or inland navigation vessel on an international voyage;

“standing recommendation” means non-binding advice issued by WHO for specific ongoing public health risks pursuant to Article 16 regarding appropriate health measures for routine or periodic

application needed to prevent or reduce the international spread of disease and minimize interference with international traffic;

“surveillance” means the systematic ongoing collection, collation and analysis of data for public health purposes and the timely dissemination of public health information for assessment and public health response as necessary;

“suspect” means those persons, baggage, cargo, containers, conveyances, goods or postal parcels considered by a State Party as having been exposed, or possibly exposed, to a public health risk and that could be a possible source of spread of disease;

“temporary recommendation” means non-binding advice issued by WHO pursuant to Article 15 for application on a time-limited, risk-specific basis, in response to a public health emergency of international concern, so as to prevent or reduce the international spread of disease and minimize interference with international traffic;

“temporary residence” has the meaning as determined in the national law of the State Party concerned;

“traveller” means a natural person undertaking an international voyage;

“vector” means an insect or other animal which normally transports an infectious agent that constitutes a public health risk;

“verification” means the provision of information by a State Party to WHO confirming the status of an event within the territory or territories of that State Party;

“WHO IHR Contact Point” means the unit within WHO which shall be accessible at all times for communications with the National IHR Focal Point.

2. Unless otherwise specified or determined by the context, reference to these Regulations includes the annexes thereto.

Article 2 Purpose and scope

The purpose and scope of these Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

Article 3 Principles

1. The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons.
2. The implementation of these Regulations shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization.
3. The implementation of these Regulations shall be guided by the goal of their universal application for the protection of all people of the world from the international spread of disease.

4. States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies. In doing so they should uphold the purpose of these Regulations.

Article 4 Responsible authorities

1. Each State Party shall designate or establish a National IHR Focal Point and the authorities responsible within its respective jurisdiction for the implementation of health measures under these Regulations.

2. National IHR Focal Points shall be accessible at all times for communications with the WHO IHR Contact Points provided for in paragraph 3 of this Article. The functions of National IHR Focal Points shall include:

(a) sending to WHO IHR Contact Points, on behalf of the State Party concerned, urgent communications concerning the implementation of these Regulations, in particular under Articles 6 to 12; and

(b) disseminating information to, and consolidating input from, relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments.

3. WHO shall designate IHR Contact Points, which shall be accessible at all times for communications with National IHR Focal Points. WHO IHR Contact Points shall send urgent communications concerning the implementation of these Regulations, in particular under Articles 6 to 12, to the National IHR Focal Point of the States Parties concerned. WHO IHR Contact Points may be designated by WHO at the headquarters or at the regional level of the Organization.

4. States Parties shall provide WHO with contact details of their National IHR Focal Point and WHO shall provide States Parties with contact details of WHO IHR Contact Points. These contact details shall be continuously updated and annually confirmed. WHO shall make available to all States Parties the contact details of National IHR Focal Points it receives pursuant to this Article.

PART II – INFORMATION AND PUBLIC HEALTH RESPONSE

Article 5 Surveillance

1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations, as specified in Annex 1.

2. Following the assessment referred to in paragraph 2, Part A of Annex 1, a State Party may report to WHO on the basis of a justified need and an implementation plan and, in so doing, obtain an extension of two years in which to fulfil the obligation in paragraph 1 of this Article. In exceptional circumstances, and supported by a new implementation plan, the State Party may request a further extension not exceeding two years from the Director-General, who shall make the decision, taking into account the technical advice of the Committee established under Article 50 (hereinafter the “Review Committee”). After the period mentioned in paragraph 1 of this Article, the State Party that has obtained an extension shall report annually to WHO on progress made towards the full implementation.

3. WHO shall assist States Parties, upon request, to develop, strengthen and maintain the capacities referred to in paragraph 1 of this Article.

4. WHO shall collect information regarding events through its surveillance activities and assess their potential to cause international disease spread and possible interference with international traffic. Information received by WHO under this paragraph shall be handled in accordance with Articles 11 and 45 where appropriate.

Article 6 Notification

1. Each State Party shall assess events occurring within its territory by using the decision instrument in Annex 2. Each State Party shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events. If the notification received by WHO involves the competency of the International Atomic Energy Agency (IAEA), WHO shall immediately notify the IAEA.

2. Following a notification, a State Party shall continue to communicate to WHO timely, accurate and sufficiently detailed public health information available to it on the notified event, where possible including case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report, when necessary, the difficulties faced and support needed in responding to the potential public health emergency of international concern.

Article 7 Information-sharing during unexpected or unusual public health events

If a State Party has evidence of an unexpected or unusual public health event within its territory, irrespective of origin or source, which may constitute a public health emergency of international concern, it shall provide to WHO all relevant public health information. In such a case, the provisions of Article 6 shall apply in full.

Article 8 Consultation

In the case of events occurring within its territory not requiring notification as provided in Article 6, in particular those events for which there is insufficient information available to complete the decision instrument, a State Party may nevertheless keep WHO advised thereof through the National IHR Focal Point and consult with WHO on appropriate health measures. Such communications shall be treated in accordance with paragraphs 2 to 4 of Article 11. The State Party in whose territory the event has occurred may request WHO assistance to assess any epidemiological evidence obtained by that State Party.

Article 9 Other reports

1. WHO may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring. Before taking any action based on such reports, WHO shall consult with and attempt to obtain verification from the State Party in whose territory the event is allegedly occurring in accordance with the procedure set forth in Article 10. To this end, WHO shall make the information received available to

the States Parties and only where it is duly justified may WHO maintain the confidentiality of the source. This information will be used in accordance with the procedure set forth in Article 11.

2. States Parties shall, as far as practicable, inform WHO within 24 hours of receipt of evidence of a public health risk identified outside their territory that may cause international disease spread, as manifested by exported or imported:

- (a) human cases;
- (b) vectors which carry infection or contamination; or
- (c) goods that are contaminated.

Article 10 Verification

1. WHO shall request, in accordance with Article 9, verification from a State Party of reports from sources other than notifications or consultations of events which may constitute a public health emergency of international concern allegedly occurring in the State's territory. In such cases, WHO shall inform the State Party concerned regarding the reports it is seeking to verify.

2. Pursuant to the foregoing paragraph and to Article 9, each State Party, when requested by WHO, shall verify and provide:

- (a) within 24 hours, an initial reply to, or acknowledgement of, the request from WHO;
- (b) within 24 hours, available public health information on the status of events referred to in WHO's request; and
- (c) information to WHO in the context of an assessment under Article 6, including relevant information as described in that Article.

3. When WHO receives information of an event that may constitute a public health emergency of international concern, it shall offer to collaborate with the State Party concerned in assessing the potential for international disease spread, possible interference with international traffic and the adequacy of control measures. Such activities may include collaboration with other standard-setting organizations and the offer to mobilize international assistance in order to support the national authorities in conducting and coordinating on-site assessments. When requested by the State Party, WHO shall provide information supporting such an offer.

4. If the State Party does not accept the offer of collaboration, WHO may, when justified by the magnitude of the public health risk, share with other States Parties the information available to it, whilst encouraging the State Party to accept the offer of collaboration by WHO, taking into account the views of the State Party concerned.

Article 11 Provision of information by WHO

1. Subject to paragraph 2 of this Article, WHO shall send to all States Parties and, as appropriate, to relevant intergovernmental organizations, as soon as possible and by the most efficient means available, in confidence, such public health information which it has received under Articles 5 to 10 inclusive and which is necessary to enable States Parties to respond to a public health risk. WHO should communicate information to other States Parties that might help them in preventing the occurrence of similar incidents.

2. WHO shall use information received under Articles 6 and 8 and paragraph 2 of Article 9 for verification, assessment and assistance purposes under these Regulations and, unless otherwise agreed with the States Parties referred to in those provisions, shall not make this information generally available to other States Parties, until such time as:

- (a) the event is determined to constitute a public health emergency of international concern in accordance with Article 12; or
- (b) information evidencing the international spread of the infection or contamination has been confirmed by WHO in accordance with established epidemiological principles; or
- (c) there is evidence that:
 - (i) control measures against the international spread are unlikely to succeed because of the nature of the contamination, disease agent, vector or reservoir; or
 - (ii) the State Party lacks sufficient operational capacity to carry out necessary measures to prevent further spread of disease; or
- (d) the nature and scope of the international movement of travellers, baggage, cargo, containers, conveyances, goods or postal parcels that may be affected by the infection or contamination requires the immediate application of international control measures.

3. WHO shall consult with the State Party in whose territory the event is occurring as to its intent to make information available under this Article.

4. When information received by WHO under paragraph 2 of this Article is made available to States Parties in accordance with these Regulations, WHO may also make it available to the public if other information about the same event has already become publicly available and there is a need for the dissemination of authoritative and independent information.

Article 12 Determination of a public health emergency of international concern

1. The Director-General shall determine, on the basis of the information received, in particular from the State Party within whose territory an event is occurring, whether an event constitutes a public health emergency of international concern in accordance with the criteria and the procedure set out in these Regulations.

2. If the Director-General considers, based on an assessment under these Regulations, that a public health emergency of international concern is occurring, the Director-General shall consult with the State Party in whose territory the event arises regarding this preliminary determination. If the Director-General and the State Party are in agreement regarding this determination, the Director-General shall, in accordance with the procedure set forth in Article 49, seek the views of the Committee established under Article 48 (hereinafter the "Emergency Committee") on appropriate temporary recommendations.

3. If, following the consultation in paragraph 2 above, the Director-General and the State Party in whose territory the event arises do not come to a consensus within 48 hours on whether the event constitutes a public health emergency of international concern, a determination shall be made in accordance with the procedure set forth in Article 49.

4. In determining whether an event constitutes a public health emergency of international concern, the Director-General shall consider:

- (a) information provided by the State Party;
- (b) the decision instrument contained in Annex 2;
- (c) the advice of the Emergency Committee;
- (d) scientific principles as well as the available scientific evidence and other relevant information; and
- (e) an assessment of the risk to human health, of the risk of international spread of disease and of the risk of interference with international traffic.

5. If the Director-General, following consultations with the State Party within whose territory the public health emergency of international concern has occurred, considers that a public health emergency of international concern has ended, the Director-General shall take a decision in accordance with the procedure set out in Article 49.

Article 13 Public health response

1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1. WHO shall publish, in consultation with Member States, guidelines to support States Parties in the development of public health response capacities.
2. Following the assessment referred to in paragraph 2, Part A of Annex 1, a State Party may report to WHO on the basis of a justified need and an implementation plan and, in so doing, obtain an extension of two years in which to fulfil the obligation in paragraph 1 of this Article. In exceptional circumstances and supported by a new implementation plan, the State Party may request a further extension not exceeding two years from the Director-General, who shall make the decision, taking into account the technical advice of the Review Committee. After the period mentioned in paragraph 1 of this Article, the State Party that has obtained an extension shall report annually to WHO on progress made towards the full implementation.
3. At the request of a State Party, WHO shall collaborate in the response to public health risks and other events by providing technical guidance and assistance and by assessing the effectiveness of the control measures in place, including the mobilization of international teams of experts for on-site assistance, when necessary.
4. If WHO, in consultation with the States Parties concerned as provided in Article 12, determines that a public health emergency of international concern is occurring, it may offer, in addition to the support indicated in paragraph 3 of this Article, further assistance to the State Party, including an assessment of the severity of the international risk and the adequacy of control measures. Such collaboration may include the offer to mobilize international assistance in order to support the national authorities in conducting and coordinating on-site assessments. When requested by the State Party, WHO shall provide information supporting such an offer.
5. When requested by WHO, States Parties should provide, to the extent possible, support to WHO-coordinated response activities.
6. When requested, WHO shall provide appropriate guidance and assistance to other States Parties affected or threatened by the public health emergency of international concern.

Article 14 Cooperation of WHO with intergovernmental organizations and international bodies

1. WHO shall cooperate and coordinate its activities, as appropriate, with other competent intergovernmental organizations or international bodies in the implementation of these Regulations, including through the conclusion of agreements and other similar arrangements.
2. In cases in which notification or verification of, or response to, an event is primarily within the competence of other intergovernmental organizations or international bodies, WHO shall coordinate its activities with such organizations or bodies in order to ensure the application of adequate measures for the protection of public health.
3. Notwithstanding the foregoing, nothing in these Regulations shall preclude or limit the provision by WHO of advice, support, or technical or other assistance for public health purposes.

PART III – RECOMMENDATIONS

Article 15 Temporary recommendations

1. If it has been determined in accordance with Article 12 that a public health emergency of international concern is occurring, the Director-General shall issue temporary recommendations in accordance with the procedure set out in Article 49. Such temporary recommendations may be modified or extended as appropriate, including after it has been determined that a public health emergency of international concern has ended, at which time other temporary recommendations may be issued as necessary for the purpose of preventing or promptly detecting its recurrence.
2. Temporary recommendations may include health measures to be implemented by the State Party experiencing the public health emergency of international concern, or by other States Parties, regarding persons, baggage, cargo, containers, conveyances, goods and/or postal parcels to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic.
3. Temporary recommendations may be terminated in accordance with the procedure set out in Article 49 at any time and shall automatically expire three months after their issuance. They may be modified or extended for additional periods of up to three months. Temporary recommendations may not continue beyond the second World Health Assembly after the determination of the public health emergency of international concern to which they relate.

Article 16 Standing recommendations

WHO may make standing recommendations of appropriate health measures in accordance with Article 53 for routine or periodic application. Such measures may be applied by States Parties regarding persons, baggage, cargo, containers, conveyances, goods and/or postal parcels for specific, ongoing public health risks in order to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic. WHO may, in accordance with Article 53, modify or terminate such recommendations, as appropriate.

Article 17 Criteria for recommendations

When issuing, modifying or terminating temporary or standing recommendations, the Director-General shall consider:

- (a) the views of the States Parties directly concerned;

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- (b) the advice of the Emergency Committee or the Review Committee, as the case may be;
- (c) scientific principles as well as available scientific evidence and information;
- (d) health measures that, on the basis of a risk assessment appropriate to the circumstances, are not more restrictive of international traffic and trade and are not more intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection;
- (e) relevant international standards and instruments;
- (f) activities undertaken by other relevant intergovernmental organizations and international bodies; and
- (g) other appropriate and specific information relevant to the event.

With respect to temporary recommendations, the consideration by the Director-General of subparagraphs (e) and (f) of this Article may be subject to limitations imposed by urgent circumstances.

Article 18 Recommendations with respect to persons, baggage, cargo, containers, conveyances, goods and postal parcels

1. Recommendations issued by WHO to States Parties with respect to persons may include the following advice:

- no specific health measures are advised;
- review travel history in affected areas;
- review proof of medical examination and any laboratory analysis;
- require medical examinations;
- review proof of vaccination or other prophylaxis;
- require vaccination or other prophylaxis;
- place suspect persons under public health observation;
- implement quarantine or other health measures for suspect persons;
- implement isolation and treatment where necessary of affected persons;
- implement tracing of contacts of suspect or affected persons;
- refuse entry of suspect and affected persons;
- refuse entry of unaffected persons to affected areas; and
- implement exit screening and/or restrictions on persons from affected areas.

2. Recommendations issued by WHO to States Parties with respect to baggage, cargo, containers, conveyances, goods and postal parcels may include the following advice:

- no specific health measures are advised;
- review manifest and routing;
- implement inspections;
- review proof of measures taken on departure or in transit to eliminate infection or contamination;
- implement treatment of the baggage, cargo, containers, conveyances, goods, postal parcels or human remains to remove infection or contamination, including vectors and reservoirs;
- the use of specific health measures to ensure the safe handling and transport of human remains;
- implement isolation or quarantine;
- seizure and destruction of infected or contaminated or suspect baggage, cargo, containers, conveyances, goods or postal parcels under controlled conditions if no available treatment or process will otherwise be successful; and
- refuse departure or entry.

PART IV – POINTS OF ENTRY

Article 19 General obligations

Each State Party shall, in addition to the other obligations provided for under these Regulations:

- (a) ensure that the capacities set forth in Annex 1 for designated points of entry are developed within the timeframe provided in paragraph 1 of Article 5 and paragraph 1 of Article 13;
- (b) identify the competent authorities at each designated point of entry in its territory; and
- (c) furnish to WHO, as far as practicable, when requested in response to a specific potential public health risk, relevant data concerning sources of infection or contamination, including vectors and reservoirs, at its points of entry, which could result in international disease spread.

Article 20 Airports and ports

1. States Parties shall designate the airports and ports that shall develop the capacities provided in Annex 1.
2. States Parties shall ensure that Ship Sanitation Control Exemption Certificates and Ship Sanitation Control Certificates are issued in accordance with the requirements in Article 39 and the model provided in Annex 3.

3. Each State Party shall send to WHO a list of ports authorized to offer:
 - (a) the issuance of Ship Sanitation Control Certificates and the provision of the services referred to in Annexes 1 and 3; or
 - (b) the issuance of Ship Sanitation Control Exemption Certificates only; and
 - (c) extension of the Ship Sanitation Control Exemption Certificate for a period of one month until the arrival of the ship in the port at which the Certificate may be received.

Each State Party shall inform WHO of any changes which may occur to the status of the listed ports. WHO shall publish the information received under this paragraph.

4. WHO may, at the request of the State Party concerned, arrange to certify, after an appropriate investigation, that an airport or port in its territory meets the requirements referred to in paragraphs 1 and 3 of this Article. These certifications may be subject to periodic review by WHO, in consultation with the State Party.
5. WHO, in collaboration with competent intergovernmental organizations and international bodies, shall develop and publish the certification guidelines for airports and ports under this Article. WHO shall also publish a list of certified airports and ports.

Article 21 Ground crossings

1. Where justified for public health reasons, a State Party may designate ground crossings that shall develop the capacities provided in Annex 1, taking into consideration:
 - (a) the volume and frequency of the various types of international traffic, as compared to other points of entry, at a State Party's ground crossings which might be designated; and
 - (b) the public health risks existing in areas in which the international traffic originates, or through which it passes, prior to arrival at a particular ground crossing.
2. States Parties sharing common borders should consider:
 - (a) entering into bilateral or multilateral agreements or arrangements concerning prevention or control of international transmission of disease at ground crossings in accordance with Article 57; and
 - (b) joint designation of adjacent ground crossings for the capacities in Annex 1 in accordance with paragraph 1 of this Article.

Article 22 Role of competent authorities

1. The competent authorities shall:
 - (a) be responsible for monitoring baggage, cargo, containers, conveyances, goods, postal parcels and human remains departing and arriving from affected areas, so that they are maintained in such a condition that they are free of sources of infection or contamination, including vectors and reservoirs;

- (b) ensure, as far as practicable, that facilities used by travellers at points of entry are maintained in a sanitary condition and are kept free of sources of infection or contamination, including vectors and reservoirs;
 - (c) be responsible for the supervision of any deratting, disinfection, disinsection or decontamination of baggage, cargo, containers, conveyances, goods, postal parcels and human remains or sanitary measures for persons, as appropriate under these Regulations;
 - (d) advise conveyance operators, as far in advance as possible, of their intent to apply control measures to a conveyance, and shall provide, where available, written information concerning the methods to be employed;
 - (e) be responsible for the supervision of the removal and safe disposal of any contaminated water or food, human or animal dejecta, wastewater and any other contaminated matter from a conveyance;
 - (f) take all practicable measures consistent with these Regulations to monitor and control the discharge by ships of sewage, refuse, ballast water and other potentially disease-causing matter which might contaminate the waters of a port, river, canal, strait, lake or other international waterway;
 - (g) be responsible for supervision of service providers for services concerning travellers, baggage, cargo, containers, conveyances, goods, postal parcels and human remains at points of entry, including the conduct of inspections and medical examinations as necessary;
 - (h) have effective contingency arrangements to deal with an unexpected public health event; and
 - (i) communicate with the National IHR Focal Point on the relevant public health measures taken pursuant to these Regulations.
2. Health measures recommended by WHO for travellers, baggage, cargo, containers, conveyances, goods, postal parcels and human remains arriving from an affected area may be reapplied on arrival, if there are verifiable indications and/or evidence that the measures applied on departure from the affected area were unsuccessful.
3. Disinsection, deratting, disinfection, decontamination and other sanitary procedures shall be carried out so as to avoid injury and as far as possible discomfort to persons, or damage to the environment in a way which impacts on public health, or damage to baggage, cargo, containers, conveyances, goods and postal parcels.

PART V – PUBLIC HEALTH MEASURES

Chapter I – General provisions

Article 23 Health measures on arrival and departure

1. Subject to applicable international agreements and relevant articles of these Regulations, a State Party may require for public health purposes, on arrival or departure:

- (a) with regard to travellers:
 - (i) information concerning the traveller's destination so that the traveller may be contacted;
 - (ii) information concerning the traveller's itinerary to ascertain if there was any travel in or near an affected area or other possible contacts with infection or contamination prior to arrival, as well as review of the traveller's health documents if they are required under these Regulations; and/or
 - (iii) a non-invasive medical examination which is the least intrusive examination that would achieve the public health objective;
 - (b) inspection of baggage, cargo, containers, conveyances, goods, postal parcels and human remains.
2. On the basis of evidence of a public health risk obtained through the measures provided in paragraph 1 of this Article, or through other means, States Parties may apply additional health measures, in accordance with these Regulations, in particular, with regard to a suspect or affected traveller, on a case-by-case basis, the least intrusive and invasive medical examination that would achieve the public health objective of preventing the international spread of disease.
3. No medical examination, vaccination, prophylaxis or health measure under these Regulations shall be carried out on travellers without their prior express informed consent or that of their parents or guardians, except as provided in paragraph 2 of Article 31, and in accordance with the law and international obligations of the State Party.
4. Travellers to be vaccinated or offered prophylaxis pursuant to these Regulations, or their parents or guardians, shall be informed of any risk associated with vaccination or with non-vaccination and with the use or non-use of prophylaxis in accordance with the law and international obligations of the State Party. States Parties shall inform medical practitioners of these requirements in accordance with the law of the State Party.
5. Any medical examination, medical procedure, vaccination or other prophylaxis which involves a risk of disease transmission shall only be performed on, or administered to, a traveller in accordance with established national or international safety guidelines and standards so as to minimize such a risk.

Chapter II – Special provisions for conveyances and conveyance operators

Article 24 Conveyance operators

1. States Parties shall take all practicable measures consistent with these Regulations to ensure that conveyance operators:
- (a) comply with the health measures recommended by WHO and adopted by the State Party;
 - (b) inform travellers of the health measures recommended by WHO and adopted by the State Party for application on board; and
 - (c) permanently keep conveyances for which they are responsible free of sources of infection or contamination, including vectors and reservoirs. The application of measures to control sources of infection or contamination may be required if evidence is found.

2. Specific provisions pertaining to conveyances and conveyance operators under this Article are provided in Annex 4. Specific measures applicable to conveyances and conveyance operators with regard to vector-borne diseases are provided in Annex 5.

Article 25 Ships and aircraft in transit

Subject to Articles 27 and 43 or unless authorized by applicable international agreements, no health measure shall be applied by a State Party to:

- (a) a ship not coming from an affected area which passes through a maritime canal or waterway in the territory of that State Party on its way to a port in the territory of another State. Any such ship shall be permitted to take on, under the supervision of the competent authority, fuel, water, food and supplies;
- (b) a ship which passes through waters within its jurisdiction without calling at a port or on the coast; and
- (c) an aircraft in transit at an airport within its jurisdiction, except that the aircraft may be restricted to a particular area of the airport with no embarking and disembarking or loading and discharging. However, any such aircraft shall be permitted to take on, under the supervision of the competent authority, fuel, water, food and supplies.

Article 26 Civilian lorries, trains and coaches in transit

Subject to Articles 27 and 43 or unless authorized by applicable international agreements, no health measure shall be applied to a civilian lorry, train or coach not coming from an affected area which passes through a territory without embarking, disembarking, loading or discharging.

Article 27 Affected conveyances

1. If clinical signs or symptoms and information based on fact or evidence of a public health risk, including sources of infection and contamination, are found on board a conveyance, the competent authority shall consider the conveyance as affected and may:

- (a) disinfect, decontaminate, disinsect or derat the conveyance, as appropriate, or cause these measures to be carried out under its supervision; and
- (b) decide in each case the technique employed to secure an adequate level of control of the public health risk as provided in these Regulations. Where there are methods or materials advised by WHO for these procedures, these should be employed, unless the competent authority determines that other methods are as safe and reliable.

The competent authority may implement additional health measures, including isolation of the conveyances, as necessary, to prevent the spread of disease. Such additional measures should be reported to the National IHR Focal Point.

2. If the competent authority for the point of entry is not able to carry out the control measures required under this Article, the affected conveyance may nevertheless be allowed to depart, subject to the following conditions:

- (a) the competent authority shall, at the time of departure, inform the competent authority for the next known point of entry of the type of information referred to under subparagraph (b); and

- (b) in the case of a ship, the evidence found and the control measures required shall be noted in the Ship Sanitation Control Certificate.

Any such conveyance shall be permitted to take on, under the supervision of the competent authority, fuel, water, food and supplies.

3. A conveyance that has been considered as affected shall cease to be regarded as such when the competent authority is satisfied that:

- (a) the measures provided in paragraph 1 of this Article have been effectively carried out; and
- (b) there are no conditions on board that could constitute a public health risk.

Article 28 Ships and aircraft at points of entry

1. Subject to Article 43 or as provided in applicable international agreements, a ship or an aircraft shall not be prevented for public health reasons from calling at any point of entry. However, if the point of entry is not equipped for applying health measures under these Regulations, the ship or aircraft may be ordered to proceed at its own risk to the nearest suitable point of entry available to it, unless the ship or aircraft has an operational problem which would make this diversion unsafe.

2. Subject to Article 43 or as provided in applicable international agreements, ships or aircraft shall not be refused *free pratique* by States Parties for public health reasons; in particular they shall not be prevented from embarking or disembarking, discharging or loading cargo or stores, or taking on fuel, water, food and supplies. States Parties may subject the granting of *free pratique* to inspection and, if a source of infection or contamination is found on board, the carrying out of necessary disinfection, decontamination, disinsection or deratting, or other measures necessary to prevent the spread of the infection or contamination.

3. Whenever practicable and subject to the previous paragraph, a State Party shall authorize the granting of *free pratique* by radio or other communication means to a ship or an aircraft when, on the basis of information received from it prior to its arrival, the State Party is of the opinion that the arrival of the ship or aircraft will not result in the introduction or spread of disease.

4. Officers in command of ships or pilots in command of aircraft, or their agents, shall make known to the port or airport control as early as possible before arrival at the port or airport of destination any cases of illness indicative of a disease of an infectious nature or evidence of a public health risk on board as soon as such illnesses or public health risks are made known to the officer or pilot. This information must be immediately relayed to the competent authority for the port or airport. In urgent circumstances, such information should be communicated directly by the officers or pilots to the relevant port or airport authority.

5. The following shall apply if a suspect or affected aircraft or ship, for reasons beyond the control of the pilot in command of the aircraft or the officer in command of the ship, lands elsewhere than at the airport at which the aircraft was due to land or berths elsewhere than at the port at which the ship was due to berth:

- (a) the pilot in command of the aircraft or the officer in command of the ship or other person in charge shall make every effort to communicate without delay with the nearest competent authority;

- (b) as soon as the competent authority has been informed of the landing it may apply health measures recommended by WHO or other health measures provided in these Regulations;
- (c) unless required for emergency purposes or for communication with the competent authority, no traveller on board the aircraft or ship shall leave its vicinity and no cargo shall be removed from that vicinity, unless authorized by the competent authority; and
- (d) when all health measures required by the competent authority have been completed, the aircraft or ship may, so far as such health measures are concerned, proceed either to the airport or port at which it was due to land or berth, or, if for technical reasons it cannot do so, to a conveniently situated airport or port.

6. Notwithstanding the provisions contained in this Article, the officer in command of a ship or pilot in command of an aircraft may take such emergency measures as may be necessary for the health and safety of travellers on board. He or she shall inform the competent authority as early as possible concerning any measures taken pursuant to this paragraph.

Article 29 Civilian lorries, trains and coaches at points of entry

WHO, in consultation with States Parties, shall develop guiding principles for applying health measures to civilian lorries, trains and coaches at points of entry and passing through ground crossings.

Chapter III – Special provisions for travellers

Article 30 Travellers under public health observation

Subject to Article 43 or as authorized in applicable international agreements, a suspect traveller who on arrival is placed under public health observation may continue an international voyage, if the traveller does not pose an imminent public health risk and the State Party informs the competent authority of the point of entry at destination, if known, of the traveller's expected arrival. On arrival, the traveller shall report to that authority.

Article 31 Health measures relating to entry of travellers

1. Invasive medical examination, vaccination or other prophylaxis shall not be required as a condition of entry of any traveller to the territory of a State Party, except that, subject to Articles 32, 42 and 45, these Regulations do not preclude States Parties from requiring medical examination, vaccination or other prophylaxis or proof of vaccination or other prophylaxis:

- (a) when necessary to determine whether a public health risk exists;
- (b) as a condition of entry for any travellers seeking temporary or permanent residence;
- (c) as a condition of entry for any travellers pursuant to Article 43 or Annexes 6 and 7; or
- (d) which may be carried out pursuant to Article 23.

2. If a traveller for whom a State Party may require a medical examination, vaccination or other prophylaxis under paragraph 1 of this Article fails to consent to any such measure, or refuses to provide the information or the documents referred to in paragraph 1(a) of Article 23, the State Party concerned may, subject to Articles 32, 42 and 45, deny entry to that traveller. If there is evidence of

an imminent public health risk, the State Party may, in accordance with its national law and to the extent necessary to control such a risk, compel the traveller to undergo or advise the traveller, pursuant to paragraph 3 of Article 23, to undergo:

- (a) the least invasive and intrusive medical examination that would achieve the public health objective;
- (b) vaccination or other prophylaxis; or
- (c) additional established health measures that prevent or control the spread of disease, including isolation, quarantine or placing the traveller under public health observation.

Article 32 Treatment of travellers

In implementing health measures under these Regulations, States Parties shall treat travellers with respect for their dignity, human rights and fundamental freedoms and minimize any discomfort or distress associated with such measures, including by:

- (a) treating all travellers with courtesy and respect;
- (b) taking into consideration the gender, sociocultural, ethnic or religious concerns of travellers; and
- (c) providing or arranging for adequate food and water, appropriate accommodation and clothing, protection for baggage and other possessions, appropriate medical treatment, means of necessary communication if possible in a language that they can understand and other appropriate assistance for travellers who are quarantined, isolated or subject to medical examinations or other procedures for public health purposes.

Chapter IV – Special provisions for goods, containers and container loading areas

Article 33 Goods in transit

Subject to Article 43 or unless authorized by applicable international agreements, goods, other than live animals, in transit without transshipment shall not be subject to health measures under these Regulations or detained for public health purposes.

Article 34 Container and container loading areas

1. States Parties shall ensure, as far as practicable, that container shippers use international traffic containers that are kept free from sources of infection or contamination, including vectors and reservoirs, particularly during the course of packing.
2. States Parties shall ensure, as far as practicable, that container loading areas are kept free from sources of infection or contamination, including vectors and reservoirs.
3. Whenever, in the opinion of a State Party, the volume of international container traffic is sufficiently large, the competent authorities shall take all practicable measures consistent with these Regulations, including carrying out inspections, to assess the sanitary condition of container loading areas and containers in order to ensure that the obligations contained in these Regulations are implemented.

4. Facilities for the inspection and isolation of containers shall, as far as practicable, be available at container loading areas.
5. Container consignees and consignors shall make every effort to avoid cross-contamination when multiple-use loading of containers is employed.

PART VI – HEALTH DOCUMENTS

Article 35 General rule

No health documents, other than those provided for under these Regulations or in recommendations issued by WHO, shall be required in international traffic, provided however that this Article shall not apply to travellers seeking temporary or permanent residence, nor shall it apply to document requirements concerning the public health status of goods or cargo in international trade pursuant to applicable international agreements. The competent authority may request travellers to complete contact information forms and questionnaires on the health of travellers, provided that they meet the requirements set out in Article 23.

Article 36 Certificates of vaccination or other prophylaxis

1. Vaccines and prophylaxis for travellers administered pursuant to these Regulations, or to recommendations and certificates relating thereto, shall conform to the provisions of Annex 6 and, when applicable, Annex 7 with regard to specific diseases.
2. A traveller in possession of a certificate of vaccination or other prophylaxis issued in conformity with Annex 6 and, when applicable, Annex 7, shall not be denied entry as a consequence of the disease to which the certificate refers, even if coming from an affected area, unless the competent authority has verifiable indications and/or evidence that the vaccination or other prophylaxis was not effective.

Article 37 Maritime Declaration of Health

1. The master of a ship, before arrival at its first port of call in the territory of a State Party, shall ascertain the state of health on board, and, except when that State Party does not require it, the master shall, on arrival, or in advance of the vessel's arrival if the vessel is so equipped and the State Party requires such advance delivery, complete and deliver to the competent authority for that port a Maritime Declaration of Health which shall be countersigned by the ship's surgeon, if one is carried.
2. The master of a ship, or the ship's surgeon if one is carried, shall supply any information required by the competent authority as to health conditions on board during an international voyage.
3. A Maritime Declaration of Health shall conform to the model provided in Annex 8.
4. A State Party may decide:
 - (a) to dispense with the submission of the Maritime Declaration of Health by all arriving ships; or
 - (b) to require the submission of the Maritime Declaration of Health under a recommendation concerning ships arriving from affected areas or to require it from ships which might otherwise carry infection or contamination.

The State Party shall inform shipping operators or their agents of these requirements.

Article 38 Health Part of the Aircraft General Declaration

1. The pilot in command of an aircraft or the pilot's agent, in flight or upon landing at the first airport in the territory of a State Party, shall, to the best of his or her ability, except when that State Party does not require it, complete and deliver to the competent authority for that airport the Health Part of the Aircraft General Declaration which shall conform to the model specified in Annex 9.
2. The pilot in command of an aircraft or the pilot's agent shall supply any information required by the State Party as to health conditions on board during an international voyage and any health measure applied to the aircraft.
3. A State Party may decide:
 - (a) to dispense with the submission of the Health Part of the Aircraft General Declaration by all arriving aircraft; or
 - (b) to require the submission of the Health Part of the Aircraft General Declaration under a recommendation concerning aircraft arriving from affected areas or to require it from aircraft which might otherwise carry infection or contamination.

The State Party shall inform aircraft operators or their agents of these requirements.

Article 39 Ship sanitation certificates

1. Ship Sanitation Control Exemption Certificates and Ship Sanitation Control Certificates shall be valid for a maximum period of six months. This period may be extended by one month if the inspection or control measures required cannot be accomplished at the port.
2. If a valid Ship Sanitation Control Exemption Certificate or Ship Sanitation Control Certificate is not produced or evidence of a public health risk is found on board a ship, the State Party may proceed as provided in paragraph 1 of Article 27.
3. The certificates referred to in this Article shall conform to the model in Annex 3.
4. Whenever possible, control measures shall be carried out when the ship and holds are empty. In the case of a ship in ballast, they shall be carried out before loading.
5. When control measures are required and have been satisfactorily completed, the competent authority shall issue a Ship Sanitation Control Certificate, noting the evidence found and the control measures taken.
6. The competent authority may issue a Ship Sanitation Control Exemption Certificate at any port specified under Article 20 if it is satisfied that the ship is free of infection and contamination, including vectors and reservoirs. Such a certificate shall normally be issued only if the inspection of the ship has been carried out when the ship and holds are empty or when they contain only ballast or other material, of such a nature or so disposed as to make a thorough inspection of the holds possible.

7. If the conditions under which control measures are carried out are such that, in the opinion of the competent authority for the port where the operation was performed, a satisfactory result cannot be obtained, the competent authority shall make a note to that effect on the Ship Sanitation Control Certificate.

PART VII – CHARGES

Article 40 Charges for health measures regarding travellers

1. Except for travellers seeking temporary or permanent residence, and subject to paragraph 2 of this Article, no charge shall be made by a State Party pursuant to these Regulations for the following measures for the protection of public health:

- (a) any medical examination provided for in these Regulations, or any supplementary examination which may be required by that State Party to ascertain the health status of the traveller examined;
- (b) any vaccination or other prophylaxis provided to a traveller on arrival that is not a published requirement or is a requirement published less than 10 days prior to provision of the vaccination or other prophylaxis;
- (c) appropriate isolation or quarantine requirements of travellers;
- (d) any certificate issued to the traveller specifying the measures applied and the date of application; or
- (e) any health measures applied to baggage accompanying the traveller.

2. States Parties may charge for health measures other than those referred to in paragraph 1 of this Article, including those primarily for the benefit of the traveller.

3. Where charges are made for applying such health measures to travellers under these Regulations, there shall be in each State Party only one tariff for such charges and every charge shall:

- (a) conform to this tariff;
- (b) not exceed the actual cost of the service rendered; and
- (c) be levied without distinction as to the nationality, domicile or residence of the traveller concerned.

4. The tariff, and any amendment thereto, shall be published at least 10 days in advance of any levy thereunder.

5. Nothing in these Regulations shall preclude States Parties from seeking reimbursement for expenses incurred in providing the health measures in paragraph 1 of this Article:

- (a) from conveyance operators or owners with regard to their employees; or
- (b) from applicable insurance sources.

6. Under no circumstances shall travellers or conveyance operators be denied the ability to depart from the territory of a State Party pending payment of the charges referred to in paragraphs 1 or 2 of this Article.

Article 41 Charges for baggage, cargo, containers, conveyances, goods or postal parcels

1. Where charges are made for applying health measures to baggage, cargo, containers, conveyances, goods or postal parcels under these Regulations, there shall be in each State Party only one tariff for such charges and every charge shall:

- (a) conform to this tariff;
- (b) not exceed the actual cost of the service rendered; and
- (c) be levied without distinction as to the nationality, flag, registry or ownership of the baggage, cargo, containers, conveyances, goods or postal parcels concerned. In particular, there shall be no distinction made between national and foreign baggage, cargo, containers, conveyances, goods or postal parcels.

2. The tariff, and any amendment thereto, shall be published at least 10 days in advance of any levy thereunder.

PART VIII – GENERAL PROVISIONS

Article 42 Implementation of health measures

Health measures taken pursuant to these Regulations shall be initiated and completed without delay, and applied in a transparent and non-discriminatory manner.

Article 43 Additional health measures

1. These Regulations shall not preclude States Parties from implementing health measures, in accordance with their relevant national law and obligations under international law, in response to specific public health risks or public health emergencies of international concern, which:

- (a) achieve the same or greater level of health protection than WHO recommendations; or
- (b) are otherwise prohibited under Article 25, Article 26, paragraphs 1 and 2 of Article 28, Article 30, paragraph 1(c) of Article 31 and Article 33,

provided such measures are otherwise consistent with these Regulations.

Such measures shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection.

2. In determining whether to implement the health measures referred to in paragraph 1 of this Article or additional health measures under paragraph 2 of Article 23, paragraph 1 of Article 27, paragraph 2 of Article 28 and paragraph 2(c) of Article 31, States Parties shall base their determinations upon:

- (a) scientific principles;

(b) available scientific evidence of a risk to human health, or where such evidence is insufficient, the available information including from WHO and other relevant intergovernmental organizations and international bodies; and

(c) any available specific guidance or advice from WHO.

3. A State Party implementing additional health measures referred to in paragraph 1 of this Article which significantly interfere with international traffic shall provide to WHO the public health rationale and relevant scientific information for it. WHO shall share this information with other States Parties and shall share information regarding the health measures implemented. For the purpose of this Article, significant interference generally means refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods, and the like, or their delay, for more than 24 hours.

4. After assessing information provided pursuant to paragraph 3 and 5 of this Article and other relevant information, WHO may request that the State Party concerned reconsider the application of the measures.

5. A State Party implementing additional health measures referred to in paragraphs 1 and 2 of this Article that significantly interfere with international traffic shall inform WHO, within 48 hours of implementation, of such measures and their health rationale unless these are covered by a temporary or standing recommendation.

6. A State Party implementing a health measure pursuant to paragraph 1 or 2 of this Article shall within three months review such a measure taking into account the advice of WHO and the criteria in paragraph 2 of this Article.

7. Without prejudice to its rights under Article 56, any State Party impacted by a measure taken pursuant to paragraph 1 or 2 of this Article may request the State Party implementing such a measure to consult with it. The purpose of such consultations is to clarify the scientific information and public health rationale underlying the measure and to find a mutually acceptable solution.

8. The provisions of this Article may apply to implementation of measures concerning travellers taking part in mass congregations.

Article 44 Collaboration and assistance

1. States Parties shall undertake to collaborate with each other, to the extent possible, in:

(a) the detection and assessment of, and response to, events as provided under these Regulations;

(b) the provision or facilitation of technical cooperation and logistical support, particularly in the development, strengthening and maintenance of the public health capacities required under these Regulations;

(c) the mobilization of financial resources to facilitate implementation of their obligations under these Regulations; and

(d) the formulation of proposed laws and other legal and administrative provisions for the implementation of these Regulations.

2. WHO shall collaborate with States Parties, upon request, to the extent possible, in:
 - (a) the evaluation and assessment of their public health capacities in order to facilitate the effective implementation of these Regulations;
 - (b) the provision or facilitation of technical cooperation and logistical support to States Parties; and
 - (c) the mobilization of financial resources to support developing countries in building, strengthening and maintaining the capacities provided for in Annex 1.
3. Collaboration under this Article may be implemented through multiple channels, including bilaterally, through regional networks and the WHO regional offices, and through intergovernmental organizations and international bodies.

Article 45 Treatment of personal data

1. Health information collected or received by a State Party pursuant to these Regulations from another State Party or from WHO which refers to an identified or identifiable person shall be kept confidential and processed anonymously as required by national law.
2. Notwithstanding paragraph 1, States Parties may disclose and process personal data where essential for the purposes of assessing and managing a public health risk, but State Parties, in accordance with national law, and WHO must ensure that the personal data are:
 - (a) processed fairly and lawfully, and not further processed in a way incompatible with that purpose;
 - (b) adequate, relevant and not excessive in relation to that purpose;
 - (c) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that data which are inaccurate or incomplete are erased or rectified; and
 - (d) not kept longer than necessary.
3. Upon request, WHO shall as far as practicable provide an individual with his or her personal data referred to in this Article in an intelligible form, without undue delay or expense and, when necessary, allow for correction.

*Article 46 Transport and handling of biological substances, reagents
and materials for diagnostic purposes*

States Parties shall, subject to national law and taking into account relevant international guidelines, facilitate the transport, entry, exit, processing and disposal of biological substances and diagnostic specimens, reagents and other diagnostic materials for verification and public health response purposes under these Regulations.

PART IX – THE IHR ROSTER OF EXPERTS, THE EMERGENCY COMMITTEE AND THE REVIEW COMMITTEE

Chapter I – The IHR Roster of Experts

Article 47 Composition

The Director-General shall establish a roster composed of experts in all relevant fields of expertise (hereinafter the “IHR Expert Roster”). The Director-General shall appoint the members of the IHR Expert Roster in accordance with the WHO Regulations for Expert Advisory Panels and Committees (hereinafter the “WHO Advisory Panel Regulations”), unless otherwise provided in these Regulations. In addition, the Director-General shall appoint one member at the request of each State Party and, where appropriate, experts proposed by relevant intergovernmental and regional economic integration organizations. Interested States Parties shall notify the Director-General of the qualifications and fields of expertise of each of the experts they propose for membership. The Director-General shall periodically inform the States Parties, and relevant intergovernmental and regional economic integration organizations, of the composition of the IHR Expert Roster.

Chapter II – The Emergency Committee

Article 48 Terms of reference and composition

1. The Director-General shall establish an Emergency Committee that at the request of the Director-General shall provide its views on:
 - (a) whether an event constitutes a public health emergency of international concern;
 - (b) the termination of a public health emergency of international concern; and
 - (c) the proposed issuance, modification, extension or termination of temporary recommendations.
2. The Emergency Committee shall be composed of experts selected by the Director-General from the IHR Expert Roster and, when appropriate, other expert advisory panels of the Organization. The Director-General shall determine the duration of membership with a view to ensuring its continuity in the consideration of a specific event and its consequences. The Director-General shall select the members of the Emergency Committee on the basis of the expertise and experience required for any particular session and with due regard to the principles of equitable geographical representation. At least one member of the Emergency Committee should be an expert nominated by a State Party within whose territory the event arises.
3. The Director-General may, on his or her own initiative or at the request of the Emergency Committee, appoint one or more technical experts to advise the Committee.

Article 49 Procedure

1. The Director-General shall convene meetings of the Emergency Committee by selecting a number of experts from among those referred to in paragraph 2 of Article 48, according to the fields of expertise and experience most relevant to the specific event that is occurring. For the purpose of this Article, “meetings” of the Emergency Committee may include teleconferences, videoconferences or electronic communications.

2. The Director-General shall provide the Emergency Committee with the agenda and any relevant information concerning the event, including information provided by the States Parties, as well as any temporary recommendation that the Director-General proposes for issuance.
3. The Emergency Committee shall elect its Chairperson and prepare following each meeting a brief summary report of its proceedings and deliberations, including any advice on recommendations.
4. The Director-General shall invite the State Party in whose territory the event arises to present its views to the Emergency Committee. To that effect, the Director-General shall notify to it the dates and the agenda of the meeting of the Emergency Committee with as much advance notice as necessary. The State Party concerned, however, may not seek a postponement of the meeting of the Emergency Committee for the purpose of presenting its views thereto.
5. The views of the Emergency Committee shall be forwarded to the Director-General for consideration. The Director-General shall make the final determination on these matters.
6. The Director-General shall communicate to States Parties the determination and the termination of a public health emergency of international concern, any health measure taken by the State Party concerned, any temporary recommendation, and the modification, extension and termination of such recommendations, together with the views of the Emergency Committee. The Director-General shall inform conveyance operators through States Parties and the relevant international agencies of such temporary recommendations, including their modification, extension or termination. The Director-General shall subsequently make such information and recommendations available to the general public.
7. States Parties in whose territories the event has occurred may propose to the Director-General the termination of a public health emergency of international concern and/or the temporary recommendations, and may make a presentation to that effect to the Emergency Committee.

Chapter III – The Review Committee

Article 50 Terms of reference and composition

1. The Director-General shall establish a Review Committee, which shall carry out the following functions:
 - (a) make technical recommendations to the Director-General regarding amendments to these Regulations;
 - (b) provide technical advice to the Director-General with respect to standing recommendations, and any modifications or termination thereof;
 - (c) provide technical advice to the Director-General on any matter referred to it by the Director-General regarding the functioning of these Regulations.
2. The Review Committee shall be considered an expert committee and shall be subject to the WHO Advisory Panel Regulations, unless otherwise provided in this Article.

3. The Members of the Review Committee shall be selected and appointed by the Director-General from among the persons serving on the IHR Expert Roster and, when appropriate, other expert advisory panels of the Organization.
4. The Director-General shall establish the number of members to be invited to a meeting of the Review Committee, determine its date and duration, and convene the Committee.
5. The Director-General shall appoint members to the Review Committee for the duration of the work of a session only.
6. The Director-General shall select the members of the Review Committee on the basis of the principles of equitable geographical representation, gender balance, a balance of experts from developed and developing countries, representation of a diversity of scientific opinion, approaches and practical experience in various parts of the world, and an appropriate interdisciplinary balance.

Article 51 Conduct of business

1. Decisions of the Review Committee shall be taken by a majority of the members present and voting.
2. The Director-General shall invite Member States, the United Nations and its specialized agencies and other relevant intergovernmental organizations or nongovernmental organizations in official relations with WHO to designate representatives to attend the Committee sessions. Such representatives may submit memoranda and, with the consent of the Chairperson, make statements on the subjects under discussion. They shall not have the right to vote.

Article 52 Reports

1. For each session, the Review Committee shall draw up a report setting forth the Committee's views and advice. This report shall be approved by the Review Committee before the end of the session. Its views and advice shall not commit the Organization and shall be formulated as advice to the Director-General. The text of the report may not be modified without the Committee's consent.
2. If the Review Committee is not unanimous in its findings, any member shall be entitled to express his or her dissenting professional views in an individual or group report, which shall state the reasons why a divergent opinion is held and shall form part of the Committee's report.
3. The Review Committee's report shall be submitted to the Director-General, who shall communicate its views and advice to the Health Assembly or the Executive Board for their consideration and action.

Article 53 Procedures for standing recommendations

When the Director-General considers that a standing recommendation is necessary and appropriate for a specific public health risk, the Director-General shall seek the views of the Review Committee. In addition to the relevant paragraphs of Articles 50 to 52, the following provisions shall apply:

- (a) proposals for standing recommendations, their modification or termination may be submitted to the Review Committee by the Director-General or by States Parties through the Director-General;

- (b) any State Party may submit relevant information for consideration by the Review Committee;
- (c) the Director-General may request any State Party, intergovernmental organization or nongovernmental organization in official relations with WHO to place at the disposal of the Review Committee information in its possession concerning the subject of the proposed standing recommendation as specified by the Review Committee;
- (d) the Director-General may, at the request of the Review Committee or on the Director-General's own initiative, appoint one or more technical experts to advise the Review Committee. They shall not have the right to vote;
- (e) any report containing the views and advice of the Review Committee regarding standing recommendations shall be forwarded to the Director-General for consideration and decision. The Director-General shall communicate the Review Committee's views and advice to the Health Assembly;
- (f) the Director-General shall communicate to States Parties any standing recommendation, as well as the modifications or termination of such recommendations, together with the views of the Review Committee;
- (g) standing recommendations shall be submitted by the Director-General to the subsequent Health Assembly for its consideration.

PART X – FINAL PROVISIONS

Article 54 Reporting and review

1. States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly.
2. The Health Assembly shall periodically review the functioning of these Regulations. To that end it may request the advice of the Review Committee, through the Director-General. The first such review shall take place no later than five years after the entry into force of these Regulations.
3. WHO shall periodically conduct studies to review and evaluate the functioning of Annex 2. The first such review shall commence no later than one year after the entry into force of these Regulations. The results of such reviews shall be submitted to the Health Assembly for its consideration, as appropriate.

Article 55 Amendments

1. Amendments to these Regulations may be proposed by any State Party or by the Director-General. Such proposals for amendments shall be submitted to the Health Assembly for its consideration.
2. The text of any proposed amendment shall be communicated to all States Parties by the Director-General at least four months before the Health Assembly at which it is proposed for consideration.

3. Amendments to these Regulations adopted by the Health Assembly pursuant to this Article shall come into force for all States Parties on the same terms, and subject to the same rights and obligations, as provided for in Article 22 of the Constitution of WHO and Articles 59 to 64 of these Regulations.

Article 56 Settlement of disputes

1. In the event of a dispute between two or more States Parties concerning the interpretation or application of these Regulations, the States Parties concerned shall seek in the first instance to settle the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation. Failure to reach agreement shall not absolve the parties to the dispute from the responsibility of continuing to seek to resolve it.

2. In the event that the dispute is not settled by the means described under paragraph 1 of this Article, the States Parties concerned may agree to refer the dispute to the Director-General, who shall make every effort to settle it.

3. A State Party may at any time declare in writing to the Director-General that it accepts arbitration as compulsory with regard to all disputes concerning the interpretation or application of these Regulations to which it is a party or with regard to a specific dispute in relation to any other State Party accepting the same obligation. The arbitration shall be conducted in accordance with the Permanent Court of Arbitration Optional Rules for Arbitrating Disputes between Two States applicable at the time a request for arbitration is made. The States Parties that have agreed to accept arbitration as compulsory shall accept the arbitral award as binding and final. The Director-General shall inform the Health Assembly regarding such action as appropriate.

4. Nothing in these Regulations shall impair the rights of States Parties under any international agreement to which they may be parties to resort to the dispute settlement mechanisms of other intergovernmental organizations or established under any international agreement.

5. In the event of a dispute between WHO and one or more States Parties concerning the interpretation or application of these Regulations, the matter shall be submitted to the Health Assembly.

Article 57 Relationship with other international agreements

1. States Parties recognize that the IHR and other relevant international agreements should be interpreted so as to be compatible. The provisions of the IHR shall not affect the rights and obligations of any State Party deriving from other international agreements.

2. Subject to paragraph 1 of this Article, nothing in these Regulations shall prevent States Parties having certain interests in common owing to their health, geographical, social or economic conditions, from concluding special treaties or arrangements in order to facilitate the application of these Regulations, and in particular with regard to:

(a) the direct and rapid exchange of public health information between neighbouring territories of different States;

(b) the health measures to be applied to international coastal traffic and to international traffic in waters within their jurisdiction;

(c) the health measures to be applied in contiguous territories of different States at their common frontier;

- (d) arrangements for carrying affected persons or affected human remains by means of transport specially adapted for the purpose; and
- (e) deratting, disinsection, disinfection, decontamination or other treatment designed to render goods free of disease-causing agents.

3. Without prejudice to their obligations under these Regulations, States Parties that are members of a regional economic integration organization shall apply in their mutual relations the common rules in force in that regional economic integration organization.

Article 58 International sanitary agreements and regulations

1. These Regulations, subject to the provisions of Article 62 and the exceptions hereinafter provided, shall replace as between the States bound by these Regulations and as between these States and WHO, the provisions of the following international sanitary agreements and regulations:

- (a) International Sanitary Convention, signed in Paris, 21 June 1926;
- (b) International Sanitary Convention for Aerial Navigation, signed at The Hague, 12 April 1933;
- (c) International Agreement for dispensing with Bills of Health, signed in Paris, 22 December 1934;
- (d) International Agreement for dispensing with Consular Visas on Bills of Health, signed in Paris, 22 December 1934;
- (e) Convention modifying the International Sanitary Convention of 21 June 1926, signed in Paris, 31 October 1938;
- (f) International Sanitary Convention, 1944, modifying the International Sanitary Convention of 21 June 1926, opened for signature in Washington, 15 December 1944;
- (g) International Sanitary Convention for Aerial Navigation, 1944, modifying the International Sanitary Convention of 12 April 1933, opened for signature in Washington, 15 December 1944;
- (h) Protocol of 23 April 1946 to prolong the International Sanitary Convention, 1944, signed in Washington;
- (i) Protocol of 23 April 1946 to prolong the International Sanitary Convention for Aerial Navigation, 1944, signed in Washington;
- (j) International Sanitary Regulations, 1951, and the Additional Regulations of 1955, 1956, 1960, 1963 and 1965; and
- (k) the International Health Regulations of 1969 and the amendments of 1973 and 1981.

2. The Pan American Sanitary Code, signed at Havana, 14 November 1924, shall remain in force with the exception of Articles 2, 9, 10, 11, 16 to 53 inclusive, 61 and 62, to which the relevant part of paragraph 1 of this Article shall apply.

Article 59 Entry into force; period for rejection or reservations

1. The period provided in execution of Article 22 of the Constitution of WHO for rejection of, or reservation to, these Regulations or an amendment thereto, shall be 18 months from the date of the notification by the Director-General of the adoption of these Regulations or of an amendment to these Regulations by the Health Assembly. Any rejection or reservation received by the Director-General after the expiry of that period shall have no effect.
2. These Regulations shall enter into force 24 months after the date of notification referred to in paragraph 1 of this Article, except for:
 - (a) a State that has rejected these Regulations or an amendment thereto in accordance with Article 61;
 - (b) a State that has made a reservation, for which these Regulations shall enter into force as provided in Article 62;
 - (c) a State that becomes a Member of WHO after the date of the notification by the Director-General referred to in paragraph 1 of this Article, and which is not already a party to these Regulations, for which these Regulations shall enter into force as provided in Article 60; and
 - (d) a State not a Member of WHO that accepts these Regulations, for which they shall enter into force in accordance with paragraph 1 of Article 64.
3. If a State is not able to adjust its domestic legislative and administrative arrangements fully with these Regulations within the period set out in paragraph 2 of this Article, that State shall submit within the period specified in paragraph 1 of this Article a declaration to the Director-General regarding the outstanding adjustments and achieve them no later than 12 months after the entry into force of these Regulations for that State Party.

Article 60 New Member States of WHO

Any State which becomes a Member of WHO after the date of the notification by the Director-General referred to in paragraph 1 of Article 59, and which is not already a party to these Regulations, may communicate its rejection of, or any reservation to, these Regulations within a period of twelve months from the date of the notification to it by the Director-General after becoming a Member of WHO. Unless rejected, these Regulations shall enter into force with respect to that State, subject to the provisions of Articles 62 and 63, upon expiry of that period. In no case shall these Regulations enter into force in respect to that State earlier than 24 months after the date of notification referred to in paragraph 1 of Article 59.

Article 61 Rejection

If a State notifies the Director-General of its rejection of these Regulations or of an amendment thereto within the period provided in paragraph 1 of Article 59, these Regulations or the amendment concerned shall not enter into force with respect to that State. Any international sanitary agreement or regulations listed in Article 58 to which such State is already a party shall remain in force as far as such State is concerned.

Article 62 Reservations

1. States may make reservations to these Regulations in accordance with this Article. Such reservations shall not be incompatible with the object and purpose of these Regulations.
2. Reservations to these Regulations shall be notified to the Director-General in accordance with paragraph 1 of Article 59 and Article 60, paragraph 1 of Article 63 or paragraph 1 of Article 64, as the case may be. A State not a Member of WHO shall notify the Director-General of any reservation with its notification of acceptance of these Regulations. States formulating reservations should provide the Director-General with reasons for the reservations.
3. A rejection in part of these Regulations shall be considered as a reservation.
4. The Director-General shall, in accordance with paragraph 2 of Article 65, issue notification of each reservation received pursuant to paragraph 2 of this Article. The Director-General shall:
 - (a) if the reservation was made before the entry into force of these Regulations, request those Member States that have not rejected these Regulations to notify him or her within six months of any objection to the reservation, or
 - (b) if the reservation was made after the entry into force of these Regulations, request States Parties to notify him or her within six months of any objection to the reservation.

States objecting to a reservation should provide the Director-General with reasons for the objection.

5. After this period, the Director-General shall notify all States Parties of the objections he or she has received with regard to reservations. Unless by the end of six months from the date of the notification referred to in paragraph 4 of this Article a reservation has been objected to by one-third of the States referred to in paragraph 4 of this Article, it shall be deemed to be accepted and these Regulations shall enter into force for the reserving State, subject to the reservation.
6. If at least one-third of the States referred to in paragraph 4 of this Article object to the reservation by the end of six months from the date of the notification referred to in paragraph 4 of this Article, the Director-General shall notify the reserving State with a view to its considering withdrawing the reservation within three months from the date of the notification by the Director-General.
7. The reserving State shall continue to fulfil any obligations corresponding to the subject matter of the reservation, which the State has accepted under any of the international sanitary agreements or regulations listed in Article 58.
8. If the reserving State does not withdraw the reservation within three months from the date of the notification by the Director-General referred to in paragraph 6 of this Article, the Director-General shall seek the view of the Review Committee if the reserving State so requests. The Review Committee shall advise the Director-General as soon as possible and in accordance with Article 50 on the practical impact of the reservation on the operation of these Regulations.
9. The Director-General shall submit the reservation, and the views of the Review Committee if applicable, to the Health Assembly for its consideration. If the Health Assembly, by a majority vote, objects to the reservation on the ground that it is incompatible with the object and purpose of these Regulations, the reservation shall not be accepted and these Regulations shall enter into force for the reserving State only after it withdraws its reservation pursuant to Article 63. If the Health Assembly

accepts the reservation, these Regulations shall enter into force for the reserving State, subject to its reservation.

Article 63 Withdrawal of rejection and reservation

1. A rejection made under Article 61 may at any time be withdrawn by a State by notifying the Director-General. In such cases, these Regulations shall enter into force with regard to that State upon receipt by the Director-General of the notification, except where the State makes a reservation when withdrawing its rejection, in which case these Regulations shall enter into force as provided in Article 62. In no case shall these Regulations enter into force in respect to that State earlier than 24 months after the date of notification referred to in paragraph 1 of Article 59.

2. The whole or part of any reservation may at any time be withdrawn by the State Party concerned by notifying the Director-General. In such cases, the withdrawal will be effective from the date of receipt by the Director-General of the notification.

Article 64 States not Members of WHO

1. Any State not a Member of WHO, which is a party to any international sanitary agreement or regulations listed in Article 58 or to which the Director-General has notified the adoption of these Regulations by the World Health Assembly, may become a party hereto by notifying its acceptance to the Director-General and, subject to the provisions of Article 62, such acceptance shall become effective upon the date of entry into force of these Regulations, or, if such acceptance is notified after that date, three months after the date of receipt by the Director-General of the notification of acceptance.

2. Any State not a Member of WHO which has become a party to these Regulations may at any time withdraw from participation in these Regulations, by means of a notification addressed to the Director-General which shall take effect six months after the Director-General has received it. The State which has withdrawn shall, as from that date, resume application of the provisions of any international sanitary agreement or regulations listed in Article 58 to which it was previously a party.

Article 65 Notifications by the Director-General

1. The Director-General shall notify all States Members and Associate Members of WHO, and also other parties to any international sanitary agreement or regulations listed in Article 58, of the adoption by the Health Assembly of these Regulations.

2. The Director-General shall also notify these States, as well as any other State which has become a party to these Regulations or to any amendment to these Regulations, of any notification received by WHO under Articles 60 to 64 respectively, as well as of any decision taken by the Health Assembly under Article 62.

Article 66 Authentic texts

1. The Arabic, Chinese, English, French, Russian and Spanish texts of these Regulations shall be equally authentic. The original texts of these Regulations shall be deposited with WHO.

2. The Director-General shall send, with the notification provided in paragraph 1 of Article 59, certified copies of these Regulations to all Members and Associate Members, and also to other parties to any of the international sanitary agreements or regulations listed in Article 58.

3. Upon the entry into force of these Regulations, the Director-General shall deliver certified copies thereof to the Secretary-General of the United Nations for registration in accordance with Article 102 of the Charter of the United Nations.

ANNEX 1

**A. CORE CAPACITY REQUIREMENTS FOR SURVEILLANCE
AND RESPONSE**

1. States Parties shall utilize existing national structures and resources to meet their core capacity requirements under these Regulations, including with regard to:

- (a) their surveillance, reporting, notification, verification, response and collaboration activities; and
- (b) their activities concerning designated airports, ports and ground crossings.

2. Each State Party shall assess, within two years following the entry into force of these Regulations for that State Party, the ability of existing national structures and resources to meet the minimum requirements described in this Annex. As a result of such assessment, States Parties shall develop and implement plans of action to ensure that these core capacities are present and functioning throughout their territories as set out in paragraph 1 of Article 5 and paragraph 1 of Article 13.

3. States Parties and WHO shall support assessments, planning and implementation processes under this Annex.

4. At the local community level and/or primary public health response level

The capacities:

- (a) to detect events involving disease or death above expected levels for the particular time and place in all areas within the territory of the State Party; and
- (b) to report all available essential information immediately to the appropriate level of health-care response. At the community level, reporting shall be to local community health-care institutions or the appropriate health personnel. At the primary public health response level, reporting shall be to the intermediate or national response level, depending on organizational structures. For the purposes of this Annex, essential information includes the following: clinical descriptions, laboratory results, sources and type of risk, numbers of human cases and deaths, conditions affecting the spread of the disease and the health measures employed; and
- (c) to implement preliminary control measures immediately.

5. At the intermediate public health response levels

The capacities:

- (a) to confirm the status of reported events and to support or implement additional control measures; and
- (b) to assess reported events immediately and, if found urgent, to report all essential information to the national level. For the purposes of this Annex, the criteria for urgent events include serious public health impact and/or unusual or unexpected nature with high potential for spread.

6. At the national level

Assessment and notification. The capacities:

- (a) to assess all reports of urgent events within 48 hours; and
- (b) to notify WHO immediately through the National IHR Focal Point when the assessment indicates the event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9.

Public health response. The capacities:

- (a) to determine rapidly the control measures required to prevent domestic and international spread;
- (b) to provide support through specialized staff, laboratory analysis of samples (domestically or through collaborating centres) and logistical assistance (e.g. equipment, supplies and transport);
- (c) to provide on-site assistance as required to supplement local investigations;
- (d) to provide a direct operational link with senior health and other officials to approve rapidly and implement containment and control measures;
- (e) to provide direct liaison with other relevant government ministries;
- (f) to provide, by the most efficient means of communication available, links with hospitals, clinics, airports, ports, ground crossings, laboratories and other key operational areas for the dissemination of information and recommendations received from WHO regarding events in the State Party's own territory and in the territories of other States Parties;
- (g) to establish, operate and maintain a national public health emergency response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of international concern; and
- (h) to provide the foregoing on a 24-hour basis.

**B. CORE CAPACITY REQUIREMENTS FOR DESIGNATED AIRPORTS,
PORTS AND GROUND CROSSINGS**

1. At all times

The capacities:

- (a) to provide access to (i) an appropriate medical service including diagnostic facilities located so as to allow the prompt assessment and care of ill travellers, and (ii) adequate staff, equipment and premises;
- (b) to provide access to equipment and personnel for the transport of ill travellers to an appropriate medical facility;
- (c) to provide trained personnel for the inspection of conveyances;

(d) to ensure a safe environment for travellers using point of entry facilities, including potable water supplies, eating establishments, flight catering facilities, public washrooms, appropriate solid and liquid waste disposal services and other potential risk areas, by conducting inspection programmes, as appropriate; and

(e) to provide as far as practicable a programme and trained personnel for the control of vectors and reservoirs in and near points of entry.

2. For responding to events that may constitute a public health emergency of international concern

The capacities:

(a) to provide appropriate public health emergency response by establishing and maintaining a public health emergency contingency plan, including the nomination of a coordinator and contact points for relevant point of entry, public health and other agencies and services;

(b) to provide assessment of and care for affected travellers or animals by establishing arrangements with local medical and veterinary facilities for their isolation, treatment and other support services that may be required;

(c) to provide appropriate space, separate from other travellers, to interview suspect or affected persons;

(d) to provide for the assessment and, if required, quarantine of suspect travellers, preferably in facilities away from the point of entry;

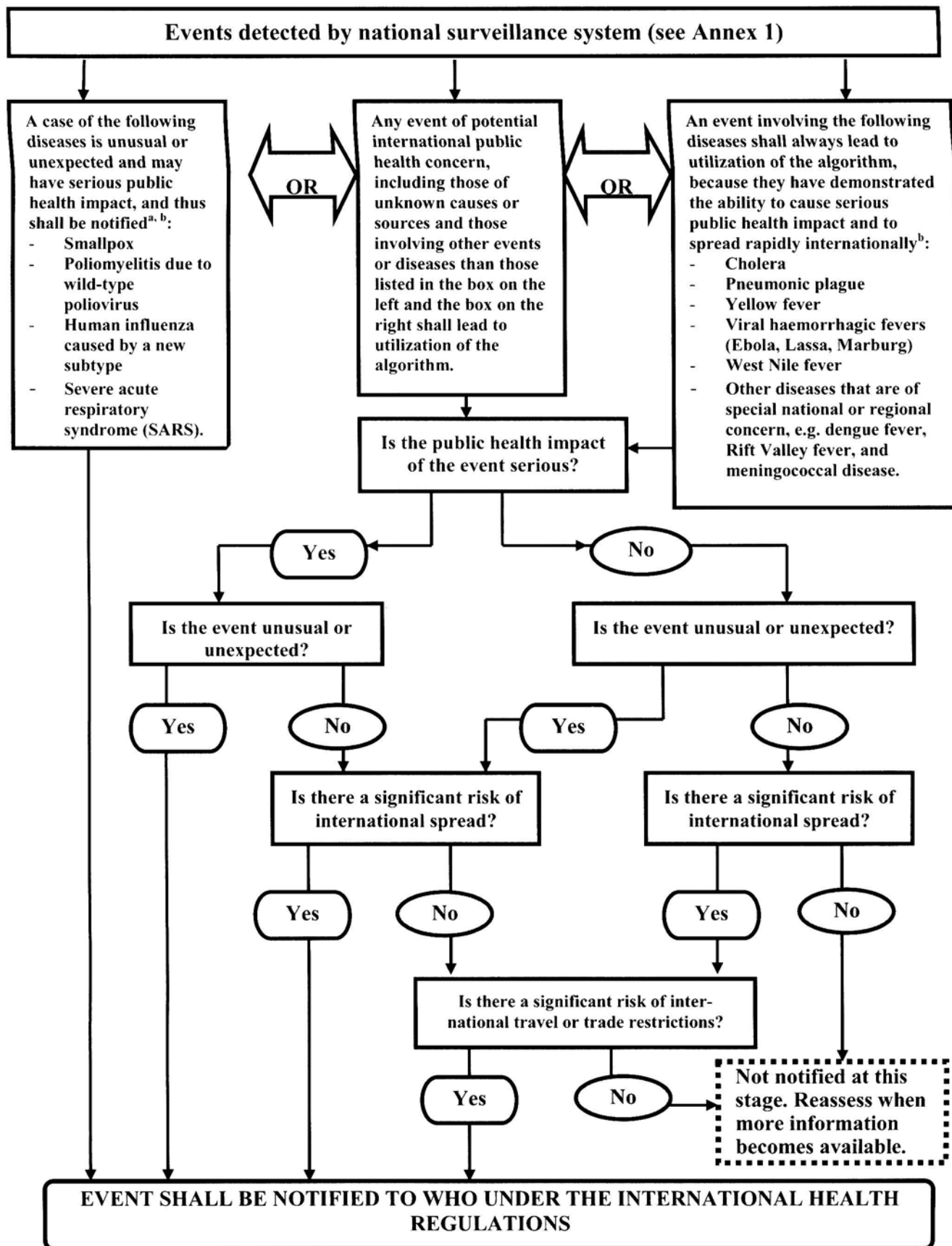
(e) to apply recommended measures to disinsect, derat, disinfect, decontaminate or otherwise treat baggage, cargo, containers, conveyances, goods or postal parcels including, when appropriate, at locations specially designated and equipped for this purpose;

(f) to apply entry or exit controls for arriving and departing travellers; and

(g) to provide access to specially designated equipment, and to trained personnel with appropriate personal protection, for the transfer of travellers who may carry infection or contamination.

ANNEX 2

DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN



^a As per WHO case definitions.

^b The disease list shall be used only for the purposes of these Regulations.

**EXAMPLES FOR THE APPLICATION OF THE DECISION INSTRUMENT FOR
THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE
A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN**

The examples appearing in this Annex are not binding and are for indicative guidance purposes to assist in the interpretation of the decision instrument criteria.

DOES THE EVENT MEET AT LEAST TWO OF THE FOLLOWING CRITERIA?

Is the public health impact of the event serious?	I. Is the public health impact of the event serious?
	1. <i>Is the number of cases and/or number of deaths for this type of event large for the given place, time or population?</i>
	2. <i>Has the event the potential to have a high public health impact?</i>
	THE FOLLOWING ARE EXAMPLES OF CIRCUMSTANCES THAT CONTRIBUTE TO HIGH PUBLIC HEALTH IMPACT:
	<ul style="list-style-type: none"> ✓ Event caused by a pathogen with high potential to cause epidemic (infectiousness of the agent, high case fatality, multiple transmission routes or healthy carrier). ✓ Indication of treatment failure (new or emerging antibiotic resistance, vaccine failure, antidote resistance or failure). ✓ Event represents a significant public health risk even if no or very few human cases have yet been identified. ✓ Cases reported among health staff. ✓ The population at risk is especially vulnerable (refugees, low level of immunization, children, elderly, low immunity, undernourished, etc.). ✓ Concomitant factors that may hinder or delay the public health response (natural catastrophes, armed conflicts, unfavourable weather conditions, multiple foci in the State Party). ✓ Event in an area with high population density. ✓ Spread of toxic, infectious or otherwise hazardous materials that may be occurring naturally or otherwise that has contaminated or has the potential to contaminate a population and/or a large geographical area.
3. <i>Is external assistance needed to detect, investigate, respond and control the current event, or prevent new cases?</i>	
THE FOLLOWING ARE EXAMPLES OF WHEN ASSISTANCE MAY BE REQUIRED:	
<ul style="list-style-type: none"> ✓ Inadequate human, financial, material or technical resources – in particular: <ul style="list-style-type: none"> – Insufficient laboratory or epidemiological capacity to investigate the event (equipment, personnel, financial resources) – Insufficient antidotes, drugs and/or vaccine and/or protective equipment, decontamination equipment, or supportive equipment to cover estimated needs – Existing surveillance system is inadequate to detect new cases in a timely manner. 	
IS THE PUBLIC HEALTH IMPACT OF THE EVENT SERIOUS?	
Answer “yes” if you have answered “yes” to questions 1, 2 or 3 above.	

Is the event unusual or unexpected?	II. Is the event unusual or unexpected?
	<p>4. <i>Is the event unusual?</i></p> <p>THE FOLLOWING ARE EXAMPLES OF UNUSUAL EVENTS:</p> <ul style="list-style-type: none"> ✓ The event is caused by an unknown agent or the source, vehicle, route of transmission is unusual or unknown. ✓ Evolution of cases more severe than expected (including morbidity or case-fatality) or with unusual symptoms. ✓ Occurrence of the event itself unusual for the area, season or population.
	<p>5. <i>Is the event unexpected from a public health perspective?</i></p> <p>THE FOLLOWING ARE EXAMPLES OF UNEXPECTED EVENTS:</p> <ul style="list-style-type: none"> ✓ Event caused by a disease/agent that had already been eliminated or eradicated from the State Party or not previously reported.
	<p>IS THE EVENT UNUSUAL OR UNEXPECTED?</p> <p>Answer “yes” if you have answered “yes” to questions 4 or 5 above.</p>

Is there a significant risk of international spread?	III. Is there a significant risk of international spread?
	<p>6. <i>Is there evidence of an epidemiological link to similar events in other States?</i></p>
	<p>7. <i>Is there any factor that should alert us to the potential for cross border movement of the agent, vehicle or host?</i></p> <p>THE FOLLOWING ARE EXAMPLES OF CIRCUMSTANCES THAT MAY PREDISPOSE TO INTERNATIONAL SPREAD:</p> <ul style="list-style-type: none"> ✓ Where there is evidence of local spread, an index case (or other linked cases) with a history within the previous month of: <ul style="list-style-type: none"> – international travel (or time equivalent to the incubation period if the pathogen is known) – participation in an international gathering (pilgrimage, sports event, conference, etc.) – close contact with an international traveller or a highly mobile population. ✓ Event caused by an environmental contamination that has the potential to spread across international borders. ✓ Event in an area of intense international traffic with limited capacity for sanitary control or environmental detection or decontamination.
	<p>IS THERE A SIGNIFICANT RISK OF INTERNATIONAL SPREAD?</p> <p>Answer “yes” if you have answered “yes” to questions 6 or 7 above.</p>

Risk of international restrictions?	IV. Is there a significant risk of international travel or trade restrictions?
	8. <i>Have similar events in the past resulted in international restriction on trade and/or travel?</i>
	9. <i>Is the source suspected or known to be a food product, water or any other goods that might be contaminated that has been exported/imported to/from other States?</i>
	10. <i>Has the event occurred in association with an international gathering or in an area of intense international tourism?</i>
	11. <i>Has the event caused requests for more information by foreign officials or international media?</i>
	IS THERE A SIGNIFICANT RISK OF INTERNATIONAL TRADE OR TRAVEL RESTRICTIONS? Answer "yes" if you have answered "yes" to questions 8, 9, 10 or 11 above.

States Parties that answer "yes" to the question whether the event meets any two of the four criteria (I-IV) above, shall notify WHO under Article 6 of the International Health Regulations.

ATTACHMENT TO MODEL SHIP SANITATION CONTROL EXEMPTION CERTIFICATE/SHIP SANITATION CONTROL CERTIFICATE

Areas/facilities/systems inspected	Evidence found	Sample results	Documents reviewed	Control measures applied	Re-inspection date	Comments regarding conditions found
Food						
Source						
Storage						
Preparation						
Service						
Water						
Source						
Storage						
Distribution						
Waste						
Holding						
Treatment						
Disposal						
Swimming pools/spas						
Equipment						
Operation						
Medical facilities						
Equipment and medical devices						
Operation						
Medicines						
Other areas inspected						

Indicate when the areas listed are not applicable by marking N/A.

ANNEX 4

**TECHNICAL REQUIREMENTS PERTAINING TO CONVEYANCES AND
CONVEYANCE OPERATORS****Section A Conveyance operators**

1. Conveyance operators shall facilitate:
 - (a) inspections of the cargo, containers and conveyance;
 - (b) medical examinations of persons on board;
 - (c) application of other health measures under these Regulations; and
 - (d) provision of relevant public health information requested by the State Party.
2. Conveyance operators shall provide to the competent authority a valid Ship Sanitation Control Exemption Certificate or a Ship Sanitation Control Certificate or a Maritime Declaration of Health, or the Health Part of an Aircraft General Declaration, as required under these Regulations.

Section B Conveyances

1. Control measures applied to baggage, cargo, containers, conveyances and goods under these Regulations shall be carried out so as to avoid as far as possible injury or discomfort to persons or damage to the baggage, cargo, containers, conveyances and goods. Whenever possible and appropriate, control measures shall be applied when the conveyance and holds are empty.
2. States Parties shall indicate in writing the measures applied to cargo, containers or conveyances, the parts treated, the methods employed, and the reasons for their application. This information shall be provided in writing to the person in charge of an aircraft and, in case of a ship, on the Ship Sanitation Control Certificate. For other cargo, containers or conveyances, States Parties shall issue such information in writing to consignors, consignees, carriers, the person in charge of the conveyance or their respective agents.

ANNEX 5

SPECIFIC MEASURES FOR VECTOR-BORNE DISEASES

1. WHO shall publish, on a regular basis, a list of areas where disinsection or other vector control measures are recommended for conveyances arriving from these areas. Determination of such areas shall be made pursuant to the procedures regarding temporary or standing recommendations, as appropriate.
2. Every conveyance leaving a point of entry situated in an area where vector control is recommended should be disinfected and kept free of vectors. When there are methods and materials advised by the Organization for these procedures, these should be employed. The presence of vectors on board conveyances and the control measures used to eradicate them shall be included:
 - (a) in the case of aircraft, in the Health Part of the Aircraft General Declaration, unless this part of the Declaration is waived by the competent authority at the airport of arrival;
 - (b) in the case of ships, on the Ship Sanitation Control Certificates; and
 - (c) in the case of other conveyances, on a written proof of treatment issued to the consignor, consignee, carrier, the person in charge of the conveyance or their agent, respectively.
3. States Parties should accept disinsecting, deratting and other control measures for conveyances applied by other States if methods and materials advised by the Organization have been applied.
4. States Parties shall establish programmes to control vectors that may transport an infectious agent that constitutes a public health risk to a minimum distance of 400 metres from those areas of point of entry facilities that are used for operations involving travellers, conveyances, containers, cargo and postal parcels, with extension of the minimum distance if vectors with a greater range are present.
5. If a follow-up inspection is required to determine the success of the vector control measures applied, the competent authorities for the next known port or airport of call with a capacity to make such an inspection shall be informed of this requirement in advance by the competent authority advising such follow-up. In the case of ships, this shall be noted on the Ship Sanitation Control Certificate.
6. A conveyance may be regarded as suspect and should be inspected for vectors and reservoirs if:
 - (a) it has a possible case of vector-borne disease on board;
 - (b) a possible case of vector-borne disease has occurred on board during an international voyage; or
 - (c) it has left an affected area within a period of time where on-board vectors could still carry disease.

7. A State Party should not prohibit the landing of an aircraft or berthing of a ship in its territory if the control measures provided for in paragraph 3 of this Annex or otherwise recommended by the Organization are applied. However, aircraft or ships coming from an affected area may be required to land at airports or divert to another port specified by the State Party for that purpose.

8. A State Party may apply vector control measures to a conveyance arriving from an area affected by a vector-borne disease if the vectors for the foregoing disease are present in its territory.

ANNEX 6

VACCINATION, PROPHYLAXIS AND RELATED CERTIFICATES

1. Vaccines or other prophylaxis specified in Annex 7 or recommended under these Regulations shall be of suitable quality; those vaccines and prophylaxis designated by WHO shall be subject to its approval. Upon request, the State Party shall provide to WHO appropriate evidence of the suitability of vaccines and prophylaxis administered within its territory under these Regulations.
2. Persons undergoing vaccination or other prophylaxis under these Regulations shall be provided with an international certificate of vaccination or prophylaxis (hereinafter the "certificate") in the form specified in this Annex. No departure shall be made from the model of the certificate specified in this Annex.
3. Certificates under this Annex are valid only if the vaccine or prophylaxis used has been approved by WHO.
4. Certificates must be signed in the hand of the clinician, who shall be a medical practitioner or other authorized health worker, supervising the administration of the vaccine or prophylaxis. The certificate must also bear the official stamp of the administering centre; however, this shall not be an accepted substitute for the signature.
5. Certificates shall be fully completed in English or in French. They may also be completed in another language, in addition to either English or French.
6. Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.
7. Certificates are individual and shall in no circumstances be used collectively. Separate certificates shall be issued for children.
8. A parent or guardian shall sign the certificate when the child is unable to write. The signature of an illiterate shall be indicated in the usual manner by the person's mark and the indication by another that this is the mark of the person concerned.
9. If the supervising clinician is of the opinion that the vaccination or prophylaxis is contraindicated on medical grounds, the supervising clinician shall provide the person with reasons, written in English or French, and where appropriate in another language in addition to English or French, underlying that opinion, which the competent authorities on arrival should take into account. The supervising clinician and competent authorities shall inform such persons of any risk associated with non-vaccination and with the non-use of prophylaxis in accordance with paragraph 4 of Article 23.
10. An equivalent document issued by the Armed Forces to an active member of those Forces shall be accepted in lieu of an international certificate in the form shown in this Annex if:
 - (a) it embodies medical information substantially the same as that required by such form; and
 - (b) it contains a statement in English or in French and where appropriate in another language in addition to English or French recording the nature and date of the vaccination or prophylaxis and to the effect that it is issued in accordance with this paragraph.

MODEL INTERNATIONAL CERTIFICATE OF VACCINATION OR PROPHYLAXIS

This is to certify that [name], date of birth, sex,
nationality, national identification document, if applicable,
whose signature follows

has on the date indicated been vaccinated or received prophylaxis against:

(name of disease or condition)

in accordance with the International Health Regulations.

Vaccine or prophylaxis	Date	Signature and professional status of supervising clinician	Manufacturer and batch No. of vaccine or prophylaxis	Certificate valid from until	Official stamp of administering centre
1.					
2.					

This certificate is valid only if the vaccine or prophylaxis used has been approved by the World Health Organization.

This certificate must be signed in the hand of the clinician, who shall be a medical practitioner or other authorized health worker, supervising the administration of the vaccine or prophylaxis. The certificate must also bear the official stamp of the administering centre; however, this shall not be an accepted substitute for the signature.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

The validity of this certificate shall extend until the date indicated for the particular vaccination or prophylaxis. The certificate shall be fully completed in English or in French. The certificate may also be completed in another language on the same document, in addition to either English or French.

ANNEX 7

**REQUIREMENTS CONCERNING VACCINATION OR
PROPHYLAXIS FOR SPECIFIC DISEASES**

1. In addition to any recommendation concerning vaccination or prophylaxis, the following diseases are those specifically designated under these Regulations for which proof of vaccination or prophylaxis may be required for travellers as a condition of entry to a State Party:

Vaccination against yellow fever.

2. Recommendations and requirements for vaccination against yellow fever:

(a) For the purpose of this Annex:

(i) the incubation period of yellow fever is six days;

(ii) yellow fever vaccines approved by WHO provide protection against infection starting 10 days following the administration of the vaccine;

(iii) this protection continues for 10 years; and

(iv) the validity of a certificate of vaccination against yellow fever shall extend for a period of 10 years, beginning 10 days after the date of vaccination or, in the case of a revaccination within such period of 10 years, from the date of that revaccination.

(b) Vaccination against yellow fever may be required of any traveller leaving an area where the Organization has determined that a risk of yellow fever transmission is present.

(c) If a traveller is in possession of a certificate of vaccination against yellow fever which is not yet valid, the traveller may be permitted to depart, but the provisions of paragraph 2(h) of this Annex may be applied on arrival.

(d) A traveller in possession of a valid certificate of vaccination against yellow fever shall not be treated as suspect, even if coming from an area where the Organization has determined that a risk of yellow fever transmission is present.

(e) In accordance with paragraph 1 of Annex 6 the yellow fever vaccine used must be approved by the Organization.

(f) States Parties shall designate specific yellow fever vaccination centres within their territories in order to ensure the quality and safety of the procedures and materials employed.

(g) Every person employed at a point of entry in an area where the Organization has determined that a risk of yellow fever transmission is present, and every member of the crew of a conveyance using any such point of entry, shall be in possession of a valid certificate of vaccination against yellow fever.

(h) A State Party, in whose territory vectors of yellow fever are present, may require a traveller from an area where the Organization has determined that a risk of yellow fever

transmission is present, who is unable to produce a valid certificate of vaccination against yellow fever, to be quarantined until the certificate becomes valid, or until a period of not more than six days, reckoned from the date of last possible exposure to infection, has elapsed, whichever occurs first.

(i) Travellers who possess an exemption from yellow fever vaccination, signed by an authorized medical officer or an authorized health worker, may nevertheless be allowed entry, subject to the provisions of the foregoing paragraph of this Annex and to being provided with information regarding protection from yellow fever vectors. Should the travellers not be quarantined, they may be required to report any feverish or other symptoms to the competent authority and be placed under surveillance.

ANNEX 8

MODEL OF MARITIME DECLARATION OF HEALTH

To be completed and submitted to the competent authorities by the masters of ships arriving from foreign ports.

Submitted at the port of Date.....
 Name of ship or inland navigation vessel..... Registration/IMO No.....arriving fromsailing to
 (Nationality)(Flag of vessel)..... Master's name
 Gross tonnage (ship).....
 Tonnage (inland navigation vessel).....
 Valid Sanitation Control Exemption/Control Certificate carried on board? yes..... no..... Issued at..... date.....
 Re-inspection required? yes..... no.....
 Has ship/vessel visited an affected area identified by the World Health Organization? yes..... no.....
 Port and date of visit
 List ports of call from commencement of voyage with dates of departure, or within past thirty days, whichever is shorter:

Upon request of the competent authority at the port of arrival, list crew members, passengers or other persons who have joined ship/vessel since international voyage began or within past thirty days, whichever is shorter, including all ports/countries visited in this period (add additional names to the attached schedule):

- (1) Namejoined from: (1).....(2).....(3).....
- (2) Namejoined from: (1).....(2).....(3).....
- (3) Namejoined from: (1).....(2).....(3).....

Number of crew members on board.....
 Number of passengers on board.....

Health questions

- (1) Has any person died on board during the voyage otherwise than as a result of accident? yes.... no.....
 If yes, state particulars in attached schedule. Total no. of deaths
- (2) Is there on board or has there been during the international voyage any case of disease which you suspect to be of an infectious nature? yes..... no..... If yes, state particulars in attached schedule.
- (3) Has the total number of ill passengers during the voyage been greater than normal/expected? yes.... no.....
 How many ill persons?
- (4) Is there any ill person on board now? yes..... no..... If yes, state particulars in attached schedule.
- (5) Was a medical practitioner consulted? yes..... no..... If yes, state particulars of medical treatment or advice provided in attached schedule.
- (6) Are you aware of any condition on board which may lead to infection or spread of disease? yes..... no.....
 If yes, state particulars in attached schedule.
- (7) Has any sanitary measure (e.g. quarantine, isolation, disinfection or decontamination) been applied on board? yes no.....
 If yes, specify type, place and date.....
- (8) Have any stowaways been found on board? yes no..... If yes, where did they join the ship (if known)?
- (9) Is there a sick animal or pet on board? yes no.....

Note: In the absence of a surgeon, the master should regard the following symptoms as grounds for suspecting the existence of a disease of an infectious nature:

- (a) fever, persisting for several days or accompanied by (i) prostration; (ii) decreased consciousness; (iii) glandular swelling; (iv) jaundice; (v) cough or shortness of breath; (vi) unusual bleeding; or (vii) paralysis.
- (b) with or without fever: (i) any acute skin rash or eruption; (ii) severe vomiting (other than sea sickness); (iii) severe diarrhoea; or (iv) recurrent convulsions.

I hereby declare that the particulars and answers to the questions given in this Declaration of Health (including the schedule) are true and correct to the best of my knowledge and belief.

Signed

Master

Countersigned

Ship's Surgeon (if carried)

Date.....

ATTACHMENT TO MODEL OF MARITIME DECLARATION OF HEALTH

Name	Class or rating	Age	Sex	Nationality	Port, date joined ship/vessel	Nature of illness	Date of onset of symptoms	Reported to a port medical officer?	Disposal of case*	Drugs, medicines or other treatment given to patient	Comments

* State: (1) whether the person recovered, is still ill or died; and (2) whether the person is still on board, was evacuated (including the name of the port or airport), or was buried at sea.

ANNEX 9

**THIS DOCUMENT IS PART OF THE AIRCRAFT GENERAL DECLARATION,
PROMULGATED BY THE INTERNATIONAL CIVIL AVIATION ORGANIZATION¹**

HEALTH PART OF THE AIRCRAFT GENERAL DECLARATION

Declaration of Health

Persons on board with illnesses other than airsickness or the effects of accidents (including persons with symptoms or signs of illness such as rash, fever, chills, diarrhoea) as well as those cases of illness disembarked during the flight

.....

Any other condition on board which may lead to the spread of disease

.....

Details of each disinsecting or sanitary treatment (place, date, time, method) during the flight. If no disinsecting has been carried out during the flight, give details of most recent disinsecting

.....

.....

Signature, if required:

Crew member concerned

(Eighth plenary meeting, 23 May 2005 –
Committee A, third report)

WHA58.4 Appropriation resolution for the financial period 2006-2007

The Fifty-eighth World Health Assembly

1. RESOLVES to appropriate for the financial period 2006-2007 an amount of US\$ 995 315 000 under the regular budget as follows:

¹ An informal working group met during the second session of the Intergovernmental Working Group and recommended changes to this document which WHO will transmit to the International Civil Aviation Organization for appropriate consideration.

Appropriation section	Purpose of appropriation	Amount
		US\$
1.	Essential health interventions	238 343 000
2.	Health policies, systems and products	164 913 000
3.	Determinants of health	96 156 000
4.	Enabling programme delivery	251 770 000
5.	WHO's core presence in countries	128 624 000
6.	Other	35 509 000
	Effective working budget	915 315 000
7.	Transfer to Tax Equalization Fund	80 000 000
	Total	995 315 000

2. RESOLVES to finance the regular budget for the financial period 2006-2007 as follows:

Source of financing	Amount
	US\$
Estimated Miscellaneous Income	22 200 000
Regular budget net assessments on Members ¹	893 115 000
Transfer to Tax Equalization Fund	80 000 000
	Total
	995 315 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2006-2007; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations voted under paragraph 1 shall be available for the payment of obligations incurred during the financial period 1 January 2006 to 31 December 2007 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 2006-2007 to appropriation sections 1 to 6;

¹See also paragraph 3(3).

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such reimbursements is estimated at US\$ 9 114 080, resulting in a total assessment on Members of US\$ 902 229 080;

4. DECIDES:

(1) that with reference to resolution WHA56.34 and notwithstanding the provisions of Financial Regulation 5.1, an amount of US\$ 8 655 000 shall be financed directly by the Miscellaneous Income account to provide an adjustment mechanism for the benefit of those Member States that will experience an increase in the rate of assessment between that applicable for the 2000-2001 financial period and for the 2006-2007 financial period and notify the Organization that they wish to benefit from the adjustment mechanism;

(2) that the amount required to meet payments under the financial incentive scheme for 2006 and for 2007 in accordance with Financial Regulation 6.5, estimated at US\$ 1 000 000, shall be financed directly by the Miscellaneous Income account;

(3) that the level of the Working Capital Fund shall remain at the level of US\$ 31 000 000 as decided earlier under resolution WHA56.32;

5. NOTES that the expenditure in the programme budget for 2006-2007 to be financed by voluntary contributions is estimated at US\$ 2 398 126 000, leading to a total effective budget under all sources of funds of US\$ 3 313 441 000;

6. COMMENDS the further progress made by the Director-General in implementing a results-based management framework, and supports the systematic review of all WHO core managerial and administrative policies and processes with the aim of simplifying and changing the way in which WHO works in order to achieve greater impact while maintaining operations of lower cost;

7. REQUESTS the Director-General:

(1) to provide, as from the 116th session of the Executive Board and bearing in mind Financial Regulation XV – Resolutions involving Expenditures – and Rule 13 of the Rules of Procedure of the World Health Assembly, a report on the administrative and financial implications of any resolution proposed for adoption by the Executive Board or Health Assembly and to ensure that this report is provided before consideration of the resolution being introduced;

(2) to continue to pursue rigorous financial discipline through transparency of resource allocations to headquarters, global activities, regions and countries, and elimination of any overlapping functions within the Organization;

(3) to implement the planned efficiency projects described in the Programme budget 2006-2007, and to set clear and measurable efficiency targets for this, and future, budgets;

(4) to ensure early implementation of the outstanding audit recommendations, and to propose to the Executive Board at its 117th session a tracking programme for external and internal audit recommendations which include timeframes for implementation;

- (5) to carry through his strong commitment to further strengthen the performance of the Organization, in particular at regional and country levels;
- (6) to provide guidance on WHO's relative priorities when requesting voluntary contributions;
- (7) to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made in implementation of this resolution.

(Eighth plenary meeting, 23 May 2005 –
Committee A, fourth report)

WHA58.5 Strengthening pandemic-influenza preparedness and response

The Fifty-eighth World Health Assembly,

Having considered the report on influenza pandemic preparedness and response;¹

Recalling resolutions WHA22.47, Diseases under surveillance: louse-borne typhus, louse-borne relapsing fever, viral influenza, paralytic poliomyelitis; WHA48.13, Communicable diseases prevention and control: new, emerging, and re-emerging infectious diseases; WHA56.19, Prevention and control of influenza pandemics and annual epidemics; and WHA56.28, Revision of the International Health Regulations; and the global agenda for influenza surveillance and control;

Acknowledging with growing concern that the evolving, unprecedented outbreak of H5N1 avian influenza in Asia represents a serious threat to human health;

Stressing the need for all countries, especially those affected by highly pathogenic avian influenza, to collaborate with WHO and the international community in an open and transparent manner in order to lessen the risk that the H5N1 influenza virus causes a pandemic among humans;

Mindful of the need to address the limited progress being made in development of influenza vaccines and transit to the production stage;

Emphasizing the importance of strengthening surveillance of human and zoonotic influenzas in all countries in order to provide an early warning of, and a timely response to, an influenza pandemic;

Noting the gaps in knowledge and the need for additional research on various aspects of the spread of influenza and for influenza preparedness and response;

Noting the importance of strengthening linkages and cooperation with the mass media;

Acknowledging that communication with the public must be improved in order to increase awareness of the seriousness of the threat that an influenza pandemic represents, and of the steps in basic hygiene that citizens can and should take in order to lessen their risk of contracting and transmitting influenza;

¹ Document A58/13.

Emphasizing the need to strengthen collaboration on human and zoonotic influenzas with organizations responsible for animal and human health at local, national and international levels;

Aware of the need to expand the availability of influenza vaccine so that protection in a pandemic can be extended to populations in more countries, with particular attention to requirements in developing countries;

Recognizing the need to prepare for international cooperation during the initial stages of a pandemic, particularly in the event of inadequate stockpiles of vaccine and antiviral medications;

Recognizing further that influenza antiviral medications will be an important component of a containment strategy, but that additional studies are required to establish their appropriate use in containment;

Recognizing also that a global stockpile of these agents is lacking and few countries have established national stockpiles,

1. URGES Member States:

- (1) to develop and implement national plans for pandemic-influenza preparedness and response that focus on limiting health impact and economic and social disruption;
- (2) to develop and strengthen national surveillance and laboratory capacity for human and zoonotic influenzas;
- (3) to achieve the target set by resolution WHA56.19, Prevention and control of influenza pandemics and annual epidemics, to increase vaccination coverage of all people at high risk, which will lead to availability of greater global vaccine-production capacity during an influenza pandemic;
- (4) seriously to consider developing domestic influenza-vaccine production capacity, based on annual vaccine needs, or to work with neighbouring States in establishing regional vaccine-production strategies;
- (5) to ensure prompt and transparent reporting of outbreaks of human and zoonotic influenzas to WHO's regional offices, FAO, *Office International des Epizooties*, and neighbouring countries, particularly when novel influenza strains are involved, and to facilitate the rapid sharing of clinical specimens and viruses through the WHO Global Influenza Surveillance Network;
- (6) to communicate clearly to health-care workers and the general public the potential threat of an influenza pandemic and to make effective use of media and other appropriate communication channels to educate the public about effective hygienic practices and other public health interventions that may protect them from influenza-virus infection;
- (7) to strengthen linkages and cooperation among national health, agriculture and other pertinent authorities in order to prepare for, including by mobilizing resources, and respond jointly to, outbreaks of highly pathogenic avian influenza;
- (8) to support an international research agenda to reduce the spread and impact of pandemic influenza viruses, to develop more effective vaccines and antiviral medications, and to advance, among various population groups, especially people with immunodeficiencies such as HIV-

infected and AIDS patients, vaccination policies and strategies, in close consultation with the communities concerned;

(9) to contribute, as feasible, their expertise and resources to strengthen WHO programmes, bilateral country activities and other international efforts to prepare for pandemic influenza;

(10) to take all necessary measures during a global pandemic, to provide timely and adequate supplies of vaccines and antiviral drugs, using to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights;

2. REQUESTS the Director-General:

(1) to continue to strengthen global influenza surveillance, including the WHO Global Influenza Surveillance Network, as a crucial component of preparedness for seasonal epidemics and pandemics of influenza;

(2) to seek solutions with other international and national partners, including the private sector, to reduce the present global shortage of influenza vaccines and antiviral medications for both epidemics and pandemics, including vaccination strategies that economize on the use of antigens, and development and licensing of antigen-sparing vaccine formulations;

(3) to provide Member States with technical support and training in order to develop health-promotion strategies in anticipation of, and during, influenza pandemics;

(4) to draw up and coordinate, in collaboration with public and private partners, an international research agenda on pandemic influenza;

(5) to assess the feasibility of using antiviral-medication stockpiles to contain an initial outbreak of influenza and to slow or prevent its international spread, and, as appropriate, to develop an operational framework for their deployment;

(6) to evaluate the potential benefit of personal protection measures, including the wearing of surgical masks, to limit transmission in different settings, especially health-care settings;

(7) to continue to develop WHO's plans and capacity to respond to an influenza pandemic, to be able to provide technical support, capacity building and technology transfer related to H5N1 influenza vaccines and diagnostics to developing countries, and to ensure clear communications with Member States;

(8) to establish joint initiatives for closer collaboration with national and international partners, including FAO and the *Office International des Epizooties*, in the early detection, reporting and investigation of influenza outbreaks of pandemic potential, and in coordinating research on the human-animal interface;

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

(Eighth plenary meeting, 23 May 2005 –
Committee A, fourth report)

WHA58.6 Health conditions in the occupied Palestinian territory, including East Jerusalem, and in the occupied Syrian Golan

The Fifty-eighth World Health Assembly,

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

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

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

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

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 impact on the Palestinian environment and in particular on Palestinian water resources of the disposal of Israeli waste in the West Bank;

Concerned about the possible health effects on the Palestinian people of the “enhanced X-ray machine” used by Israel at Palestinian border-crossing points,

1. CALLS UPON Israel, the occupying power, to halt immediately all its practices, policies and plans which seriously affect the health conditions of civilians under occupation;
2. DEMANDS that Israel reverse its practice of dumping waste in the occupied Palestinian territory;
3. EXTENDS its gratitude to Member States, and to intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people;
4. EXPRESSES its deep appreciation to the Director-General for his efforts to provide necessary assistance to the Palestinian people, the rest of the Arab population in the occupied Arab territories, and other peoples of the region;
5. REQUESTS the Director-General:
 - (1) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory;
 - (2) to undertake without delay an independent health-impact assessment of the “enhanced X-ray machine” used by Israel at Palestinian border-crossing points;

¹ Document A58/24.

- (3) to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties and to help it during and after the announced Israeli withdrawal from the Gaza Strip and parts of the West Bank, in particular so as to guarantee the free movement of all health personnel and patients within and out of the occupied Palestinian territory, including East Jerusalem, and the normal provision of medical supplies to the Palestinian medical premises;
- (4) to provide health-related technical assistance to the Arab 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 Fifty-ninth World Health Assembly.

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.7 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Fifty-eighth World Health Assembly,

Having considered the third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth Health Assembly on Special arrangements for settlement of arrears (Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution);¹

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

Noting that Uruguay was in arrears at the time of the opening of the Fifty-eighth World Health Assembly to such an extent that it is necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of Uruguay should be suspended at the opening of the Fifty-ninth World Health Assembly,

¹ Document A58/43 Rev.1.

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 Fifty-ninth Health Assembly, Uruguay is still in arrears in the payment of its contributions to an extent that would justify invoking Article 7 of the Constitution, Uruguay's voting privileges shall be suspended as from the said opening;
- (2) that any suspension that takes effect as aforesaid shall continue at the Fifty-ninth and subsequent Health Assemblies, until the arrears of Uruguay have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;
- (3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.8 Arrears in payment of contributions: Georgia

The Fifty-eighth World Health Assembly,

Having considered the third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly on Special arrangements for settlement of arrears: Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution,¹ with respect to the request of Georgia for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report on special arrangements for settlement of arrears annexed to the third report,

1. DECIDES to restore the voting privileges of Georgia at the Fifty-eighth World Health Assembly;
2. ACCEPTS that Georgia shall pay its outstanding contributions, totalling US\$ 4 439 163, in 15 annual instalments payable in each of the years 2006 to 2020, as set out below, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period:

	US\$
2006	88 785
2007	88 785
2008	133 175
2009	221 960
2010	221 960
2011	221 960
2012	221 960
2013	221 960
2014	355 130

¹ Document A58/43 Rev.1.

	US\$
2015	443 915
2016	443 915
2017	443 915
2018	443 915
2019	443 915
2020	443 913
Total	4 439 163

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

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

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

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.9 Arrears in payment of contributions: Iraq

The Fifty-eighth World Health Assembly,

Having considered the third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly on Special arrangements for settlement of arrears: Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution,¹ with respect to the request of Iraq for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report on special arrangements for settlement of arrears annexed to the third report,

1. DECIDES to restore the voting privileges of Iraq at the Fifty-eighth World Health Assembly;
2. ACCEPTS that Iraq shall pay its outstanding contributions, totalling US\$ 6 398 801, in 15 annual instalments payable in each of the years 2006 to 2020, as set out below, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period:

	US\$
2006	426 579
2007	426 579
2008	426 579
2009	426 579

¹ Document A58/43 Rev.1.

	US\$
2010	426 579
2011	426 579
2012	426 579
2013	426 579
2014	426 579
2015	426 579
2016	426 579
2017	426 579
2018	426 579
2019	426 579
2020	426 695
Total	6 398 801

3. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if Iraq does not meet the requirements laid down in paragraph 2 above;
4. REQUESTS the Director-General to report to the Fifty-ninth World Health Assembly on the prevailing situation;
5. REQUESTS the Director-General to communicate this resolution to the Government of Iraq.

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.10 Arrears in payment of contributions: Republic of Moldova

The Fifty-eighth World Health Assembly,

Having considered the third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly on Special arrangements for settlement of arrears: Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution,¹ with respect to the request of Republic of Moldova for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report on special arrangements for settlement of arrears annexed to the third report,

1. DECIDES to restore the voting privileges of Republic of Moldova at the Fifty-eighth World Health Assembly;
2. ACCEPTS that Republic of Moldova shall pay its outstanding contributions, totalling US\$ 2 950 023, in 15 annual instalments payable in each of the years 2006 to 2020, as set out below, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period:

¹ Document A58/43 Rev.1.

	US\$
2006	245 000
2007	200 000
2008	200 000
2009	192 088
2010	192 085
2011	192 085
2012	192 085
2013	192 085
2014	192 085
2015	192 085
2016	192 085
2017	192 085
2018	192 085
2019	192 085
2020	192 085
Total	2 950 023

3. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if Republic of Moldova does not meet the requirements laid down in paragraph 2 above;
4. REQUESTS the Director-General to report to the Fifty-ninth World Health Assembly on the prevailing situation;
5. REQUESTS the Director-General to communicate this resolution to the Government of Republic of Moldova.

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.11 Arrears in payment of contributions: Tajikistan

The Fifty-eighth World Health Assembly,

Having considered the third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly on Special arrangements for settlement of arrears: Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution,¹ with respect to the request of Tajikistan for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report on special arrangements for settlement of arrears annexed to the third report,

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

¹ Document A58/43 Rev.1.

2. ACCEPTS that Tajikistan shall pay its outstanding contributions, totalling US\$ 514 604, in 10 annual instalments payable in each of the years 2006 to 2015, as set out below, subject to the provisions of Financial Regulation 6.4, in addition to the annual contributions due during the period:

	US\$
2006	51 460
2007	51 460
2008	51 460
2009	51 460
2010	51 460
2011	51 460
2012	51 460
2013	51 460
2014	51 460
2015	51 464
Total	514 604

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

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

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

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.12 Salaries of staff in ungraded posts and of the Director-General

The Fifty-eighth 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. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 172 860 per annum before staff assessment, resulting in a modified net salary of US\$ 117 373 (dependency rate) or US\$ 106 285 (single rate);

2. ESTABLISHES the salary of the Director-General at US\$ 233 006 per annum before staff assessment, resulting in a modified 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 2005.

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.13 Blood safety: proposal to establish World Blood Donor Day

The Fifty-eighth World Health Assembly,

Recalling resolution WHA28.72 which urged the development of national blood services based on the voluntary, nonremunerated donation of blood;

Having considered the report on blood safety;¹

Alarmed by the chronic shortage of safe blood and blood products, particularly in low- and medium-income countries;

Mindful that preventing the transmission of HIV and other bloodborne pathogens through unsafe blood and blood-product transfusions requires the collection of blood only from donors at the lowest risk of carrying such infectious agents;

Recognizing that voluntary, nonremunerated blood donation is the cornerstone of a safe and adequate national blood supply that meets the transfusion requirements of all patients;

Noting the positive responses to World Blood Donor Day, 14 June 2004, for the promotion of voluntary, nonremunerated blood donation,

1. AGREES to the establishment of an annual World Blood Donor Day, to be celebrated on 14 June each year;
2. RECOMMENDS that this blood donor day should be an integral part of the national blood-donor recruitment programme;
3. URGES Member States:
 - (1) to promote and support the annual celebration of World Blood Donor Day;
 - (2) to establish or strengthen systems for the recruitment and retention of voluntary, nonremunerated blood donors and the implementation of stringent criteria for donor selection;
 - (3) to introduce legislation, where needed, to eliminate paid blood donation except in limited circumstances of medical necessity and, in such cases, to require informed assent of the transfusion recipient;
 - (4) to provide adequate financing for high-quality blood donation services and for extension of such services to meet the needs of the patients;
 - (5) to promote multisectoral collaboration between government ministries, blood transfusion services, professional bodies, nongovernmental organizations, civil society and the media in the promotion of voluntary, nonremunerated blood donation;

¹ Document A58/38.

- (6) to ensure the proper use of blood transfusion in clinical practice so as to avoid abuse of blood transfusion, which may result in a shortage of blood and hence stimulate the need for paid blood donation;
 - (7) to support the full implementation of well-organized, nationally coordinated and sustainable blood programmes with appropriate regulatory systems through, in particular:
 - (a) government commitment and support for a national blood programme with quality-management systems, by means of a legal framework, a national blood-safety policy and plan, and adequate resources
 - (b) organization, management and infrastructure to permit a sustainable blood transfusion service
 - (c) equitable access to blood and blood products
 - (d) voluntary, nonremunerated blood donors from low-risk populations
 - (e) appropriate testing and processing of all donated blood and blood products
 - (f) appropriate clinical use of blood and blood products;
 - (8) to establish a quality process for policy- and decision-making for blood safety and availability based on ethical considerations, transparency, assessment of national needs, scientific evidence, and risk/benefit analysis;
 - (9) to share information nationally and internationally in order to make clear the scientific, economic and social basis of national policy decisions related to blood safety and availability;
 - (10) to strengthen partnerships at all levels in order to accomplish these recommended actions;
4. CALLS UPON international organizations and bodies concerned with global blood safety to collaborate in promoting and supporting World Blood Donor Day;
 5. INVITES donor agencies to provide adequate funding for initiatives to promote voluntary, nonremunerated blood donation;
 6. REQUESTS the Director-General:
 - (1) to work with other organizations of the United Nations system, multilateral and bilateral agencies, and nongovernmental organizations to promote World Blood Donor Day;
 - (2) to work with concerned organizations to provide support to Member States in strengthening their capacity to screen all donated blood against major infectious diseases in order to ensure that all blood collected and transfused is safe.

(Eighth plenary meeting, 23 May 2005 –
Committee B, first report)

WHA58.14 Sustainable financing for tuberculosis prevention and control

The Fifty-eighth World Health Assembly,

Having considered the report on sustainable financing for tuberculosis prevention and control;¹

Aware of the need to diminish the global burden of tuberculosis and thereby lower this barrier to socioeconomic development;

Noting with concern the increasing number of cases of multidrug-resistant tuberculosis, and worsening morbidity and mortality among HIV-positive tuberculosis patients, especially in the African Region;

Welcoming the progress made towards achieving the global tuberculosis-control targets for 2005 following the establishment, in response to resolution WHA51.13, of the Stop Tuberculosis Initiative;²

Noting the need to strengthen health systems development for the successful delivery of tuberculosis-control activities;

Stressing the importance of engagement of the full range of health providers in delivering the international standard of tuberculosis care in line with the strategy of directly observed treatment, short-course (DOTS);

Concerned that lack of commitment to sustained financing for tuberculosis control will impede the sound long-term planning necessary to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Encouraging the development of a global plan for the period 2006-2015, which will address the need for sustained financing in order to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration,

1. ENCOURAGES all Member States:

(1) to estimate the total resources required for prevention and control of tuberculosis, including HIV-related tuberculosis and multidrug-resistant tuberculosis, in the medium term, and the resources available from domestic and international sources in order to identify the funding gap;

(2) to fulfil the commitments made in endorsing resolution WHA53.1 and hence the Amsterdam Declaration to Stop Tuberculosis, including their commitment to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

¹ Document A58/7.

² Now known as the Stop TB Partnership.

- (3) to strengthen integration between financial, operational and social partners by setting up national Stop TB partnerships in each country and to ensure that such partnerships at country level provide a vehicle to support the implementation of long-term plans for expansion of DOTS through national interagency coordination committees;
- (4) to ensure that all tuberculosis patients have access to the universal standard of care based on proper diagnosis, treatment and reporting consistent with the DOTS strategy by promoting both supply and demand;
- (5) to strengthen prevention of, and social mobilization against, tuberculosis;
- (6) to set up collaboration between tuberculosis and HIV programmes, in order to address more effectively the dual tuberculosis/HIV epidemic;
- (7) to integrate the prevention and control of tuberculosis in the mainstream of their health development plans;

2. REQUESTS the Director-General:

- (1) to intensify support to Member States in developing capacity and improving the performance of national tuberculosis-control programmes within the broad context of strengthening health systems in order:
 - (a) to accelerate progress towards reaching the global target of detecting 70% of new infectious cases and successfully treating 85% of those detected, and to report to the Health Assembly in 2007 on the progress made by the end of 2005;
 - (b) to sustain achievement of that target in order to reach the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
- (2) to strengthen cooperation with Member States with a view to improving collaboration between tuberculosis programmes and HIV programmes, in order:
 - (a) to implement the expanded strategy to control HIV-related tuberculosis;
 - (b) to enhance HIV/AIDS programmes, including delivery of antiretroviral treatment for patients with tuberculosis who are also infected with HIV;
- (3) to implement and strengthen strategies for the effective control of, and management of persons with, drug-resistant tuberculosis;
- (4) to take the lead in cooperation with national health authorities in working with partners to devise, strengthen and support mechanisms to facilitate sustainable financing of tuberculosis control;
- (5) to enhance WHO's support to the Stop TB Partnership in its efforts to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration and provide regular reports on the progress made to achieve the goals;

- (6) to recommend, at the high-level plenary meeting on the outcome of the Millennium Summit of the United Nations General Assembly to review progress in fulfilment of commitments contained in the United Nations Millennium Declaration, that tuberculosis should be specifically mentioned in Goal 6 and Target 8, instead of being included among other diseases;
- (7) to promote research and development for new control tools as part of the global plan to stop tuberculosis.

(Ninth plenary meeting, 25 May 2005 –
Committee A, fifth report)

WHA58.15 Global immunization strategy

The Fifty-eighth World Health Assembly,

Having considered the report on the draft immunization strategy;¹

Alarmed that globally and in some regions immunization coverage had increased only marginally since the early 1990s, and that in 2003 more than 27 million children worldwide were not immunized during their first year of life;

Recognizing that each year 1.4 million children under five years of age die from diseases preventable by currently available vaccines;

Further recognizing that each year an additional 2.6 million children under five years of age die from diseases potentially preventable by new vaccines;

Acknowledging the contributions of WHO, UNICEF, the Global Alliance for Vaccines and Immunization (GAVI) and all partners in their efforts to strengthen immunization services, expand immunization coverage and introduce new and underused vaccines in developing countries;

Welcoming the achievements of the accelerated disease-control initiatives against poliomyelitis, measles, and maternal and neonatal tetanus in immunizing previously unreached populations, and noting that these initiatives have established extensive networks on which surveillance for other disease and health trends can be built or expanded;

Concerned that, owing to financial, structural and/or managerial constraints, national immunization programmes fail to reach all who are eligible for immunization, particularly children and women, underuse many existing vaccines, and are not widely introducing new vaccines;

Emphasizing the need for all countries to strive towards achieving the internationally agreed development goal contained in the United Nations Millennium Declaration of reducing by two-thirds, between 1990 and 2015, the under-five child mortality rate;

¹ See Annex.

Recalling the target adopted at the United Nations General Assembly's twenty-seventh special session on children (2002) to ensure full immunization of children under one year of age, at 90% coverage nationally, with at least 80% coverage in every district or equivalent administrative unit;¹

Recognizing that resolution WHA53.12 highlights immunization as a major factor in promoting child health;

Having considered the draft global immunization vision and strategy,²

1. WELCOMES the Global Immunization Vision and Strategy;
2. URGES Member States:
 - (1) to meet immunization targets expressed in the United Nations General Assembly special session on children;
 - (2) to adopt the Global Immunization Vision and Strategy as the framework for strengthening of national immunization programmes between 2006 and 2015, with the goal of achieving greater coverage and equity in access to immunizations, of improving access to existing and future vaccines, and of extending the benefits of vaccination linked with other health interventions to age groups beyond infancy;
 - (3) to ensure that immunization remains a priority on the national health agenda, and is supported by systematic planning, implementation, monitoring and evaluation processes, and long-term financial commitment;
3. REQUESTS the Director-General:
 - (1) to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles;
 - (2) to work closely with UNICEF, the Global Alliance for Vaccines and Immunization (GAVI) and other partners to provide support to Member States in implementation of the Global Immunization Vision and Strategy;
 - (3) to strengthen relations at global, regional and subregional levels with UNICEF, GAVI and other partners in order to mobilize the needed resources for countries, in particular developing countries, to implement the Global Immunization Vision and Strategy;
 - (4) to report every three years to the Health Assembly on progress towards achievement of global immunization targets, including that adopted at the United Nations General Assembly special session on children.

(Ninth plenary meeting, 25 May 2005 –
Committee A, fifth report)

¹ United Nations General Assembly resolution S-27/2, Annex.

² Document WHO/IVB/05.05.

WHA58.16 Strengthening active and healthy ageing

The Fifty-eighth World Health Assembly,

Having considered the document on International Plan of Action on Ageing: report on implementation;¹

Noting that more than 1000 million people will be over 60 years old by 2025, the vast majority in the developing world, and that this figure is expected to double by 2050, which will lead to increasing demands on health and social-service systems worldwide;

Recalling resolution WHA52.7 on active ageing that called upon all Member States to take appropriate steps to carry out measures that ensure the highest attainable standard of health and well-being for the growing numbers of their older citizens;

Recalling also United Nations General Assembly resolution 58/134 of 22 December 2003, which requested the organizations and bodies of the United Nations system and the specialized agencies to integrate ageing, including from a gender perspective, into their programmes of work;

Recalling further United Nations General Assembly resolution 59/150, which called on governments, the organizations of the United Nations system, nongovernmental organizations and the private sector to ensure that the challenges of population ageing and the concerns of older persons were adequately incorporated into their programmes and projects, especially at country level, and invited Member States to submit, whenever possible, information to the United Nations database on ageing;

Acknowledging the active ageing policy framework, WHO's contribution to the United Nations Second World Assembly on Ageing, and its vision for the framing of integrated intersectoral policies on ageing;²

Mindful of the important role played by WHO in implementing the objectives of the Madrid International Plan of Action on Ageing, 2002, particularly Priority Direction II: Advancing health and well-being into old age;

Recognizing the contributions that older persons make to development, and the importance of lifelong education and active community involvement for older persons;

Stressing the important role of public-health policies and programmes in enabling the rapidly growing numbers of older persons in both developed and developing countries to remain in good health and maintain their many vital contributions to the well-being of their families, communities and societies;

Stressing also the importance of developing care services, including eHealth services, to enable older persons to remain in their homes for as long as possible;

¹ Document A58/19.

² Document WHO/NMH/NPH/02.8.

Underlining the need for incorporating a gender perspective into policies and programmes relating to active and healthy ageing;

Welcoming WHO's focus on primary health care, such as the development of "age-friendly" primary health care,

1. URGES Member States:

- (1) to develop, implement and evaluate policies and programmes that promote healthy and active ageing and the highest attainable standard of health and well-being for their older citizens;
- (2) to consider the situation of older persons as an integral part of their efforts to achieve the internationally agreed development goals of the United Nations Millennium Declaration, and to mobilize political will and financial resources for that purpose;
- (3) to take measures to ensure that gender-sensitive health policies, plans and programmes recognize and address the rights and comprehensive health, social-service and development needs of older women and men, with special attention to the socially excluded, older persons with disabilities, and those unable to meet their basic needs;
- (4) to take steps and encourage measures to ensure that resources are made available for persons or legal entities who take care of older persons;
- (5) to pay special attention to the key role that older persons, especially older women, play as caregivers in their families and the community, and particularly the burdens placed on them by the HIV/AIDS pandemic;
- (6) to consider establishing an appropriate legal framework, to enforce legislation and to strengthen legal efforts and community initiatives designed to eliminate economic, physical and mental elder abuse;
- (7) to develop, use and maintain systems to provide data, throughout the life-course, disaggregated by age and sex, on intersectoral determinants of health and health status in order to underpin the planning, implementation, monitoring and evaluation of evidence-based health-policy interventions relevant to older persons;
- (8) to undertake education and recruitment measures and incentives, taking into account the particular circumstances in developing countries, in order to ensure sufficient health personnel to meet the needs of older persons;
- (9) to strengthen national action in order to ensure sufficient resources to fulfil commitments to implementing the Madrid International Plan of Action on Ageing, 2002, and related regional plans of action relating to the health and well-being of older persons;
- (10) to develop health care of older persons within primary care in the existing national health systems;
- (11) to provide progress reports on the status of older persons and on active and healthy ageing programmes when making country health reports;

- (12) to support WHO's advocacy for active and healthy ageing through new, multisectoral partnerships with intergovernmental, nongovernmental, private-sector and voluntary organizations;
2. REQUESTS the Commission on Social Determinants of Health to consider including issues related to active and healthy ageing throughout the life-course among its policy recommendations;
3. REQUESTS the Director-General:
- (1) to raise awareness of the challenge of the ageing of societies, the health and social needs of older persons, and the contributions of older persons to society, including by working with Member States and nongovernmental and private-sector employers;
 - (2) to provide support to Member States in their efforts to fulfil their commitments to the goals and outcomes of relevant United Nations conferences and summits, particularly the Second World Assembly on Ageing, related to the health and social needs of older persons, in collaboration with relevant partners;
 - (3) to continue to focus on primary health care, with an emphasis on existing community structures where applicable, that is age appropriate, accessible and available for older persons, thereby strengthening their capability to remain vital resources to their families, the economy, the community and society for as long as possible;
 - (4) to provide support to Member States, by promoting research and strengthening capacity for health promotion and disease prevention strategies, policies and interventions throughout the life-course, in their efforts to develop integrated care for older persons, including support for both formal and informal caregivers;
 - (5) to undertake initiatives to improve the access of older persons to relevant information and health-care and social services in order, particularly, to reduce their risk of HIV infection, to improve the quality of life and dignity of those living with HIV/AIDS, and to help them support family members affected by HIV/AIDS and their orphaned grandchildren;
 - (6) to provide support to Member States, upon request, for compiling, using and maintaining systems to provide information, throughout the life-course, disaggregated by age and sex, health status and selected intersectoral information, on determinants of health, in order to underpin the planning, implementation, monitoring and evaluation of evidence-based health-policy interventions relevant to older persons;
 - (7) to strengthen WHO's capacity to incorporate work on ageing throughout its activities and programmes at all levels and to facilitate the role of WHO regional offices in the implementation of United Nations regional plans of action on ageing;
 - (8) to cooperate with other agencies and organizations of the United Nations system in order to ensure intersectoral action towards active and healthy ageing;
 - (9) to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

(Ninth plenary meeting, 25 May 2005 –
Committee B, second report)

WHA58.17 International migration of health personnel: a challenge for health systems in developing countries

The Fifty-eighth World Health Assembly,

Having examined the report on international migration of health personnel: a challenge for health systems in developing countries;¹

Concerned that migration and recruitment of health personnel, particularly highly trained and skilled health personnel, from developing to developed countries continue to be a major challenge for health systems in developing countries;

Recalling the requests directed to the Director-General in resolution WHA57.19, and noting with satisfaction that the Director-General has taken steps to address some of them;

Noting that there are additional areas related to international migration of health personnel, within the context of resolution WHA57.19 that require further attention by the Director-General;

Bearing in mind the high-level debate to be held at the United Nations General Assembly in 2006 on international migration,

1. EXPRESSES GRATITUDE to the Director-General for the steps he has taken to implement some of the requests directed to him in resolution WHA57.19;
2. REQUESTS the Director-General:
 - (1) to intensify his efforts to implement fully resolution WHA57.19;
 - (2) to strengthen WHO's programme on human resources for health by allocating to it adequate resources, in particular financial and human resources;
 - (3) to report on implementation of this resolution to the Fifty-ninth World Health Assembly;
3. DECIDES to include, as a substantive item on the agenda of the Fifty-ninth World Health Assembly, "International migration of health personnel: a challenge for health systems in developing countries".

(Ninth plenary meeting, 25 May 2005 –
Committee B, second report)

WHA58.18 Unaudited interim financial report on the accounts of WHO for 2004

The Fifty-eighth World Health Assembly,

Having examined the Unaudited interim financial report for the year 2004;²

¹ Document A58/23, Section F.

² Documents A58/26 and A58/26 Add.1.

Having noted the first report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly,¹

ACCEPTS the Director-General's Unaudited interim financial report for the year 2004.

(Ninth plenary meeting, 25 May 2005 –
Committee B, third report)

WHA58.19 Assessments for 2006-2007

The Fifty-eighth World Health Assembly,

Having considered the report of the Director-General,²

ADOPTS the scale of assessments of Members for the biennium 2006-2007, reflecting the latest available United Nations scale, as set out below:

Members and Associate Members	WHO scale for 2006-2007 %
Afghanistan	0.00200
Albania	0.00500
Algeria	0.07600
Andorra	0.00500
Angola	0.00100
Antigua and Barbuda	0.00300
Argentina	0.95600
Armenia	0.00200
Australia	1.59200
Austria	0.85900
Azerbaijan	0.00500
Bahamas	0.01300
Bahrain	0.03000
Bangladesh	0.01000
Barbados	0.01000
Belarus	0.01800
Belgium	1.06900
Belize	0.00100
Benin	0.00200
Bhutan	0.00100
Bolivia	0.00900
Bosnia and Herzegovina	0.00300
Botswana	0.01200
Brazil	1.52300
Brunei Darussalam	0.03400
Bulgaria	0.01700

¹ Document A58/27.

² Document A58/30.

Members and Associate Members	WHO scale for 2006-2007
	%
Burkina Faso	0.00200
Burundi	0.00100
Cambodia	0.00200
Cameroon	0.00800
Canada	2.81300
Cape Verde	0.00100
Central African Republic	0.00100
Chad	0.00100
Chile	0.22300
China	2.05300
Colombia	0.15500
Comoros	0.00100
Congo	0.00100
Cook Islands	0.00100
Costa Rica	0.03000
Côte d'Ivoire	0.01000
Croatia	0.03700
Cuba	0.04300
Cyprus	0.03900
Czech Republic	0.18300
Democratic People's Republic of Korea	0.01000
Democratic Republic of the Congo	0.00300
Denmark	0.71800
Djibouti	0.00100
Dominica	0.00100
Dominican Republic	0.03500
Ecuador	0.01900
Egypt	0.12000
El Salvador	0.02200
Equatorial Guinea	0.00200
Eritrea	0.00100
Estonia	0.01200
Ethiopia	0.00400
Fiji	0.00400
Finland	0.53300
France	6.03010
Gabon	0.00900
Gambia	0.00100
Georgia	0.00300
Germany	8.66230
Ghana	0.00400
Greece	0.53000
Grenada	0.00100
Guatemala	0.03000
Guinea	0.00300
Guinea-Bissau	0.00100
Guyana	0.00100
Haiti	0.00300
Honduras	0.00500

Members and Associate Members	WHO scale for 2006-2007
	%
Hungary	0.12600
Iceland	0.03400
India	0.42100
Indonesia	0.14200
Iran (Islamic Republic of)	0.15700
Iraq	0.01600
Ireland	0.35000
Israel	0.46700
Italy	4.88510
Jamaica	0.00800
Japan	19.46830
Jordan	0.01100
Kazakhstan	0.02500
Kenya	0.00900
Kiribati	0.00100
Kuwait	0.16200
Kyrgyzstan	0.00100
Lao People's Democratic Republic	0.00100
Latvia	0.01500
Lebanon	0.02400
Lesotho	0.00100
Liberia	0.00100
Libyan Arab Jamahiriya	0.13200
Lithuania	0.02400
Luxembourg	0.07700
Madagascar	0.00300
Malawi	0.00100
Malaysia	0.20300
Maldives	0.00100
Mali	0.00200
Malta	0.01400
Marshall Islands	0.00100
Mauritania	0.00100
Mauritius	0.01100
Mexico	1.88300
Micronesia (Federated States of)	0.00100
Monaco	0.00300
Mongolia	0.00100
Morocco	0.04700
Mozambique	0.00100
Myanmar	0.01000
Namibia	0.00600
Nauru	0.00100
Nepal	0.00400
Netherlands	1.69000
New Zealand	0.22100
Nicaragua	0.00100
Niger	0.00100

Members and Associate Members	WHO scale for 2006-2007 %
Nigeria	0.04200
Niue	0.00100
Norway	0.67900
Oman	0.07000
Pakistan	0.05500
Palau	0.00100
Panama	0.01900
Papua New Guinea	0.00300
Paraguay	0.01200
Peru	0.09200
Philippines	0.09500
Poland	0.46100
Portugal	0.47000
Puerto Rico	0.00100
Qatar	0.06400
Republic of Korea	1.79600
Republic of Moldova	0.00100
Romania	0.06000
Russian Federation	1.10000
Rwanda	0.00100
Saint Kitts and Nevis	0.00100
Saint Lucia	0.00200
Saint Vincent and the Grenadines	0.00100
Samoa	0.00100
San Marino	0.00300
Sao Tome and Principe	0.00100
Saudi Arabia	0.71300
Senegal	0.00500
Serbia and Montenegro	0.01900
Seychelles	0.00200
Sierra Leone	0.00100
Singapore	0.38800
Slovakia	0.05100
Slovenia	0.08200
Solomon Islands	0.00100
Somalia	0.00100
South Africa	0.29200
Spain	2.52000
Sri Lanka	0.01700
Sudan	0.00800
Suriname	0.00100
Swaziland	0.00200
Sweden	0.99800
Switzerland	1.19700
Syrian Arab Republic	0.03800
Tajikistan	0.00100
Thailand	0.20900
The former Yugoslav Republic of Macedonia	0.00600
Timor-Leste	0.00100

Members and Associate Members	WHO scale for 2006-2007 %
Togo	0.00100
Tokelau	0.00100
Tonga	0.00100
Trinidad and Tobago	0.02200
Tunisia	0.03200
Turkey	0.37200
Turkmenistan	0.00500
Tuvalu	0.00100
Uganda	0.00600
Ukraine	0.03900
United Arab Emirates	0.23500
United Kingdom of Great Britain and Northern Ireland	6.12720
United Republic of Tanzania	0.00600
United States of America	22.00000
Uruguay	0.04800
Uzbekistan	0.01400
Vanuatu	0.00100
Venezuela (Bolivarian Republic of)	0.17100
Viet Nam	0.02100
Yemen	0.00600
Zambia	0.00200
Zimbabwe	0.00700
Total	100.00000

(Ninth plenary meeting, 25 May 2005 –
Committee B, third report)

WHA58.20 Amendments to the Financial Regulations and Financial Rules

The Fifty-eighth World Health Assembly,

Having considered the report on amendments to the Financial Regulations and Financial Rules,¹

1. APPROVES the changes to the Financial Regulations, to be effective as from 1 January 2006;²

¹ Document A58/32.

² See document EB115/2005/REC/1, Annex 2, Appendix 1.

2. AUTHORIZES, as a transitional measure, that at the end of the financial period 2006-2007 any unliquidated obligations from the financial period 2004-2005 shall be cancelled and credited to Miscellaneous Income.

(Ninth plenary meeting, 25 May 2005 –
Committee B, third report)

WHA58.21 Real Estate Fund

The Fifty-eighth World Health Assembly,

Having considered the report of the Director-General on the use of the Real Estate Fund for the construction of offices of WHO Representatives in the Eastern Mediterranean Region,¹

Noting that it is proving difficult to find suitable accommodation for the offices of the WHO Representatives in certain countries in the Eastern Mediterranean Region at a reasonable cost that are secure, safe, and allow staff to work together effectively,

1. EXPRESSES its appreciation to the governments that have made available land in their countries and to those that have pledged cash to assist in the construction of offices of WHO Representatives;

2. AUTHORIZES the Director-General:

(1) to proceed with the retrofitting or the construction of suitable accommodation for offices of the WHO Representatives in Iraq, Jordan and Tunisia;

(2) to use the amount of US\$ 1.5 million planned in the Proposed programme budget 2006-2007 under Real Estate Fund for the Eastern Mediterranean Region to contribute towards the retrofitting, or the construction, of suitable accommodation for offices of the WHO Representatives in Iraq, Jordan and Tunisia.

(Ninth plenary meeting, 25 May 2005 –
Committee B, third report)

WHA58.22 Cancer prevention and control

The Fifty-eighth World Health Assembly,

Having examined the report on the prevention and control of cancer;²

Recalling resolutions WHA51.18 and WHA53.17 on the prevention and control of noncommunicable diseases, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA56.1 on tobacco control, WHA57.12 on the reproductive health strategy, including control of cervical cancer, and WHA57.16 on health promotion and healthy lifestyles;

¹ Document A58/33.

² Document A58/16.

Recognizing the suffering of cancer patients and their families and the extent to which cancer threatens development when it affects economically active members of society;

Alarmed by the rising trends of cancer risk-factors, the number of new cancer cases, and cancer morbidity and mortality worldwide, in particular in developing countries;

Recognizing that many of these cases of cancer and deaths could be prevented, and that the provision of palliative care for all individuals in need is an urgent, humanitarian responsibility;

Recognizing that the technology for diagnosis and treatment of cancer is mature and that many cases of cancer may be cured, especially if detected earlier;

Recognizing that tobacco use is the world's most avoidable cause of cancer and that control measures, such as legislation, education, promotion of smoke-free environments, and treatment of tobacco dependence, can be effectively applied in all resource settings;

Recognizing that among all cancer sites cervical cancer, causing 11% of all cancer deaths in women in developing countries, has one of the greatest potential for early detection and cure, that cost-effective interventions for early detection are available and not yet widely used, and that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health;

Recognizing the value of multidisciplinary management and the importance of surgery, radiotherapy, chemotherapy, palliative care and other approaches in the treatment of cancer;

Recognizing the contribution of IARC, over 40 years, to research on cancer etiology and prevention, providing evidence on global cancer prevalence and incidence, the causes of cancer, mechanisms of carcinogenesis, and effective strategies for cancer prevention and early detection;

Mindful of the need for careful planning and priority-setting in the use of resources in order to undertake effective activities to reduce the cancer burden;

Recognizing the importance of adequate funding for cancer-prevention, control and palliative-care programmes, especially in developing countries;

Encouraged by the prospects offered by partnerships with international and national organizations within the Global Alliance for Cancer Control, and other bodies such as patient organizations;

Recognizing the support given by IAEA to combat cancer, and welcoming the initiative of the Agency to establish the Programme of Action for Cancer Therapy, and research efforts of national cancer institutes in various Member States,

1. URGES Member States:

- (1) to collaborate with the Organization in developing and reinforcing comprehensive cancer-control programmes tailored to the socioeconomic context, and aimed at reducing cancer incidence and mortality and improving the quality of life of cancer patients and their families, specifically through the systematic, stepwise and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment, rehabilitation and palliative care, and to evaluate the impact of implementing such programmes;

- (2) to set priorities based on national burden of cancer, resource availability and health system capacity for cancer-prevention, control and palliative-care programmes;
- (3) to integrate national cancer-control programmes in existing health systems that set out outcome-oriented and measurable goals and objectives for the short, medium and long term, as recommended in the Annex to the present resolution, to identify evidence-based, sustainable actions across the continuum of care, and to make the best use of resources to the benefit of the entire population by emphasizing the effective role of primary health care in promoting prevention strategies;
- (4) to encourage and to frame policies for strengthening and maintaining technical equipment for diagnosis and treatment of cancer in hospitals providing oncology and other relevant services;
- (5) to pay special attention to cancers for which avoidable exposure is a factor, particularly exposure to chemicals and tobacco smoke in the workplace and the environment, certain infectious agents, and ionizing and solar radiation;
- (6) to encourage the scientific research necessary to increase knowledge about the burden and causes of human cancer, giving priority to tumours, such as cervical and oral cancer, that have a high incidence in low-resource settings and are amenable to cost-effective interventions;
- (7) to give priority also to research on cancer prevention, early detection and management strategies, including, where appropriate, traditional medicines and therapies, including for palliative care;
- (8) to consider an approach in the planning, implementation and evaluation phases of cancer control that involves all key stakeholders representing governmental, nongovernmental and community-based organizations, including those representing patients and their families;
- (9) to ensure access to appropriate information in relation to preventive, diagnostic and treatment procedures and options, especially by cancer patients, and to palliative care;
- (10) to develop appropriate information systems, including outcome and process indicators, that support planning, monitoring and evaluation of cancer-prevention, control and palliative-care programmes;
- (11) to assess periodically the performance of cancer prevention and control programmes, allowing countries to improve the effectiveness and efficiency of their programmes;
- (12) to participate actively in implementing WHO's integrated health promotion and prevention strategies targeting risk factors for noncommunicable diseases, including cancer, such as tobacco use, unhealthy diet, harmful use of alcohol and exposure to biological, chemical and physical agents known to cause cancer, and to consider signing, ratifying, accepting, approving, formally confirming or acceding to the WHO Framework Convention on Tobacco Control;
- (13) to improve access to appropriate technologies, with support from WHO, for the diagnosis and treatment of cancer, in order to promote its early diagnosis and treatment, especially in developing countries;

(14) to determine cost-effective minimum standards, adapted to local situations, for cancer treatment and palliative care that use WHO's strategies for nationwide provision of essential drugs, technologies, diagnostics and vaccines, taking into consideration in the case of palliative care the recommendations of the Second Global Summit of National Hospice and Palliative Care Associations (Seoul, 2005);

(15) to ensure the medical availability of opioid analgesics according to international treaties and recommendations of WHO and the International Narcotics Control Board and subject to an efficient monitoring and control system;

(16) to ensure, where appropriate, the documented, scientific, evidence-based safety and efficacy of available traditional medicines and therapies;

(17) to develop and strengthen health system infrastructure, particularly related to human resources for health, in order to build adequate capacity for effective implementation of cancer-prevention and control programmes, including a cancer registry system;

(18) to accord high priority to cancer-control planning and implementation for high-risk groups, including relatives of patients and those having experienced long-duration and high-intensity carcinogen exposure;

2. REQUESTS the Director-General:

(1) to develop WHO's work and capacity in cancer prevention and control and to promote effective, comprehensive cancer prevention and control strategies in the context of the global strategy for the prevention and control of noncommunicable diseases, the Global Strategy on Diet, Physical Activity and Health, and resolution WHA57.16 on health promotion and healthy lifestyles, with special emphasis on less developed countries;

(2) to provide technical support to Member States in setting priorities for cancer prevention, control and palliative-care programmes;

(3) to strengthen WHO's involvement in international partnerships and collaboration with Member States, other bodies of the United Nations system and actors from a wide variety of related sectors and disciplines in order to advocate, mobilize resources, and build capacity for, a comprehensive approach to cancer control;

(4) to continue developing WHO's strategy for the formulation and refinement of cancer prevention and control programmes by collecting, analysing and disseminating national experiences in that regard, and providing appropriate guidance, upon request, to Member States;

(5) to contribute to drawing up recommendations on early diagnosis of cancer, especially in order to define and reach the target populations that should benefit from such diagnosis;

(6) to consider allocating additional resources so that the knowledge provided by research is translated into effective and efficient public-health measures for cancer prevention and control;

(7) to promote research on cost-effectiveness of different strategies for prevention and management of various cancers;

(8) to promote and support research that evaluates low-cost interventions that are affordable and sustainable in low-income countries;

- (9) to promote research on development of an effective vaccine against cervical cancer;
- (10) to support the further development and expansion of a research agenda in IARC and other bodies that is appropriate to the framing of integrated policies and strategies for cancer control, and to promote and support technical and medical programmes in cancer treatment;
- (11) to promote guiding principles on palliative care for cancer patients, including ethical aspects;
- (12) to provide adequate resources and leadership support to the International Programme on Chemical Safety for its active role in international multisectoral mechanisms for chemical safety, including support for capacity building in chemical safety at country level;
- (13) to support and strengthen mechanisms to transfer to developing countries technical expertise on cancer prevention and control, including surveillance, screening and research;
- (14) to advise Member States, especially developing countries, on development or maintenance of a national cancer registry containing the type, location of the cancer and its geographical distribution;
- (15) to collaborate with Member States in their efforts to establish national cancer institutes;
- (16) to explore appropriate mechanisms for adequately funding cancer-prevention, control and palliative-care programmes, especially in developing countries;
- (17) to explore the feasibility of initiating the development of a joint programme between WHO and IAEA for cancer prevention, control, treatment and research;
- (18) to examine jointly with the International Narcotics Control Board the feasibility of a possible assistance mechanism that would facilitate the adequate treatment of pain using opioid analgesics;
- (19) to explore all opportunities to improve the accessibility, affordability and availability of chemotherapy drugs, particularly in developing countries, for the treatment of HIV/AIDS-related cancers;
- (20) to report regularly on implementation of this resolution to the Health Assembly.

ANNEX

NATIONAL CANCER CONTROL PROGRAMMES: RECOMMENDATIONS FOR OUTCOME-ORIENTED OBJECTIVES

National health authorities may wish to consider the following outcome-oriented objectives for their cancer control programmes, according to type of cancer:

- preventable tumours (such as those of lung, colon, rectum, skin and liver): to avoid and reduce exposure to risk factors (such as tobacco use, unhealthy diets, harmful use of alcohol,

sedentariness, excess exposure to sunlight, communicable agents, including hepatitis B virus and liver fluke, and occupational exposures), thus limiting cancer incidence;

- cancers amenable to early detection and treatment (such as oral, cervical, breast and prostate cancers): to reduce late presentation and ensure appropriate treatment, in order to increase survival, reduce mortality and improve quality of life;
- disseminated cancers that have potential of being cured or the patients' lives prolonged considerably (such as acute leukaemia in childhood): to provide appropriate care in order to increase survival, reduce mortality and improve quality of life;
- advanced cancers: to enhance relief from pain and other symptoms and improve quality of life of patients and their families.

(Ninth plenary meeting, 25 May 2005 –
Committee B, third report)

WHA58.23 Disability, including prevention, management and rehabilitation

The Fifty-eighth World Health Assembly,

Having considered the report on disability, including prevention, management and rehabilitation;¹

Noting that about 600 million people live with disabilities of various types;

Aware of the global magnitude of the health and rehabilitation needs of persons with disabilities and the cost of their exclusion from society;

Concerned by the rapid increase in the number of persons with disabilities as a result of population growth, growth of the ageing population, chronic conditions, malnutrition, injuries caused by land mines, war, violence, especially domestic violence, AIDS, environmental degradation, and road traffic, domestic injuries, injuries caused by games, occupational injuries, and other causes often related to poverty;

Stressing that 80% of people with disabilities, particularly in the child population, live in low-income countries and that poverty further limits access to basic health services, including rehabilitation services;

Recognizing that people with disabilities are important contributors to society and that allocating resources to their rehabilitation is an investment;

Recognizing the importance of reliable information on various aspects of disability prevention, rehabilitation and care, and the need to invest in health and rehabilitation services required to ensure equality of opportunities and good quality of life for persons with disabilities;

¹ Document A58/17.

Recalling the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;¹

Recalling the International Classification of Functioning, Disability, and Health officially endorsed at the Fifty-fourth World Health Assembly in 2001;²

Recalling also the United Nations World Programme of Action concerning Disabled Persons, indicating inter alia that the sphere of responsibility of WHO includes disability prevention and medical rehabilitation;³

Noting the African Decade of Disabled Persons (2000-2009), the Asian and Pacific Decade of Disabled Persons (1993-2002), the New Asian Pacific Decade of Disabled Persons (2003-2012), and the European Year of People with Disabilities (2003);

Recalling United Nations General Assembly resolutions 56/168 of 19 December 2001, 57/229 of 18 December 2002, and 58/246 of 23 December 2003;

Mindful that the internationally agreed development goals contained in the United Nations Millennium Declaration would not be achieved without addressing issues related to the health and rehabilitation of persons with disabilities;

Recognizing the importance of the early conclusion of the United Nations comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities;⁴

1. URGES Member States:

- (1) to strengthen national policies, strategies and programmes for implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (2) to increase awareness of the public at large of the importance of the issue of disability and to coordinate efforts of all sectors of society to participate in disability prevention activities;
- (3) to develop their knowledge base with a view to promoting and protecting the rights and dignity of persons with disabilities and ensure their full inclusion in society, particularly by encouraging training and protecting employment;
- (4) to take all necessary steps for the reduction of risk factors contributing to disabilities during pregnancy and childhood;
- (5) to promote early intervention and identification of disability, especially during pregnancy and for children, and full physical, informational, and economic accessibility in all spheres of

¹ Adopted by United Nations General Assembly resolution 48/96.

² Resolution WHA54.21.

³ United Nations General Assembly resolution 37/52.

⁴ United Nations General Assembly resolution 56/168.

life, including to health and rehabilitation services, in order to ensure full participation and equality of persons with disabilities;

(6) to implement, as appropriate, family counselling programmes, including premarital confidential testing for diseases such as anaemia and thalassaemia, along with prevention counselling for intra-family marriages;

(7) to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated in the health system;

(8) to facilitate access to appropriate assistive technology and to promote its development and other means that encourage the inclusion of persons with disabilities in society;

(9) to include a disability component in their health policies and programmes, in particular in the areas of child and adolescent health, sexual and reproductive health, mental health, ageing, HIV/AIDS, and chronic conditions such as diabetes mellitus, cardiovascular diseases and cancer;

(10) to coordinate policies and programmes on disability with those on ageing where appropriate;

(11) to ensure gender equality in all measures, with special attention to women and girls with disabilities, often subject to social, cultural and economic disadvantages;

(12) to participate actively and constructively in the preparatory work for the United Nations comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities,¹ in order that it may be adopted by the General Assembly as a matter of priority;

(13) to investigate and put into practice, under their specific conditions, the most effective actions to prevent disabilities, with the participation of other sectors of the community;

(14) to ensure provision of adequate and effective medical care to people with special needs and to facilitate their access to such care, including to prostheses, wheelchairs, driving aids and other devices;

(15) to research and implement the most effective measures to prevent disabilities in collaboration with communities and other sectors;

2. REQUESTS the Director-General:

(1) to intensify collaboration within the Organization in order to work towards enhancing quality of life and promoting the rights and dignity of persons with disabilities, inter alia by including gender-disaggregated statistical analysis and information on disability in all areas of work;

¹ United Nations General Assembly resolution 56/168.

- (2) to provide support to Member States in strengthening national rehabilitation programmes and implementing the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (3) to provide support to Member States in collecting more reliable data on all relevant aspects, including cost-effectiveness of interventions for disability prevention, rehabilitation and care, and in assessing potential use of available national and international resources for disability prevention, rehabilitation and care;
- (4) to further strengthen collaborative work within the United Nations system and with Member States, academia, the private sector, and nongovernmental organizations, including organizations of people with disabilities;
- (5) to contribute appropriately to the work of the Ad Hoc Committee responsible for preparing the United Nations comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities;
- (6) to organize a meeting of experts to review the health and rehabilitation requirements of persons with disabilities;
- (7) to promote studies of incidence and prevalence of disabilities as a basis for the formulation of strategies for prevention, treatment and rehabilitation;
- (8) to produce a world report on disability and rehabilitation based on the best available scientific evidence;
- (9) to promote a clear understanding of the contributions that people with disabilities can make to society;
- (10) to provide support to Member States in taking the necessary steps to reduce the risk factors that lead to disabilities;
- (11) to report on progress in implementation of this resolution to the Sixtieth World Health Assembly, through the Executive Board.

(Ninth plenary meeting, 25 May 2005 –
Committee B, third report)

WHA58.24 Sustaining the elimination of iodine deficiency disorders

The Fifty-eighth World Health Assembly,

Having taken note of WHO's report on iodine status worldwide;¹

¹ *Iodine status worldwide: WHO Global Database on Iodine Deficiency*. Geneva, World Health Organization, 2004.

Affirming the priority of preventing and controlling iodine deficiency disorders contained in resolutions WHA49.13 and WHA52.24, and the elimination target set by the United Nations General Assembly twenty-seventh special session on children (2002);¹

Concerned that iodine deficiency disorders remain a serious public-health threat in that they cause invisible brain damage to hundreds of millions of children as well as visible goitre, cretinism, stillbirth, miscarriage and physical impairment;

Noting that the global battle against iodine deficiency disorders through universal salt iodization constitutes one of the most cost-effective interventions, contributing to economic and social development;

Recognizing that the final choice on a measure should always be defined taking into account the degree of iodine deficiency in order to manage the risk of excessive iodine intake in the most sensitive populations, namely children;

Noting resolution WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, and the necessity that action in respect of iodine deficiency should be compatible with the strategy recommendation to limit salt (sodium) consumption from all sources;

Recognizing that in the past decade 2000 million more people have adopted the use of iodized salt, but that despite that substantial progress fully one third of the world's population still remain at risk, mostly in the poorest and economically least developed areas;

Realizing that a sustainable solution such as universal salt iodization is needed in order to maintain the regular intake of trace amounts of iodine, because deficiency disorders cannot be eradicated, and interruption of such regular intake paves the way for their return;

Convinced that sustainability of control activities requires communication and public education in order to maintain the continuing use of iodized salt and to avoid the reappearance of deficiency disorders in the absence of long-term control strategies;

Applauding the establishment in 2002 of the global Network for Sustainable Elimination of Iodine Deficiency as a model of public/private collaboration among stakeholders for a worldwide effort, in which a number of salt associations are founding members along with international development agencies and Kiwanis International,

1. URGES Member States:

- (1) to strengthen their commitment to sustained elimination of iodine deficiency disorders as part of their regular health programmes and antipoverty efforts including through universal salt iodization;
- (2) to take urgent measures to reach the remaining one third of the world population, mostly the poorest and economically disadvantaged groups;
- (3) to include health promotion in their control strategies so that the use of iodized salt becomes a standard practice based on awareness of the need for iodine in the diet in order to

¹ United Nations General Assembly resolutions S-27/2, Annex.

ensure physical and mental well-being, especially for expectant and breastfeeding mothers and infants and young children;

(4) to establish multidisciplinary national coalitions that include the salt industry (salt producers, distributors and retailers), and the education and media sectors, in order to monitor the state of iodine nutrition every three years and to report to the Health Assembly on progress;

2. REQUESTS the Director-General:

(1) to strengthen cooperation with Member States, at their request, with international organizations, including UNICEF, bilateral aid agencies and international bodies such as the International Council for Control of Iodine Deficiency Disorders, the Micronutrient Initiative, and the Global Alliance for Improved Nutrition, in providing technical assistance to regulators and salt producers in producing and marketing iodized salt, strengthening quality-control systems, and facilitating a network of reference laboratories for estimation of iodine intake;

(2) to strengthen advocacy efforts involving public media and civil society for renewed commitment to combating iodine deficiency disorders, including appropriate research with relevant partners;

(3) to report on implementation of this resolution to the Sixtieth World Health Assembly, and every three years thereafter.

(Ninth plenary meeting, 25 May 2005 –
Committee A, sixth report)

WHA58.25 United Nations reform process and WHO's role in harmonization of operational development activities at country level

The Fifty-eighth World Health Assembly,

Taking note of the report on collaboration within the United Nations system;¹

Recognizing the primacy of national planning and priorities and, in this respect, the leadership of national governments for coordination of development activities;

Mindful of the crucial importance of the United Nations reform process related, inter alia, to operational activities for development launched by the United Nations Secretary-General and aimed at both ensuring a better coordination of field-level activities and delivering services in a coherent and effective way;

Recognizing the contributions that WHO makes to such development activities;

Mindful also of the need to ensure that United Nations operational activities for development include focus on achievement of the internationally agreed development goals, including those contained in the Millennium Declaration;

¹ Document A58/40.

Mindful in particular of the ongoing exchanges of views among Member States generated by the United Nations Secretary-General's report "In larger freedom: towards development, security and human rights for all", which outlines actions he believes would make the United Nations a more effective and efficient instrument for forging a united response to shared threats and shared needs, including the reforming, restructuring and revitalizing of its major organs and institutions where necessary, to enable them to respond effectively to the changed threats, needs and circumstances of the twenty-first century;¹

Determined to reduce the transaction costs of international cooperation in the field of health for both recipients and providers, and to improve its efficiency, monitoring, and reporting;

Eager to realize the unused potential offered by effective collaboration between organizations of the United Nations system, bilateral donors, global initiatives, and other stakeholders in advancing health development;

Recalling the adoption of United Nations General Assembly resolution 59/250 on the Triennial comprehensive policy review of operational activities for development of the United Nations system (22 December 2004), which calls for better coherence and coordination between United Nations entities at country level and for the simplification and harmonization of their rules and procedures;

Taking note of the Rome Declaration on Harmonisation (2003) and of the Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability (2005);

Willing to ensure a more effective use of human and financial resources at country level, avoiding in particular duplication of activities within the United Nations development system and the Bretton Woods institutions;

Noting the preliminary work under way at WHO on ownership, alignment, harmonization and results, WHO's active role as a member of the United Nations Development Group, and its efforts to strengthen country-level response in accordance with its mandate and through its country focus policy;

Underlining the importance of applying the "Three Ones" principle launched by UNAIDS and approved in resolution WHA57.14,

1. URGES Member States to ensure that operational development activities are planned and implemented in dialogue with, and under the stewardship of, the national government and in conformity with its priorities, while being aware of the coordinated efforts of bodies of the United Nations system carried in the context of the United Nations Development Assistance Framework;

2. REQUESTS the Director General:

(1) to ensure that WHO continues to implement country-level activities in accordance with Member States' priorities, as agreed by the governing bodies, and to coordinate the activities of WHO with those of other organizations of the United Nations system and, where appropriate, with other relevant actors working to improve health outcomes;

(2) to ensure that WHO staff and programmes at headquarters, and regional and country offices adhere to the international harmonization and alignment agenda, as reflected *inter alia* in

¹ Document A/59/2005.

the Rome Declaration and Paris Declaration, and actively participate in the preparation and implementation of the United Nations Development Assistance Framework, working closely with other members of the United Nations country team and in close collaboration with the United Nations Resident Coordinator at country level, in order to ensure coherence and efficiency;

(3) to take into account the Triennial comprehensive policy review of operational activities for development of the United Nations system, including gender mainstreaming and the promotion of gender equality, in order to guide WHO actions at country level, and to participate actively in examination of the Triennial comprehensive policy review at the Economic and Social Council and at the United Nations General Assembly;

(4) in particular, to examine ways and take specific steps to further rationalize procedures and reduce transaction costs as outlined in Chapter 4, paragraph 36, of United Nations General Assembly resolution 59/250;

(5) to submit to the Fifty-ninth World Health Assembly, through the Executive Board, an interim report on progress in implementing this resolution and, to the Sixty-first World Health Assembly, a comprehensive analysis of WHO's contribution to implementation of United Nations General Assembly resolution 59/250, in particular the alignment of WHO's operational development activities at country level with those of the United Nations system and the impact of such coordination effort on aid effectiveness and its monitoring.

(Ninth plenary meeting, 25 May 2005 –
Committee B, fourth report)

WHA58.26 Public-health problems caused by harmful use of alcohol

The Fifty-eighth World Health Assembly,

Having considered the report on public health problems caused by harmful use of alcohol;¹

Reaffirming resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles, and WHA57.17 on the Global Strategy on Diet, Physical Activity and Health;

Recalling *The world health report 2002*, which indicated that 4% of the burden of disease and 3.2% of all deaths globally were attributed to alcohol, and that alcohol was the foremost risk to health in low-mortality developing countries and the third in developed countries;²

Recognizing that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children –

¹ Document A58/18.

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

disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities;

Emphasizing the risk of harm due to alcohol consumption, particularly in the context of driving a vehicle, at the workplace, and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognizing that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex;

Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to the health, social welfare and criminal justice systems, lost productivity, and reduced economic development;

Recognizing the threats posed to public health by the factors that have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol-related harm;

Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol;

Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word “harmful” in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way,

1. REQUESTS Member States:

- (1) to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol;
- (2) to encourage mobilization and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;
- (3) to support the work requested of the Director-General below, including, if necessary, through voluntary contributions by interested Member States;

2. REQUESTS the Director-General:

- (1) to strengthen the Secretariat’s capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;

- (2) to consider intensifying international cooperation in reducing public-health problems caused by the harmful use of alcohol, and to mobilize the necessary support at global and regional levels;
- (3) to consider also conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health;
- (4) to report to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public-health problems caused by harmful use of alcohol;
- (5) to draw up recommendations for effective policies and interventions to reduce alcohol-related harm, and to develop technical tools that will support Member States in implementing and evaluating recommended strategies and programmes;
- (6) to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States and promoting research where such data are not available;
- (7) to promote and support global and regional activities aimed at identifying and managing alcohol-use disorders in health-care settings and enhancing the capacity of health-care professionals to address problems of their patients associated with harmful patterns of alcohol consumption;
- (8) to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;
- (9) to organize open consultations with representatives of the industry, agriculture and trade sectors in order to limit the health impact of harmful alcohol consumption;
- (10) to report through the Executive Board to the Sixtieth World Health Assembly on progress made in implementation of this resolution.

(Ninth plenary meeting, 25 May 2005 –
Committee B, fourth report)

WHA58.27 Improving the containment of antimicrobial resistance

The Fifty-eighth World Health Assembly,

Having considered the report on rational use of medicines by prescribers and patients;¹

Acknowledging that the containment of antimicrobial resistance is a prerequisite for attaining several of the internationally agreed health-related goals contained in the United Nations Millennium Declaration;

¹ Document A58/14.

Recalling the recommendations of the Second International Conference on Improving Use of Medicines (Chiang Mai, Thailand, 2004);

Recalling also the findings of relevant WHO reports, including “Priority medicines for Europe and the world”,¹ and the Copenhagen Recommendation from the European Union conference on “The Microbial Threat” (Copenhagen, 1998);

Aware that the spread of antimicrobial resistance recognizes no national boundaries and has reached proportions that require urgent action at national, regional and global levels, especially in view of the decreasing development of new antimicrobial agents;

Recalling previous resolutions WHA39.27 and WHA47.13 on the rational use of drugs, WHA51.17 on antimicrobial resistance, and WHA54.14 on global health security;

Recognizing the efforts of WHO, in collaboration with governments, universities, the private sector and nongovernmental organizations, to contain antimicrobial resistance, thereby contributing to prevention of the spread of infectious diseases;

Noting that, despite some progress, the strategy for containment of antimicrobial resistance has not been widely implemented;²

Wishing to intensify efforts to contain antimicrobial resistance and to promote rational use of antimicrobial agents by providers and consumers in order to improve global health security;

Re-emphasizing the need for a coherent, comprehensive and integrated national approach to promoting the containment of antimicrobial resistance;

Convinced that it is time for governments, the health professions, civil society, the private sector and the international community to reaffirm their commitment to ensuring that sufficient investment is made to contain antimicrobial resistance,

1. URGES Member States:

- (1) to ensure the development of a coherent, comprehensive and integrated national approach to implementing the strategy for containment of antimicrobial resistance taking account, where appropriate, of financial and other incentives that might have a harmful impact on policies for prescribing and dispensing;
- (2) to enhance rational use of antimicrobial agents, including through development and enforcement of national standard-practice guidelines for common infections, in public and private health sectors;
- (3) to strengthen, as appropriate, their legislation on availability of medicines in general and of antimicrobial agents in particular;

¹ Document WHO/EDM/PAR/2004.7.

² Document WHO/CDS/CSR/DRS/2001.2.

- (4) to mobilize human and financial resources in order to minimize the development and spread of antimicrobial resistance, in particular by promotion of the rational use of antimicrobial agents by providers and consumers;
- (5) to monitor effectively and to control nosocomial infections;
- (6) to monitor regularly the use of antimicrobial agents and the level of antimicrobial resistance in all relevant sectors;
- (7) to share actively knowledge and experience on best practices in promoting the rational use of antimicrobial agents;

2. REQUESTS the Director-General:

- (1) to strengthen the leadership role of WHO in containing antimicrobial resistance;
- (2) to accelerate the implementation of resolutions WHA51.17 and WHA54.14 concerning the containment of antimicrobial resistance by expanding and strengthening the provision of technical support to Member States, at their request;
- (3) to collaborate with other relevant programmes and partners in order to promote the appropriate use of antimicrobial agents in the context of the rational use of medicines, by scaling up interventions proven to be effective, and to provide support for the sharing of knowledge and experience among stakeholders on best practice;
- (4) to provide support for the generation of up-to-date information on antimicrobial resistance at regional and subregional levels and to make this available to Member States and other parties;
- (5) to provide support for gathering and sharing of evidence on cost-effective interventions for prevention and control of antimicrobial resistance at national and local levels;
- (6) to report to the Sixtieth World Health Assembly, and subsequently on a regular basis, on progress achieved, problems encountered and further actions proposed in implementing this resolution.

(Ninth plenary meeting, 25 May 2005 –
Committee A, seventh report)

WHA58.28 eHealth

The Fifty-eighth World Health Assembly,

Having considered the report on eHealth;¹

¹ Document A58/21.

Noting the potential impact that advances in information and communication technologies could have on health-care delivery, public health, research and health-related activities for the benefit of both low- and high-income countries;

Aware that advances in information and communication technologies have raised expectations for health;

Respecting human rights, ethical issues and the principles of equity, and considering differences in culture, education, language, geographical location, physical and mental ability, age, and sex;

Recognizing that a WHO eHealth strategy would serve as a basis for WHO's activities on eHealth;

Recalling resolution WHA51.9 on cross-border advertising, promotion, and sale of medical products through the Internet;

Stressing that eHealth is the cost-effective and secure use of information and communications technologies in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research,

1. URGES Member States:

- (1) to consider drawing up a long-term strategic plan for developing and implementing eHealth services in the various areas of the health sector, including health administration, which would include an appropriate legal framework and infrastructure and encourage public and private partnerships;
- (2) to develop the infrastructure for information and communication technologies for health as deemed appropriate to promote equitable, affordable, and universal access to their benefits, and to continue to work with information and telecommunication agencies and other partners in order to reduce costs and make eHealth successful;
- (3) to build on closer collaboration with the private and non-profit sectors in information and communication technologies, so as to further public services for health and make use of the eHealth services of WHO and other health organizations, and to seek their support in the area of eHealth;
- (4) to endeavour to reach communities, including vulnerable groups, with eHealth services appropriate to their needs;
- (5) to mobilize multisectoral collaboration for determining evidence-based eHealth standards and norms, to evaluate eHealth activities, and to share the knowledge of cost-effective models, thus ensuring quality, safety and ethical standards and respect for the principles of confidentiality of information, privacy, equity and equality;
- (6) to establish national centres and networks of excellence for eHealth best practice, policy coordination, and technical support for health-care delivery, service improvement, information to citizens, capacity building, and surveillance;
- (7) to consider establishing and implementing national electronic public-health information systems and to improve, by means of information, the capacity for surveillance of, and rapid response to, disease and public-health emergencies;

2. REQUESTS the Director-General:

- (1) to promote international, multisectoral collaboration with a view to improving compatibility of administrative and technical solutions and ethical guidelines in the area of eHealth;
- (2) to expand the use of electronic information through the submission of regular reports, to document and analyse developments and trends, to inform policy and practice in countries, and to report regularly on use of eHealth worldwide;
- (3) to facilitate the development of model eHealth solutions which, with appropriate modification, could be established in national centres and networks of excellence for eHealth;
- (4) to provide technical support to Member States in relation to eHealth products and services by disseminating widely experiences and best practices, in particular on telemedicine technology, devising assessment methodologies, promoting research and development, and furthering standards through diffusion of guidelines;
- (5) to facilitate the integration of eHealth in health systems and services, including in the deployment of telemedicine infrastructure in countries where medical coverage is inadequate, in the training of health-care professionals, and in capacity building, in order to improve access to, and quality and safety of, care;
- (6) to continue the expansion to Member States of mechanisms such as the Health Academy, which promote health awareness and healthy lifestyles through eLearning;¹
- (7) to provide support to Member States to promote the development, application and management of national standards of health information; and to collect and collate available information on standards with a view to establishing national standardized health information systems in order to facilitate easy and effective exchange of information among Member States;
- (8) to support in the area of eHealth regional and interregional initiatives or those among groups of countries that speak a common language;
- (9) to submit to the Executive Board, at its 117th session, a list of proposed specific activities upon which the Secretariat will focus, which should be entirely aimed at tools and services that Member States can incorporate into their own national solutions or adapt as necessary, and an outline of the budgetary implications of proposed activities.

(Ninth plenary meeting, 25 May 2005 –
Committee A, seventh report)

WHA58.29 Enhancement of laboratory biosafety

The Fifty-eighth World Health Assembly,

Considering that release of microbiological agents and toxins may have global ramifications;

¹ eLearning is understood in this context to mean use of any electronic technology and media in support of learning.

Acknowledging that the containment of microbiological agents and toxins in laboratories is critical to preventing outbreaks of emerging and re-emerging diseases such as severe acute respiratory syndrome (SARS);

Recognizing the work of WHO in promoting laboratory biosafety;

Acknowledging that a number of Member States do have in place effective laboratory biosafety controls and guidelines for laboratory practice in order to manage the risks to laboratory workers and the community from microbiological agents and toxins;

Recognizing that some Member States may not have adequate biosafety controls in place;

Noting that an integrated approach to laboratory biosafety, including containment of microbiological agents and toxins, promotes global public health,

1. URGES Member States:

(1) to review the safety of their laboratories and their existing protocols for the safe handling of microbiological agents and toxins, consistent with WHO's biosafety guidance;

(2) to implement specific programmes, consistent with WHO's biosafety guidance, to promote biosafety laboratory practices for the safe handling and transport, including containment, of microbiological agents and toxins;

(3) to develop national preparedness plans and national programmes that enhance compliance of laboratories, including those within the government, at universities and research centres and in the private sector, particularly those handling highly virulent microbiological agents and toxins, with biosafety guidelines for laboratory practices;

(4) to mobilize national and international human and financial resources to improve laboratory biosafety, including containment of microbiological agents and toxins, in order to minimize the possibility of laboratory-acquired infections and resultant spread to the community;

(5) to cooperate with other Member States to facilitate access to laboratory biosafety equipment, including personal protective equipment and containment devices, for the prevention and control of laboratory-acquired infection;

(6) to encourage the development of biological-safety training programmes and competency standards for laboratory workers in order to improve safety awareness and safe laboratory practices;

2. REQUESTS the Director-General:

(1) to ensure that WHO plays an active role, in accordance with its mandate, in the task of improving laboratory biosafety, including containment of microbiological agents and toxins;

(2) to provide support to other relevant programmes and partners in strengthening their efforts to promote improved laboratory biosafety, including containment of microbiological agents and toxins;

- (3) to provide support for the generation and sharing of knowledge and experience among Member States for enhancing laboratory biosafety, including containment of microbiological agents and toxins, through, inter alia, the regular update of relevant WHO guidelines and manuals in consultation with all Member States with a view to accommodating their concerns;
- (4) to provide, in response to requests from Member States, technical support for strengthening laboratory biosafety, including containment of microbiological agents and toxins;
- (5) to report regularly to the Executive Board on implementation of this resolution.

(Ninth plenary meeting, 25 May 2005 –
Committee A, seventh report)

WHA58.30 Accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration

The Fifty-eighth World Health Assembly,

Having considered the report on achievement of health-related Millennium Development Goals;¹

Recalling the commitments made in the United Nations Millennium Declaration adopted by the United Nations General Assembly in September 2000² and the United Nations Secretary-General's road map towards its implementation;³

Recognizing that the internationally agreed development goals, including all those contained in the United Nations Millennium Declaration, especially the health-related goals, mark a turning point in international development, represent a powerful consensus and commitment between rich and poor nations, and set clear priorities for action and benchmarks against which to measure progress;

Recognizing that health is central to achievement of the internationally agreed development goals, including all those contained in the United Nations Millennium Declaration, and that such goals create an opportunity to position health as a core part of the development agenda and to raise political commitment and financial resources for the sector;

Noting with concern that current trends suggest that many low-income countries will not reach the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, that many countries may achieve them only among their richer population groups, broadening inequalities, and that urgent action is needed;

Recognizing the importance of using applicable human-rights instruments in efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

¹ Document A58/5.

² United Nations General Assembly resolution 55/2.

³ Document A/56/326.

Acknowledging that rapid progress will require political commitment and a scaling-up of more efficient and effective strategies and actions, greater investment of financial resources, adequately staffed and effective health systems, capacity-building in the public and private sectors, a clear focus on equity in access and outcomes, and collective action within and between countries;

Recognizing that internationally agreed development goals, including those contained in the United Nations Millennium Declaration, are complementary and synergistic and cannot be achieved in isolation since health is central to the achievement of non-health goals and their attainment will affect health targets, including those for HIV/AIDS, tuberculosis and malaria, and other targets set by the Health Assembly;

Recalling that at its Thirty-eighth session (April 2005) the United Nations Commission on Population and Development emphasized

*the importance of integrating the goal of universal access to reproductive health by 2015 set at the International Conference on Population and Development into strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, in particular those related to improving maternal health, reducing infant and child mortality, promoting gender equality, combating HIV/AIDS, eradicating poverty and achieving universal access to primary education;*¹

Recognizing WHO's leadership with the World Bank in the High-Level Forum on the Health MDGs (Abuja, 2004) and the impact this has had in catalysing action and progress on the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

Recalling resolution WHA55.19 which calls on the international donor community to increase its assistance to developing countries in the health sector; encourages developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance to developing countries, and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Developed Countries (Brussels, 2001); and encourages developing countries to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

Noting that the Heads of State and Government of the Organization of African Unity at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja, 2001) pledged to set a target of allocating at least 15% of their annual budget to the improvement of the health sector;²

Noting that many countries have cooperation and partnership mechanisms with civil society, including nongovernmental organizations, the broader community, religious organizations and the private sector which cover all levels of the administration (national, regional and district);

Recognizing the importance of action and empowerment for gender equality in bringing about more equitable and effective approaches to national development,

¹ Draft resolution E/CN.9/2005/L.5, 11 April 2005, paragraph 3.

² Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, paragraph 26.

1. REQUESTS Member States:

- (1) to reaffirm the internationally agreed health-related development goals, including those for health development contained in the United Nations Millennium Declaration;
- (2) to develop and implement in the context of existing policy and planning processes nationally relevant “road maps” on achievement of the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, which incorporate the following actions to accelerate progress:
 - (a) prioritizing the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, within national development and health plans, including where appropriate Poverty Reduction Strategy Papers, plans that are led by national governments with support from development partners and civil society and take into account the overall health priorities of the countries concerned; and ensuring that priorities for health and poverty reduction are reflected in associated budgets and expenditure frameworks;
 - (b) raising the level of funding for effective interventions that address health conditions relevant to the achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
 - (c) implementing related Health Assembly resolutions, including resolution WHA56.21 on child and adolescent health, resolution WHA57.12 on reproductive health and resolution WHA57.14 on HIV/AIDS, which are components of a global partnership for development and crucial for attainment of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and the goal of universal access to reproductive health by 2015 set at the United Nations International Conference on Population and Development (Cairo, 1994); and establishing or sustaining national monitoring mechanisms for measuring progress towards achievement of the agreed goals;
 - (d) strengthening collaboration and partnership among relevant sectors, including ministries of finance, and with the international financial institutions, on investments in the health sector with a view to increasing the share of overall government resources allocated to health and, where appropriate, revising ceilings on public-sector spending in order to allow for increases in health spending financed from development assistance;
 - (e) strengthening the core functions of public or private components of the health system, as appropriate, in line with the Declaration of Alma Ata (1978) so that they contribute to the delivery of better and more equitable health outcomes in areas relevant to the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
 - (f) improving health and nutrition information systems, including strengthening of vital registration systems, supported by critical health-systems research, in order to inform policy-making while avoiding an increase in the reporting burden and emphasizing the need for data disaggregated by age, socioeconomic quintile, sex and ethnicity; and to strengthen monitoring and evaluation systems that promote accountability, empowerment and participation;

- (g) ensuring that health and development policies are underpinned by a gender analysis and striving for gender equality and women's empowerment;
 - (h) strengthening equity and nondiscrimination in development efforts and facilitating the empowerment and participation of the population in decision-making processes;
2. CALLS on developed and developing countries to address with shared responsibility the growing crisis of human resources for health; and on developed countries to strive towards self-sufficiency without adversely impacting on the human-resource situation in developing countries and to provide support to developing countries to achieve self-sufficiency through planning, training, recruitment and retention of all categories of health professionals;
3. URGES developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance to developing countries, and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Developed Countries (Brussels, 2001);
4. URGES developing countries to continue to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;
5. URGES those countries which are Members of the African Union to fulfil the commitment made at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja, 2001) to set a target of allocating at least 15% of annual budget to the improvement of the health sector;¹
6. REQUESTS the Director-General:
- (1) to ensure that priority actions to support Member States in accelerating progress towards the internationally agreed health-related goals, including those contained in the Millennium Declaration, are reflected in the Programme budget 2006-2007, in future budgets, and in the Eleventh General Programme of Work; and to develop a coherent and adequately resourced strategy, with clear goals and deliverable products, for advancing work in the areas mentioned below, and to report to the Health Assembly on progress;
 - (2) to provide support to Member States, at their request:
 - (a) to develop outcome-oriented and adequately resourced policies and strategies for health development;
 - (b) to strengthen the capacity of public and private health systems, as appropriate, to deliver equitable outcomes on a national scale, through measures that require interdepartmental collaboration, and to convene and support nationally led teams that work with all local actors in order to facilitate access to all sources of financing; develop the education, recruitment and retention of health professionals; integrate community health workers into overall systems; and implement resolution WHA57.19 on international migration of health personnel;

¹ Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, paragraph 26.

- (c) to identify vulnerable groups with specific health needs and to devise appropriate programmes that deliver equitable outcomes;
 - (d) to strengthen intersectoral linkages to address the social and environmental determinants of health;
 - (e) to engage in technical and policy dialogue with international financial institutions, including on the impact of their policies on health-related needs; to lead harmonization and coordination processes among development partners in health; and to ensure alignment of support around country priorities;
 - (f) to use appropriate monitoring and evaluation frameworks, including those related to universal access to reproductive health, that measure progress towards the internationally agreed health-related development goals, including those contained in the Millennium Declaration, in order to determine cost-effective programmes that achieve better health and nutrition outcomes without adding to the reporting burden in countries;
 - (g) to promote research that guides successful implementation of activities to achieve internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (3) to ensure that due attention is devoted to the particular health problems of countries emerging from conflict and other forms of crisis;
 - (4) to support actively and contribute to, in the context of reform of the United Nations system, heightening the impact and effectiveness of the United Nations Country Teams; to simplify further, harmonize and coordinate procedures within the United Nations system and with other partners; and to improve alignment of the United Nations inputs with national priorities;¹
 - (5) to promote efforts that increase coherence and coordination in development assistance for health so that resources effectively strengthen broad-based health systems;
 - (6) to participate appropriately in the high-level plenary of the United Nations General Assembly on the outcome of the Millennium Summit (September 2005).

¹ See also resolution WHA58.25.

ANNEX



Health in the Millennium Development Goals

Millennium Development Goals, targets and indicators related to health

Health targets		Health indicators
GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER		
Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	
Target 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption
GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION		
Target 3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	
GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN		
Target 4	Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015	
GOAL 4: REDUCE CHILD MORTALITY		
Target 5	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one-year-old children immunized against measles
GOAL 5: IMPROVE MATERNAL HEALTH		
Target 6	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES		
Target 7	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among pregnant women aged 15-24 years 19. Condom use rate of the contraceptive prevalence rate 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 8	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under DOTS (directly observed treatment short-course)
GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY		
Target 9	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	29. Proportion of population using solid fuels
Target 10	Halve by 2015 the proportion of people without sustainable access to safe drinking-water and sanitation	30. Proportion of population with sustainable access to an improved water source, urban and rural
Target 11	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31. Proportion of population with access to improved sanitation, urban and rural
GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT		
Target 12	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system	
Target 13	Address the special needs of the least developed countries	
Target 14	Address the special needs of landlocked countries and small island developing states	
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	
Target 17	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	

Sources: "Implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/57/270 (31 July 2002), first annual report based on the "Road map towards the implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/56/326 (6 September 2001); United Nations Statistics Division, Millennium Indicators Database, verified in July 2004; World Health Organization.

WHA58.31 Working towards universal coverage of maternal, newborn and child health interventions

The Fifty-eighth World Health Assembly,

Concerned by the high level of maternal, newborn and child morbidity and mortality in the world, by the fact that the maternal mortality ratio worldwide has not changed substantially over the past decade, by the slow pace of progress in improving maternal, newborn and child health, by the growing inequalities between and within Member States, and by the continuing need to address gender inequalities;

Alarmed by the inadequate resources for maternal, newborn and child health and by the lack of appreciation of the great impact of maternal, newborn and child health in sustaining socioeconomic development;

Concerned by the inadequacy of vital registration and other data required to produce accurate information on maternal, infant and under-five mortality, on their breakdown by socioeconomic groups, on income quintiles, and on urban rural differentials;

Mindful that cost-effective interventions exist to meet the health needs of women, newborns and children;

Aware that care needs to be provided as a seamless continuum both throughout the life-cycle and spanning individuals, families, communities and the various levels of the health system, including reproductive health care, thus creating an integrated approach to maternal, newborn and child health;

Convinced that only through coordinated and concerted action and unprecedented resource mobilization at international and national levels will it be possible to deal with the global crisis that currently affects the health workforce and strengthen health systems in order to end the exclusion of the poor, the marginalized and the underserved;

Welcoming the increased commitment of the international community and WHO to the health of women, newborns and children, and to meeting the internationally agreed development goals, including those contained in the Millennium Declaration;

Recalling resolution WHA56.21 welcoming the strategic directions for child and adolescent health and development, resolution WHA57.12 adopting the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health and aware of the need for stepping up efforts to achieve international goals for reproductive, maternal, newborn and child health and development, and resolution WHA55.19 which calls for an increase in investment in health in developing countries;

Recalling the goals and objectives of the World Summit for Children (New York, 1990), the Programme of Action of the International Conference on Population and Development (Cairo, 1994), and the Platform for Action of the Fourth World Conference on Women (Beijing, 1995) and their respective follow-ups; the United Nations General Assembly special session on HIV/AIDS (New York, 2001); and the United Nations General Assembly special session on children (New York, 2002);

Recalling also the Delhi Declaration on Maternal, Newborn and Child Health (April 2005);

Welcoming *The world health report 2005: Making every mother and child count*¹ and the guidance offered by the associated policy briefs,

1. URGES Member States:

- (1) to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care;
- (2) to establish or sustain national and international targets, and to establish monitoring mechanisms for measuring progress towards the achievement of agreed goals, particularly the target of universal access to reproductive health by 2015;
- (3) to involve all key stakeholders, including civil-society organizations and communities, in setting priorities, developing plans and programmes, measuring progress and evaluating impact;
- (4) to improve the quality and completeness of vital registration and other relevant household-survey data, where appropriate, to reflect mortality differentials among mothers, infants and under-fives;
- (5) to adopt and implement, in line with international agreements, the legal and regulatory frameworks to promote gender equality and protect the rights of women and children, including equal access to health care, with special attention for those thus far excluded, particularly the poor, the marginalized and the underserved;
- (6) to ensure that national strategic-planning and budgetary processes include interventions at political and programme levels to strengthen health-care delivery systems for effective and rapid advance towards universal coverage, including:
 - (a) realigning the content of programmes for maternal, newborn and child health and nutrition, incorporating their management structures and services, and embedding them in core development processes for health systems in order to ensure that reproductive health care is fully integrated;
 - (b) addressing the workforce crisis by drawing up national plans for development of human resources for health that include financial incentives and mechanisms for equitable deployment and retention, especially for rural primary care, so as to give the poor better access to care;
 - (c) building realistic scenarios, with their costing and budget implications, for scaling up the health systems required for delivering maternal, newborn and child health care;
 - (d) building the institutional capacity to manage appropriate financing reform, inter alia a move from user fees to prepayment mechanisms and pooling systems, including tax-based and insurance systems, in order to achieve the goal of universal access and financial and social protection;

¹ *The world health report 2005. Making every mother and child count.* Geneva, World Health Organization, 2005.

(e) building a national consensus around the need for moving towards universal coverage, with mechanisms for predictable, sustained and increased funding; around maternal, newborn and child health as the core of the citizen's health care, including entitlements where appropriate; and around the human-resources-for-health crisis as a national priority;

(f) creating partnerships between government, civil-society organizations, private sector entities and development agencies to maintain the political momentum, overcome resistance to change, and mobilize resources;

(g) establishing participation mechanisms for not-for-profit civil-society organizations and religious organizations in order to strengthen accountability mechanisms and systems of checks and balances;

2. REQUESTS the Director-General:

(1) to strengthen the coordination, collaboration and synergies of WHO's programmes on reproductive, maternal, newborn and child health, its programmes on malaria, HIV/AIDS, tuberculosis and health promotion, and its programme on health systems development, in support of countries;

(2) to ensure that WHO fully participates in harmonization efforts within the United Nations system, supports efforts of Member States to establish policy coherence and synergies between and within national and international initiatives in maternal, newborn and child health, particularly between those taken by partners within the United Nations system and others;

(3) to support the efforts of national health authorities to ensure that reproductive, maternal, newborn and child health are systematically included in frameworks for socioeconomic development and plans to ensure sustainability;

(4) to collaborate further with relevant partners to produce information on health status inequalities, such as through UNICEF's Multiple Indicator Cluster Surveys or Demographic and Health Surveys, in order to inform appropriate and specific policy actions by all concerned partners;

(5) to intensify technical support to Member States for developing their institutional capacity for achieving international goals and targets through universal access to, and coverage of, reproductive, maternal, newborn and child health programmes, in the context of strengthening health systems;

(6) to mobilize the international community so that it commits the additional resources required to achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care;

(7) to declare an annual world maternal, newborn, and child health day in order to ensure continued global visibility of the reproductive, maternal, newborn and child health agenda and to provide an opportunity for countries and the international community to reassert their commitment to this issue;

(8) to report biennially to the Health Assembly on progress towards reducing exclusion and achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care, and on the support provided by WHO to Member States to attain this goal.

(Ninth plenary meeting, 25 May 2005 –
Committee B, fifth report)

WHA58.32 Infant and young child nutrition

The Fifty-eighth World Health Assembly,

Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes annexed to resolution WHA34.22, resolutions WHA39.28, WHA41.11, WHA46.7, WHA47.5, WHA49.15, WHA54.2 on infant and young child nutrition, appropriate feeding practices and related questions, and particularly resolution WHA55.25, which endorses the global strategy for infant and young child feeding;

Having considered the report on infant and young child nutrition;¹

Aware that the joint FAO/WHO expert meeting on *Enterobacter sakazakii* and other microorganisms in powdered infant formula (2004) concluded that intrinsic contamination of powdered infant formula with *E. sakazakii* and *Salmonella* had been a cause of infection and illness, including severe disease in infants, particularly preterm, low birth-weight or immunocompromised infants, and could lead to serious developmental sequelae and death;²

Noting that such severe outcomes are especially serious in preterm, low birth-weight and immunocompromised infants, and therefore are of concern to all Member States;

Bearing in mind that the Codex Alimentarius Commission is revising its recommendations on hygienic practices for the manufacture of foods for infants and young children;

Recognizing the need for parents and caregivers to be fully informed of evidence-based public-health risks of intrinsic contamination of powdered infant formula and the potential for introduced contamination, and the need for safe preparation, handling and storage of prepared infant formula;

Concerned that nutrition and health claims may be used to promote breast-milk substitutes as superior to breastfeeding;

Acknowledging that the Codex Alimentarius Commission plays a pivotal role in providing guidance to Member States on the proper regulation of foods, including foods for infants and young children;

Bearing in mind that on several occasions the Health Assembly has called upon the Commission to give full consideration, within the framework of its operational mandate, to evidence-based action that it might take to improve the health standards of foods, consistent with the aims and objectives of

¹ Document A58/15.

² FAO/WHO Expert Meeting on *E. sakazakii* and other Microorganisms in Powdered Infant Formula: Meeting Report. Microbiological Risk Assessment Series No. 6, 2004, p. 37.

relevant public health strategies, particularly WHO's global strategy for infant and young child feeding (resolution WHA55.25) and Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17);

Recognizing that such action requires a clear understanding of the respective roles of the Health Assembly and the Codex Alimentarius Commission, and that of food regulation in the broader context of public health policies;

Taking into account resolution WHA56.23 on the joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission, which endorsed WHO's increased direct involvement in the Commission and requested the Director-General to strengthen WHO's role in complementing the work of the Commission with other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in Health Assembly resolutions,

1. URGES Member States:

- (1) to continue to protect, promote and support exclusive breastfeeding for six months as a global public-health recommendation, taking into account the findings of the WHO Expert Consultation on optimal duration of exclusive breastfeeding,¹ and to provide for continued breastfeeding up to two years of age or beyond, by implementing fully the WHO global strategy on infant and young child feeding that encourages the formulation of a comprehensive national policy, including where appropriate a legal framework to promote maternity leave and a supportive environment for six months' exclusive breastfeeding, a detailed plan of action to implement, monitor and evaluate the policy, and allocation of adequate resources for this process;
- (2) to ensure that nutrition and health claims are not permitted for breast-milk substitutes, except where specifically provided for in national legislation;²
- (3) to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging;
- (4) to ensure that financial support and other incentives for programmes and health professionals working in infant and young child health do not create conflicts of interest;
- (5) to ensure that research on infant and young child feeding, which may form the basis for public policies, always contains a declaration relating to conflicts of interest and is subject to independent peer review;

¹ As formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28-30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4).

² The reference to national legislation also applies to regional economic integration organizations.

- (6) to work closely with relevant entities, including manufacturers, to continue to reduce the concentration and prevalence of pathogens, including *Enterobacter sakazakii*, in powdered infant formula;
- (7) to continue to ensure that manufacturers adhere to Codex Alimentarius or national food standards and regulations;
- (8) to ensure policy coherence at national level by stimulating collaboration between health authorities, food regulators and food standard-setting bodies;
- (9) to participate actively and constructively in the work of the Codex Alimentarius Commission;
- (10) to ensure that all national agencies involved in defining national positions on public health issues for use in all relevant international forums, including the Codex Alimentarius Commission, have a common and consistent understanding of health policies adopted by the Health Assembly, and to promote these policies;

2. REQUESTS the Codex Alimentarius Commission:

- (1) to continue to give full consideration, when elaborating standards, guidelines and recommendations, to those resolutions of the Health Assembly that are relevant in the framework of its operational mandate;
- (2) to establish standards, guidelines and recommendations on foods for infants and young children formulated in a manner that ensures the development of safe and appropriately labelled products that meet their known nutritional and safety needs, thus reflecting WHO policy, in particular the WHO global strategy for infant and young child feeding and the International Code of Marketing of Breast-milk Substitutes and other relevant resolutions of the Health Assembly;
- (3) urgently to complete work currently under way on addressing the risk of microbiological contamination of powdered infant formula and establish appropriate microbiological criteria or standards related to *E. sakazakii* and other relevant microorganisms in powdered infant formula; and to provide guidance on safe handling and on warning messages on product packaging;

3. REQUESTS the Director-General:

- (1) in collaboration with FAO, and taking into account the work undertaken by the Codex Alimentarius Commission, to develop guidelines for clinicians and other health-care providers, community health workers and family, parents and other caregivers on the preparation, use, handling and storage of infant formula so as to minimize risk, and to address the particular needs of Member States in establishing effective measures to minimize risk in situations where infants cannot be, or are not, fed breast milk;
- (2) to take the lead in supporting independently reviewed research, including by collecting evidence from different parts of the world, in order to understand better the ecology, taxonomy, virulence and other characteristics of *E. sakazakii*, in line with the recommendations of the FAO/WHO Expert Meeting on *E. sakazakii* and other Microorganisms in Powdered Infant Formula, and to explore means of reducing its level in reconstituted powdered infant formula;

(3) to provide information in order to promote and facilitate the contribution of the Codex Alimentarius Commission, within the framework of its operational mandate, to full implementation of international public-health policies;

(4) to report to the Health Assembly each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and the relevant resolutions of the Health Assembly, on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action.

(Ninth plenary meeting, 25 May 2005 –
Committee A, eighth report)

WHA58.33 Sustainable health financing, universal coverage and social health insurance

The Fifty-eighth World Health Assembly,

Having considered the report on social health insurance;¹

Noting that health-financing systems in many countries need to be further developed in order to guarantee access to necessary services while providing protection against financial risk;

Accepting that, irrespective of the source of financing for the health system selected, prepayment and pooling of resources and risks are basic principles in financial-risk protection;

Considering that the choice of a health-financing system should be made within the particular context of each country;

Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, including the introduction of social health insurance;

Noting that some countries have recently been recipients of large inflows of external funding for health;

Recognizing the important role of State legislative and executive bodies in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:

(1) to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;

(2) to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package;

¹ Document A58/20.

- (3) to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;
- (4) to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all;
- (5) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, sociocultural and political context of each country;
- (6) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship;
- (7) to share experiences on different methods of health financing, including the development of social health-insurance schemes, and private, public, and mixed schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system;

2. REQUESTS the Director-General:

- (1) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly prepayment schemes, including social health insurance, with a view to achieving the goal of universal coverage and taking account of the special needs of small island countries and other countries with small populations; and to collaborate with Member States in the process of social dialogue on health-financing options;
- (2) to provide Member States, in coordination with the World Bank and other relevant partners, with technical information on the potential impact of inflows of external funds for health on macroeconomic stability;
- (3) to create sustainable and continuing mechanisms, including regular international conferences, subject to availability of resources, in order to facilitate the continuous sharing of experiences and lessons learnt on social health insurance;
- (4) to provide technical support in identifying data and methodologies better to measure and analyse the benefits and cost of different practices in health financing, covering collection of revenues, pooling, and provision or purchasing of services, and taking account of economic and sociocultural differences;
- (5) to provide support to Member States, as appropriate, for developing and applying tools and methods to evaluate the impact on health services of changes in health-financing systems as they move towards universal coverage;

(6) to report to the Fifty-ninth World Health Assembly, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Fifty-eighth World Health Assembly.

(Ninth plenary meeting, 25 May 2005 –
Committee A, eighth report)

WHA58.34 Ministerial Summit on Health Research

The Fifty-eighth World Health Assembly,

Having considered the Mexico Statement on Health Research resulting from the Ministerial Summit on Health Research convened by the Director-General of WHO and the Government of Mexico (Mexico City, 16-20 November 2004) and the report of the Secretariat;¹

Acknowledging that high-quality research, and the generation and application of knowledge are critical for achieving the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, improving the performance of health systems, advancing human development, and attaining equity in health;

Recognizing the need to strengthen evidence-based evaluation of the consequences of health and other policies and practices impacting on health at national, regional, and local levels;

Reaffirming the need to create demand for research and to foster participation in the research process;

Sensitive to the need to strengthen national health-research systems by building relevant capacity, developing capable leadership, providing essential monitoring and evaluation tools, improving capacity for ethical review of research, and determining necessary ethical standards and regulations for population health, health care, and clinical research;

Committed to promoting access to reliable, relevant, and up-to-date evidence on the effects of interventions, based on systematic review of the totality of available research findings, and taking into account existing models;

Conscious of the need to identify relatively underfunded areas of research, such as health systems and public health, where increased resources and leadership would accelerate the achievement of internationally agreed health-related development goals;

Emphasizing that research is a global endeavour based on the sharing of knowledge and information and conducted according to appropriate national ethical guidelines and standards,

1. ACKNOWLEDGES the Mexico Statement on Health Research resulting from the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004);

¹ Document A58/22.

2. URGES Member States:

(1) to consider implementing the recommendation made by the Commission on Health Research for Development in 1990 that “developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening, and at least 5% of project and program aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening”;¹

(2) to establish and implement or strengthen a national health-research policy with appropriate political support and to allocate adequate funding and human resources for health-systems research;

(3) to encourage collaboration with other partners in health research so as to facilitate the conduct of such research within their health systems;

(4) to promote activities to strengthen national health-research systems, including improvement of the knowledge base for making decisions, setting priorities, managing research, monitoring performance, and adopting standards and regulations for high-quality research and its ethical oversight, and ensure participation in such activities of the community, nongovernmental organizations, and patients;

(5) to establish or strengthen mechanisms to transfer knowledge in support of evidence-based public health and health-care delivery systems, and evidence-based health-related policies;

(6) to support, together with WHO and the global scientific community, networking of national research agencies and other stakeholders with a view to conducting collaborative research in order to address global health priorities;

(7) to encourage public debate on the ethical dimension and societal implications of health research among researchers, practitioners, patients and representatives of civil society and the private sector and to encourage transparency on research results and on possible conflicts of interest;

3. CALLS UPON the global scientific community, international partners, the private sector, civil society, and other relevant stakeholders, as appropriate:

(1) to provide support for a substantive and sustainable programme of health-systems research aligned with priority country needs and aimed at achieving the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

(2) to establish a voluntary platform to link clinical trials registers in order to ensure a single point of access and the unambiguous identification of trials with a view to enhancing access to information by patients, families, patient groups and others;

(3) to strengthen or establish the transfer of knowledge in order to communicate, improve access to, and promote use of, reliable, relevant, unbiased, and timely health information;

¹ Commission on Health Research for Development. *Health research: essential link to equity in development*. New York, Oxford University Press, 1990.

- (4) to provide support for national, regional, and global research partnerships, including public-private partnerships, to accelerate the development of essential medicines, vaccines, and diagnostics, and mechanisms for their equitable delivery;
- (5) to recognize the need to involve the relevant authorities in the Member States concerned in the initial planning of health-research projects;
- (6) to support, together with Member States and the WHO Secretariat, networking of national research agencies and other stakeholders to the greatest extent possible as a means of identifying and conducting collaborative research that would address global health priorities;

4. REQUESTS the Director-General:

- (1) to undertake an assessment of WHO's internal resources, expertise and activities in the area of health research, with a view to developing a position paper on WHO's role and responsibilities in the area of health research, and to report through the Executive Board to the Fifty-ninth World Health Assembly;
- (2) to engage in consultation with interested stakeholders on creation of a programme on health-systems research geared to providing support to Member States to accelerate achievement of internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;
- (3) to pursue with interested partners the development of a voluntary platform to link clinical trials registers;
- (4) to assist in the development of more effective mechanisms to bridge the divide between ways in which knowledge is generated and ways in which it is used, including the transformation of health-research findings into policy and practice;
- (5) to consider the possibility, with other interested stakeholders, of convening an international conference on research into human resources for health, and to consider convening the next ministerial-level meeting on health research in 2008;
- (6) to ensure that meetings open to all Member States on health research organized by WHO that are characterized as summits or as ministerial summits are first approved by the Health Assembly.

(Ninth plenary meeting, 25 May 2005 –
Committee A, eighth report)

DECISIONS

WHA58(1) Composition of the Committee on Credentials

The Fifty-eighth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Algeria, Benin, Bhutan, Chad, Czech Republic, Honduras, Kiribati, Morocco, Peru, Serbia and Montenegro, Slovakia, Yemen.

(First plenary meeting, 16 May 2005)

WHA58(2) Composition of the Committee on Nominations

The Fifty-eighth World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Bahamas, Bolivia, Bosnia and Herzegovina, Cameroon, China, Comoros, France, Gambia, Guatemala, Guyana, India, Kuwait, Lithuania, Palau, Paraguay, Russian Federation, Senegal, Seychelles, Timor-Leste, Togo, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Viet Nam, and Mr Muhammad Nasir Khan, Pakistan (President, Fifty-seventh World Health Assembly, ex officio).

(First plenary meeting, 16 May 2005)

WHA58(3) Election of officers of the Fifty-eighth World Health Assembly

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

President:	Ms E. Salgado (Spain)
Vice-Presidents:	Mr S. Meki (Eritrea) Dr M. Fernández Galeano (Uruguay) Dr M. Fikri (United Arab Emirates) Professor Suchai Charoenratanakul (Thailand) Ms A. King (New Zealand)

(First plenary meeting, 16 May 2005)

WHA58(4) Election of officers of the main committees

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

Committee A: Chairman Dr B. Sadrizadeh (Islamic Republic of Iran)

Committee B: Chairman Dr J. Walcott (Barbados)

(First plenary meeting, 16 May 2005)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Dr H. Ntaba (Malawi)
Pehin Dato Abu Bakar Apong (Brunei Darussalam)

Rapporteur Dr R. Busuttil (Malta)

Committee B: Vice-Chairmen Professor J. Pereira Miguel (Portugal)
Dr M.A. Rahman Khan (Bangladesh)

Rapporteur Mr Yee Ping Yi (Singapore)

(First meetings of Committees A and B, 17 and 19 May 2005)

WHA58(5) Establishment of the General Committee

The Fifty-eighth 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: Bhutan, Brazil, China, Congo, Cuba, Equatorial Guinea, Ethiopia, France, Latvia, Lebanon, Luxembourg, Malawi, Mongolia, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United States of America, Zimbabwe.

(First plenary meeting, 16 May 2005)

WHA58(6) Adoption of the agenda

The Fifty-eighth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 115th session with the deletion of one item and one subitem, and the addition of a supplementary item.

(Second plenary meeting, 16 May 2005)

WHA58(7) Verification of credentials

The Fifty-eighth 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; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; 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; Somalia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Tunisia; Turkey; 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 and eighth plenary meetings, 18 and 23 May 2005)

WHA58(8) Election of Members entitled to designate a person to serve on the Executive Board

The Fifty-eighth 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: Azerbaijan, Bhutan, Iraq, Japan, Liberia, Madagascar, Mexico, Namibia, Portugal, Rwanda.

(Seventh plenary meeting, 20 May 2005)

WHA58(9) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Fifty-eighth World Health Assembly nominated Mrs R. Veerapen, delegate of Mauritius, as member of the WHO Staff Pension Committee, and Mrs C. Patterson, delegate of Australia, as alternate member, each for a three-year period, namely until May 2008.

(Eighth plenary meeting, 23 May 2005)

¹ Document A58/51.

WHA58(10) Selection of the country in which the Fifty-ninth World Health Assembly would be held

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

(Ninth plenary meeting, 25 May 2005)

WHA58(11) Reports of the Executive Board on its 114th and 115th sessions

The Fifty-eighth World Health Assembly, after reviewing the Executive Board's reports on its 114th and 115th 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, 25 May 2005)

¹ Document A58/2.

หน้าว่าง

ANNEX

ANNEX

Global Immunization Vision and Strategy 2006-2015¹

Executive summary

[A58/12, Annex – 28 April 2005]

A NEW VISION FOR IMMUNIZATION

1. In response to the challenges of a rapidly changing and increasingly interdependent world, WHO and UNICEF have jointly drafted a global immunization vision and strategy for the years 2006-2015. Its goal is to protect more people against more diseases, by expanding the reach of immunization to every eligible person, including those in age groups beyond infancy, within a context in which immunization is high on every health agenda. It aims to sustain existing levels of vaccine coverage, extend immunization services to those who are currently unreached and to age groups beyond infancy, introduce new vaccines and technologies, and link immunization with the delivery of other health interventions and the overall development of the health sector (see box). It places immunization firmly within the context of the health system, highlighting the fact that immunization can both benefit from and contribute to the development of the health sector and to overcoming system-wide barriers. The strategy also underlines the crucial contribution of immunization to global preparedness for epidemics and complex emergencies. The realization of this vision of immunization will need strengthened surveillance, monitoring and evaluation, and the application of solid data for programme management.

VISION

– **A world in 2015 in which:**

- immunization is highly valued
- every child, adolescent and adult has equal access to immunization as provided for in their national schedule
- more people are protected against more diseases
- immunization and related interventions are sustained in conditions of diverse social values, changing demographics and economies, and evolving diseases
- immunization is seen as crucial for the wider strengthening of health systems and a major element of efforts to attain the Millennium Development Goals
- vaccines are put to best use in improving health and security globally
- solidarity among the global community guarantees equitable access for all people to the vaccines they need.

¹ Document WHO/IVB/05.05.

GUIDING PRINCIPLES

2. The following guiding principles have inspired the formulation of the global strategy:

Equity and gender equality. All people – without distinction of race, religion, political belief, economic or social condition – should have a right to equal access to the needed vaccines and interventions.

Ownership, partnership and responsibility. Goals are commonly agreed and pursued by governments and their partners, joined by international solidarity, which engage in coordinated activities determined by national plans.

Accountability. Stakeholders and actors in immunization are publicly accountable for their policies and actions.

Assured quality and safe products and services. All products made available meet internationally recognized standards of quality and safety, and services are delivered according to best practices.

Strong district-based immunization systems. Interventions and their monitoring at district level ensure local commitment and ownership and the appropriate adaptation of the programme to local needs and circumstances.

Sustainability through technical and financial capacity building. Financial and technical self-reliance is a target for national governments and partners working collectively, with continuing, incremental infrastructure building.

Policies and strategies based on evidence and best practices. The choice of policies, strategies and practice is informed by data from operational research, surveillance, monitoring and evaluation, disease burden and impact assessments, and economic analyses, and by the sharing of lessons and experiences from countries in similar circumstances.

FOUR STRATEGIC AREAS

3. The global strategy comprises four main areas with 24 component strategies. The strategic approaches are: protecting more people in a changing world; introducing new vaccines and technologies; integrating immunization, other health interventions and surveillance in the context of health systems; and immunizing in the context of global interdependence. Immunization and the other linked interventions described will contribute significantly to achievement of the Millennium Development Goals, the immunization-related goals set by the United Nations General Assembly special session on children in 2002, and the goals set by the Global Alliance for Vaccines and Immunization and its financing arm, the Vaccine Fund. They will also help Member States, as urged in resolution WHA56.19, to increase vaccination coverage against influenza of all people at high risk. In today's increasingly interdependent world, acting together against vaccine-preventable diseases of public health importance and preparing for the possible emergence of diseases with pandemic potential will contribute significantly to improving global health and security.

4. The global strategy has been drawn up against a background of increasing demand for immunization, rapid progress in the development of new vaccines and technologies, continuing health-

sector development, increasing vulnerability to pandemics and other health emergencies, and expanding opportunities for partnerships.

GOALS

5. Between 2006 and 2015, all those working on immunization and related product development should strive to prevent morbidity and mortality by achieving the goals and targets set out below.

By 2010 or earlier:

- **increase coverage.** Countries will reach at least 90% national vaccination coverage¹ and at least 80% vaccination coverage in every district or equivalent administrative unit.
- **reduce measles mortality.** Globally, mortality due to measles will have been reduced by 90% compared to the 2000 level.²

By 2015 or earlier (as the case may be):

- **sustain coverage.** The vaccination coverage goal reached in 2010 will have been sustained.
- **reduce morbidity and mortality.** Global childhood morbidity and mortality due to vaccine-preventable diseases will have been reduced by at least two-thirds³ compared to 2000 levels.
- **ensure access to vaccines of assured quality.** Every person eligible for immunization included in national programmes will have been offered vaccination with vaccines of assured quality according to established national schedules.
- **introduce new vaccines.** Immunization with newly introduced vaccines will have been offered to the entire eligible population within five years of the introduction of these new vaccines in national programmes.
- **ensure capacity for surveillance and monitoring.** All countries will have developed the capacity at all levels to conduct case-based surveillance of vaccine-preventable diseases,

¹ Referring to vaccines containing all antigens given to children under one year of age, those containing measles antigen for children up to two years of age, and those given to women of child-bearing age, as provided for in national immunization schedules. In the case of newly introduced vaccines, these should have been incorporated in a country's national schedule for at least five years.

² This provisional goal has been proposed and will be finalized during 2005.

³ This goal correlates with Goal 4 of the Millennium Development Goals with its target of reducing the under-five mortality rate by two-thirds between 1990 and 2015. It is expected that the additional reduction in mortality will be achieved through effective case management. Assuming a rapid increase in access to vaccines, including the introduction of new vaccines and the greater use of underused vaccines, it is expected that the two-thirds reduction in mortality due to vaccine-preventable diseases will be achieved mainly through a 70% to 80% reduction in the number of deaths from diseases that are currently vaccine preventable (i.e. measles, pertussis, diphtheria, tetanus, illness due to *Haemophilus influenzae* type b infection) once coverage reaches 90%, and a 40% to 50% reduction in deaths from diseases that are expected to be prevented by new vaccines in the near future (i.e. against rotavirus and pneumococcal infection). This estimation will be revised over time, as better projections are developed and better data become available.

supported by laboratory confirmation where necessary, in order to measure vaccine coverage accurately and use these data appropriately.

- **strengthen systems.** All national immunization plans will have been formulated as an integral component of sector-wide plans for human resources, financing and logistics.
- **assure sustainability.** All national immunization plans will have been formulated, costed and implemented so as to ensure that human resources, funding and supplies are adequate.

THE CONTEXT

6. The establishment of strong national immunization services in many countries over recent years has ensured that today more than 70% of the world's targeted population is reached by those services. It is estimated that the vaccinations administered in 2003 alone will prevent more than two million deaths from vaccine-preventable diseases and an additional 600 000 deaths related to hepatitis B (from liver cirrhosis and hepatocellular carcinoma) that would otherwise have occurred in adulthood among the children immunized in that year.

7. Despite these achievements, commitment to immunization has not been sustained in all countries. Worldwide in 2003 an estimated 27 million infants and 40 million pregnant women remained in need of immunization. Moreover, beyond infancy, children, adolescents and adults do not yet fully benefit from the protection provided through immunization against diseases from which they are at risk.

Strength through partnerships

8. In response to immunization needs worldwide, global partnerships, such as the Global Alliance for Vaccines and Immunization, the Vaccine Fund, and the Measles Partnership, have been created in order to attain shared goals. Such partnerships bring together major stakeholders in immunization from the public and private sectors, including the vaccine industry. Initiatives for eradication of poliomyelitis, reduction of measles mortality and elimination of maternal and neonatal tetanus have shown that partnerships enable immunization services to be brought to even the most hard-to-reach communities. Through the Global Polio Eradication Initiative, for example, countries have clearly demonstrated the capacity to achieve high vaccination coverage rates and conduct high-performance disease surveillance, even in areas affected by political turmoil or other difficult circumstances. However, accessing hard-to-reach populations on a regular basis and those affected by outbreaks and emergency situations requires specially designed strategies.

New vaccines and technologies

9. Efforts are under way to develop new vaccines against major infectious diseases (including malaria, HIV/AIDS and tuberculosis). Meanwhile, many other new vaccines and technologies are already licensed or at an advanced stage of development (including rotavirus and pneumococcal vaccines) and other vaccines are readily available, but underused. Activities to ensure the safety of immunization are also being implemented (such as the use of auto-disable syringes), and the subject is becoming a top priority for countries. During the period 2006-2015, countries may be faced with an unprecedented array of new vaccines and technologies for introduction. To ensure that countries can make rational, evidence-based decisions about the choice of new vaccines and technologies, current gaps in knowledge (including disease burden, the cost-effectiveness of various strategies, and regulatory issues) will have to be filled.

Financing

10. Immunization is a highly cost-effective and relatively inexpensive health intervention. The overall cost of immunization, however, including the procurement of new vaccines, new vaccine formulations and technologies, is expected to rise sharply in the future. The expansion of vaccination schedules to include new vaccines has greatly increased the amount of resources that need to be mobilized. Although some relief may be obtained over time as the larger amounts of vaccine to be procured leads to greater competition among manufacturers and a reduction in price, experience has shown that it takes several years before increased demand for new vaccines is matched by lower prices. Meanwhile, the rising cost of immunization delivery needs to be added to the cost of vaccines; logistics and labour are becoming more expensive, and the extension of services to populations that are currently not being reached will need additional resources.

11. Securing the financing for introduction of new vaccines and increasing coverage with existing vaccines will test all countries and their partners. Ways need to be found to maximize the cost-effectiveness of contacts with immunization services (such as spreading the cost of these contacts across relevant health initiatives) and to strengthen national capability to project financial needs and obtain the required resources. Evidence-based policy decisions will have to be taken on the “affordability” of vaccines in relation to the reduction of disease burden.

Contribution to overcoming system-wide barriers

12. Increasingly, immunization will help to overcome barriers to equitable health-service delivery and sector-wide development, and will benefit from those efforts. The benefits include better public health and improved efficiency of public health services. Immunization services inevitably experience the constraints that affect the health system as a whole, but they can help significantly in overcoming system-wide barriers through the strengthening of district teams and their capacity to make optimal use of the resources and opportunities available locally. In turn, sector-wide approaches to strengthening cross-cutting areas such as human resources management, financing, logistics, public-private partnerships and information sharing can clearly benefit immunization.

Strong monitoring and surveillance capacity

13. Over the past decade, considerable progress has been made in establishing systems for monitoring and surveillance of coverage rates and trends of vaccination and its impact on vaccine-preventable diseases, and in using those data for guiding public policy, strategies and programmes. Through extensive and growing laboratory networks, surveillance for poliomyelitis and measles has not only generated crucial information for guiding the respective eradication and mortality reduction initiatives, but has also supported the prevention and control of epidemics of, for instance, meningitis, diphtheria, rubella and vector-borne diseases such as dengue and yellow fever. In countries vulnerable to such epidemics, the combination of effective national laboratories and regional reference centres where further laboratory investigations can be conducted has proved to be an important and effective public health tool. These systems have enormous potential to provide a platform for the development of mechanisms to detect both emerging infections and outbreaks of disease.

Links to other health interventions

14. Immunization services are often widely available and potentially can support, and be supported by, additional health interventions. The combined delivery, or integration, of linked health interventions is a more effective way of achieving common health goals. For example, the benefits of combining immunization with two other interventions, namely vitamin A supplementation and the

distribution of insecticide-treated bednets for malaria prevention, are increasingly being seen. Such integration will require an evidence base to guide policies, strategies and investments, and methods for evaluating the impact of linked interventions. Access to integrated services needs to be systematized in order to maximize the benefits to mothers and children attending health facilities.

Preparedness for global epidemics and emergencies

15. Countries at risk of epidemics need preparedness plans that are firmly rooted in their overall immunization plan and services. Similarly, capacity is required at country and global levels to prepare for a rapid and appropriate response to emergencies and natural disasters since that response may involve the rational use of vaccines. In the case of influenza, a global laboratory network monitors the circulating virus strains and all countries need up-to-date preparedness plans for coping with a pandemic. Many national preparedness plans, however, are nonexistent, out of date, or impractical. Governments, WHO, UNICEF, vaccine manufacturers and research institutes are currently involved in efforts to support the development of national preparedness plans and to expand capacity for production of influenza vaccines worldwide, including work on the development of a new vaccine against virus strains with pandemic potential.

COMPONENT STRATEGIES

16. **Strategic area 1: Protecting more people in a changing world** covers the key strategies needed to reach more people with immunization services, especially those who are hard to reach and those who are eligible for newly introduced vaccines. The aims are to ensure that every infant has at least four contacts with immunization services, to expand immunization to other age groups in an effort to maximize the impact of existing vaccines, and to improve vaccine-management systems in order to ensure immunization safety, including the availability of safe and effective vaccines at all times. The strategies in this area seek to prioritize underserved populations and areas and will use the “reach every district” approach.

Strategy 1: Use a combination of approaches to reach everybody targeted for immunization

Strategy 2: Increase community demand for immunization

Strategy 3: Ensure that unreached people are reached in every district at least four times a year

Strategy 4: Expand vaccination beyond the traditional target group

Strategy 5: Improve vaccine, immunization and injection safety

Strategy 6: Improve and strengthen vaccine management systems

Strategy 7: Evaluate and strengthen national immunization programmes.

17. **Strategic area 2: Introducing new vaccines and technologies** focuses on the need to promote the development of high-priority new vaccines and technologies and to enable countries to decide on, and proceed with, their introduction. The strategies in this area aim to ensure that countries have the evidence base and capacity to evaluate the need, and establish priorities for, the introduction of new vaccines and technologies, and a supply of new vaccines and technologies adequate to meet their needs, with the necessary financial resources. They also aim to ensure that new vaccines will be offered to the entire eligible population within five years of their introduction in national programmes,

and that future vaccines against diseases of public health importance are researched, developed and made available, especially for disadvantaged populations with a high disease burden.

Strategy 8: Strengthen country capacity to determine and set policies and priorities for new vaccines and technologies

Strategy 9: Ensure effective and sustainable introduction of new vaccines and technologies

Strategy 10: Promote research and development of vaccines against diseases of public health importance.

18. Strategic area 3: Integrating immunization, other linked health interventions and surveillance in the context of health systems emphasizes the role of immunization in strengthening health systems through the benefits that accrue to the whole system as a result of building human resource capacity, improving logistics and securing financial resources. The aim is to link immunization with other potentially life-saving interventions in order to accelerate reduction in child mortality. The component strategies also aim to improve disease surveillance and programme monitoring so as to strengthen not only immunization programmes but the health system as a whole, and to ensure that immunization is included in emergency preparedness plans and activities for complex humanitarian emergencies.

Strategy 11: Strengthen immunization programmes within the context of health systems development

Strategy 12: Improve management of human resources

Strategy 13: Assess and develop appropriate interventions for integration

Strategy 14: Maximize the synergy from integrating interventions

Strategy 15: Sustain the benefits of integrated interventions

Strategy 16: Strengthen monitoring of coverage and case-based surveillance

Strategy 17: Strengthen laboratory capacity through the creation of laboratory networks

Strategy 18: Strengthen the management, analysis, interpretation, use and exchange of data at all levels

Strategy 19: Provide access to immunization services in complex humanitarian emergencies.

19. Strategic area 4: Immunizing in the context of global interdependence builds on the recognition that equity in access to vaccines and related financing and equal availability of information are in every country's interest. The component strategies in this area aim to increase awareness of, and respond to, the reality that every country is vulnerable to the impact of global issues and events on vaccine supply, financing, collaboration of partners, communication and epidemic preparedness.

Strategy 20: Ensure reliable global supply of affordable vaccines of assured quality

Strategy 21: Ensure adequate and sustainable financing of national immunization systems

Strategy 22: Improve communication and dissemination of information

Strategy 23: Define and recognize the roles, responsibilities and accountability of partners

Strategy 24: Include vaccines in global epidemic preparedness plans and measures.

Framework for planning and collaboration

20. The global strategy offers a broad framework rather than a detailed plan of action in order to enable all stakeholders to direct or redirect their contribution to immunization worldwide. In view of the marked differences between countries' capacities, priorities and resources, it presents a range of strategies from which countries will be able to select those most suited to their individual needs. To support this national planning process, WHO, UNICEF, multilateral and bilateral partners, nongovernmental organizations and the private sector will intensify their coordination in order to collaborate effectively with countries. The strategy urges Member States, international organizations, nongovernmental organizations, the private sector, interest groups and other stakeholders to make an unprecedented commitment to immunization at global, national and local levels.

THE WAY FORWARD

21. The final section of the global strategy focuses on the actions needed to facilitate its implementation: consultations to ensure that countries apply the guiding principles to their own strategic planning through strategies tailored to individual needs, capacity and resources; securing the early engagement of immunization partners; concerted strengthening of the capacity of immunization services at district level, especially in low-performing countries; establishment of a knowledge base on successfully linked health interventions as a resource for their potential scaling up; development of an evaluation and review process to measure progress up to 2015; and production and dissemination of supportive documentation detailing plans and policies and providing further information on technical issues.

22. The strategic options outlined above are not exhaustive. The strategy should be seen not as a detailed blueprint but rather as an evolving plan. As the strategy and vision unfold over the next 10 years, new challenges will arise and new responses and innovations will be needed.

A VISION WITH BROAD STRATEGIC DIRECTIONS

23. The Global Immunization Vision and Strategy:

- provides a vision of an expanded role for immunization in improving public health, with broad strategic directions for national policy and programme development, in the context of support to immunization programmes by all partners
- extends the reach of immunization beyond infancy to other age groups and beyond the existing confines of immunization programmes into other settings, while maintaining the priority of vaccination in early childhood
- encourages a package of interventions to reduce child mortality
- contributes to global preparedness against the threat of emerging pandemics

- commits all stakeholders to unprecedented efforts to reach the “hard-to-reach”
 - promotes data-driven ways of solving problems for improving programme effectiveness
 - prepares the way for the introduction and widespread use of new and underused vaccines and technologies, all of which will require long-term financial planning
 - promotes the development of case-based surveillance for all vaccine-preventable diseases, with expansion of laboratory networks for viral and bacterial diseases.
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