ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

- ACC - Administrative Committee on Coordination
- ACHR - Advisory Committee on Health Research
- AGFUND - Arab Gulf Programme for United Nations Development Organizations
- ASEAN - Association of South-East Asian Nations
- CIDA - Canadian International Development Agency
- CIOMS - Council for International Organizations of Medical Sciences
- DANIDA - Danish International Development Agency
- ECA - Economic Commission for Africa
- ECE - Economic Commission for Europe
- ECLAC - Economic Commission for Latin America and the Caribbean
- ESCAP - Economic and Social Commission for Asia and the Pacific
- ESCWA - Economic and Social Commission for Western Asia
- FAO - Food and Agriculture Organization of the United Nations
- FINNIDA - Finnish International Development Agency
- IAEA - International Atomic Energy Agency
- IARC - International Agency for Research on Cancer
- ICAO - International Civil Aviation Organization
- IFAD - International Fund for Agricultural Development
- ILO - International Labour Organization (Office)
- IMO - International Maritime Organization
- ITU - International Telecommunication Union
- NORAD - Norwegian Agency for International Development
- OAU - Organization of African Unity
- OECD - Organisation for Economic Co-operation and Development
- PAHO - Pan American Health Organization
- SAREC - Swedish Agency for Research Cooperation with Developing Countries
- SIDA - Swedish International Development Authority
- UNAIDS - United Nations Joint Programme on HIV/AIDS
- UNCTAD - United Nations Conference on Trade and Development
- UNDCP - United Nations International Drug Control Programme
- UNDP - United Nations Development Programme
- UNEP - United Nations Environment Programme
- UNESCO - United Nations Educational, Scientific and Cultural Organization
- UNFPA - United Nations Population Fund
- UNHCR - Office of the United Nations High Commissioner for Refugees
- UNICEF - United Nations Children’s Fund
- UNIDO - United Nations Industrial Development Organization
- UNRWA - United Nations Relief and Works Agency for Palestine Refugees in the Near East
- UNSCEAR - United Nations Scientific Committee on the Effects of Atomic Radiation
- USAID - United States Agency for International Development
- WFP - World Food Programme
- WIPO - World Intellectual Property Organization
- 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 Fiftieth World Health Assembly was held at the Palais des Nations, Geneva, from 5 to 14 May 1997, in accordance with the decision of the Executive Board at its ninety-eighth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions,\(^1\) annexes and list of participants - document WHA50/1997/REC/1

Verbatim records of plenary meetings - document WHA50/1997/REC/2

Summary records and reports of committees - document WHA50/1997/REC/3

\(^1\) The resolutions, which are reproduced in the order in which they were adopted, have been cross-referenced to the relevant sections of the WHO Handbook of Resolutions and Decisions, volumes I, II and III (third edition), which contain most of the resolutions adopted by the Health Assembly and the Executive Board between 1948 and 1992. A list of the dates of sessions, indicating resolution symbols and the volumes in which the resolutions and decisions were first published, is given in volume III (third edition) of the Handbook (page XIII).
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President
Mr Saleem I. SHERVANI (India)

Vice-Presidents
Dr A. M'HATEF (Algeria)
Dr J. F. OLETTA (Venezuela)
Mr S. ELEGHMARY (Libyan Arab Jamahiriya)
Mrs M. de B. ROSERIA (Portugal)
Dr ZHANG WENKANG (China)

Secretary
Dr H. NAKAJIMA, Director-General

Committee on Credentials
The Committee on Credentials was composed of delegates of the following Member States: Bhutan, Congo, Ghana, Iran (Islamic Republic of), Luxembourg, Pakistan, Romania, Uruguay, Uzbekistan and Vanuatu.

Chairman: Dr J. D. OTOO (Ghana)
Vice-Chairman: Dr G. BIKANDOU (Congo)
Rapporteur: Dr J. SINGAY (Bhutan)
Secretary: Mr T. S. R. TOPPING, Legal Counsel

Committee on Nominations
The Committee on Nominations was composed of delegates of the following Member States: Antigua and Barbuda, Belgium, Brazil, Cambodia, Central African Republic, China, Colombia, France, Gambia, Indonesia, Kiribati, Lesotho, Madagascar, Malawi, Maldives, Mali, Mexico, Oman, Paraguay, Qatar, Russian Federation, The Former Yugoslav Republic of Macedonia, Turkey, United Kingdom of Great Britain and Northern Ireland and Yemen.

Chairman: Dr W. B. MUKIWA (Malawi)
Secretary: Dr H. NAKAJIMA, 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: Argentina, Bulgaria, Côte d'Ivoire, Cuba, Eritrea, France, Japan, Morocco, Mozambique, Myanmar, Russian Federation, Seychelles, South Africa, Sweden, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, and United States of America.

Chairman: Mr Saleem I. SHERVANI (India)
Secretary: Dr H. NAKAJIMA, 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 R. CAMPOS (Belize)
Vice-Chairmen: Professor H. ACHOUR (Tunisia) and Mr K. R. C. PILLAY (Mauritius)
Rapporteur: Dr S. ZOBRIST (Switzerland)
Secretary: Dr B.-I. THYLEFORS, Director, Programme for the Prevention of Blindness and Deafness

Committee B
Chairman: Dr T. TAITAI (Kiribati)
Vice-Chairmen: Dr M. N. SAVEL’EV (Russian Federation) and Dr S. R SIMKHADA (Nepal)
Rapporteur: Dr W. AMMAR (Lebanon)
Secretary: Mr A. K. ASAMOAH, Chief, Administration and Staff Support Service

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   13.4 Ihsan Dogramaci Family Health Foundation Prize and Fellowship

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   13.6 Francesco Pocchiari Fellowship

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1 The agenda was adopted at the third plenary meeting.

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13.7 Dr Comlan A.A. Quenum Prize for Public Health in Africa

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17.2 Financial review

18. Preparation of the Tenth General Programme of Work

19. Implementation of resolutions and decisions (progress reports by the Director-General)

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  - Reorientation of medical education and medical practice (resolution WHA48.8)

  - Guidelines on the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce (resolution WHA22.50)

  - Quality of biological products moving in international commerce

  - Reproductive health

  - Tobacco or health (resolution WHA43.16)

  - World Tuberculosis Day (resolution WHA46.36)

  - HIV/AIDS and sexually transmitted diseases (resolution WHA49.27)

20. Control of tropical diseases

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24. Scale of assessments
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25. Real Estate Fund

26. WHO reform
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30. United Nations Joint Staff Pension Fund

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Report of the Executive Board to the World Health Assembly on the proposed programme budget for the financial period 1998-1999 and response by the Director-General

A50/5  
Preparation of the Tenth General Programme of Work. Report by the Director-General

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Control of tropical diseases. Report by the Director-General

A50/8  
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A50/9  
Status of collection of assessed contributions. Report by the Director-General

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Renewing the health-for-all strategy. Progress report by the Director-General

¹ Issued in Arabic, Chinese, English, French, Russian and Spanish.
² See page xiii.
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¹ See document WHA50/1997/REC/1, Annex 1.
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A50/INF.DOC./5 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine
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A50/INF.DOC./7 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine
A50/INF.DOC./8 Resolutions of the Fiftieth World Health Assembly relating to the programme budget for the financial period 1998-1999 and Statement showing the computation of contributions to the programme budget for the financial period 1998-1999

1 Issued in English and French.
2 Also available in Arabic.
SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 5 May 1997, at 13:05

Chairman: Mr Saleem I. SHERVANI (India)
President of the Health Assembly

1. ADOPTION OF THE AGENDA, PROGRAMME OF WORK OF THE HEALTH ASSEMBLY AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Documents A50/1 and A50/GC/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 33 of the Rules of Procedure of the Health Assembly, its first task was to consider item 8 (Adoption of the agenda and allocation of items to the main committees) of the provisional agenda, which had been prepared by the Executive Board and issued as document A50/1.

Deletion of agenda items

The CHAIRMAN indicated that, if there was no objection, three items on the provisional agenda would be deleted, namely, item 11 (Admission of new Members and Associate Members), item 22.4 (Amendments to the Financial Regulations), and item 23 (Supplementary budget for 1996-1997).

It was so agreed.

Allocation of items to the main committees and programme of work of the Health Assembly

Referring to the agenda items to be considered in plenary, namely items 1 to 15, the CHAIRMAN noted that the Health Assembly had already dealt with items 1 to 7 that morning. The Committee was at present dealing with item 8, on which he would transmit its recommendations to the plenary meeting that afternoon. The remaining items (9 to 15) would be taken up in plenary, as scheduled.

He further noted that the Executive Board had allocated the items on the provisional agenda between Committee A and Committee B according to the terms of reference of those committees, and drew attention to the preliminary draft timetable prepared by the Executive Board and subsequently adjusted.¹

The General Committee then drew up the programme of work of the Assembly for Tuesday, 6 May, Wednesday, 7 May, Thursday, 8 May, and Friday, 9 May.

Dr AL-SAIF (representative of the Executive Board), referring to the decision of the Executive Board Special Group for the Review of the Constitution of the World Health Organization to convene its fourth

¹ Documents A50/GC/1 and A50/GC/1 Rev.1.
meeting during the current Health Assembly, proposed that it should be held on the morning of Saturday, 10 May.

It was so agreed.

The CHAIRMAN concluded that the Committee wished to recommend to the Health Assembly that it should accept the allocation of the items to the main committees as set out in the provisional agenda, and that it agreed with the preliminary timetable, as amended, on the understanding that certain items might subsequently be transferred from one committee to the other depending on their workload.

It was so agreed.

The CHAIRMAN reminded the Committee that the Executive Board in decision EB99(19) had decided that the Fiftieth World Health Assembly should close no later than Wednesday, 14 May.

2. PROPOSED SUPPLEMENTARY AGENDA ITEMS

The CHAIRMAN drew the Committee's attention to two proposals for inclusion of a supplementary agenda item in accordance with Rule 12 of the Rules of Procedure of the Health Assembly, namely, from the Government of Argentina on “Cloning in human reproduction”, and from the Governments of Senegal, Honduras, Nicaragua, Gambia, Dominica and Belize “To invite the Republic of China (Taiwan) to participate in the World Health Assembly as an observer”.

The LEGAL COUNSEL confirmed that the proposals had been received within the time limit provided for under Rule 12 of the Rules of Procedure of the Health Assembly. The General Committee, after considering the proposals, could make a recommendation thereon to the Assembly. Upon that recommendation, the Health Assembly could decide to add the items to the agenda.

First proposed supplementary agenda item

The delegate of ARGENTINA observed that in view of the growing importance of cloning, and the many recent official statements on the matter, it was essential that the Health Assembly should debate the issue and adopt a position.

The delegate of FRANCE endorsed the proposal.

The CHAIRMAN, in the absence of any objection, proposed to submit the proposal for inclusion of a supplementary agenda item on cloning in human reproduction to the Health Assembly at its plenary meeting that afternoon.

It was so agreed.

Second proposed supplementary agenda item

The delegate of CHINA stressed that the second proposal, unlike the first, was a political issue which contravened the terms of United Nations General Assembly resolution 2758(XXVI) and resolution WHA25.1. Further, Articles 3 to 8 of the Constitution and Rule 3 of the Rules of Procedure of the Health Assembly stipulated the three categories of parties entitled to participate in the Health Assembly. Taiwan did not fall into any of those categories. As Taiwan was a province of China, only the Chinese Government was entitled to apply

1 Contained in document A50/GC/2.
on its behalf for observer status; no other country had the right to do so. Moreover, the proposal interfered with the internal affairs of a Member State. No country that acknowledged international realities would attempt to separate Taiwan from China. He regretted that Senegal, like China a developing country, should have submitted such a proposal, and suggested that the Committee should reject it.

The delegates of MYANMAR, ARGENTINA, CUBA, UNITED STATES OF AMERICA, JAPAN, SOUTH AFRICA and RUSSIAN FEDERATION endorsed the views of the previous speaker, noting that the Health Assembly was not the forum in which to debate political issues.

The delegate of BELIZE pointed out that his Government had supported the proposal of Senegal on the understanding that it did not contravene any resolution or regulation of the Organization. If that were not so, it would withdraw its support.

The delegate of the NETHERLANDS, speaking on behalf of the European Union at the invitation of the CHAIRMAN, agreed that the Health Assembly was not the appropriate forum for such a proposal. However, he requested the Legal Counsel's opinion on the assertion that the proposal contravened Articles 3 to 8 of the Constitution and Rule 3 of the Rules of Procedure.

The CHAIRMAN, noting the consensus on rejection of the proposal to include a supplementary agenda item to invite the Republic of China (Taiwan) to participate in the World Health Assembly, proposed that a report be made to that effect to the Health Assembly at its plenary meeting that afternoon.

It was so agreed.

Referring to the list of speakers for the debate on agenda item 10 (Review of The world health report 1997), the CHAIRMAN suggested that, in accordance with established procedure, the order of speakers on the list should be strictly followed, and that new names should be entered in the order in which they were received by the Assistant to the Secretary of the Assembly. If the Committee had no objection, he would inform the plenary of those provisions.

It was so agreed.

The CHAIRMAN reminded the Committee that its next meeting would be held on Friday, 9 May at 17:10.

The meeting rose at 13:40.
Constitution and by Rule 102 of the Rules of Procedure of the Health Assembly. To help the General Committee in its task, two documents were before it: a list indicating the present composition of the Executive Board by region, on which were underlined the names of the 10 Members whose term of office would expire at the end of the Fiftieth World Health Assembly and which had to be replaced, and a table, by region, of Members of the Organization which were or had been entitled to designate persons to serve on the Executive Board. Vacant seats, by region, were: Africa, one; the Americas, two; South-East Asia, one; Europe, three; Eastern Mediterranean, two; and Western Pacific, one. A third document contained a list of the 10 Members that it was suggested should be entitled to designate a person to serve on the Executive Board.

As no additional suggestions were made by the General Committee, he noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 80 of the Rules of Procedure, to proceed without taking a vote.

There being no objection he concluded that it was the Committee's decision, in accordance with Rule 102 of the Rules of Procedure, to transmit a list comprising the names of the following 10 Members to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board: Burundi, Canada, Cook Islands, Cyprus, Germany, Netherlands, Norway, Oman, Peru, Sri Lanka.

It was so agreed.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee heard reports from Dr CAMPOS (Belize), Chairman of Committee A, and Dr TAITAI (Kiribati), Chairman of Committee B, on the progress of work in their committees.

In view of the progress made in the committees, the CHAIRMAN noted that it might be possible to close the Health Assembly earlier than originally scheduled. He proposed to review subsequent progress of work with the Chairmen of the committees and to revise the programme, if necessary.

It was so agreed.

The General Committee then drew up the programme of meetings for Monday, 12 May and Tuesday, 13 May, and also for Wednesday, 14 May, should it not be possible to finish the work of the Assembly by Tuesday.

The CHAIRMAN noted that it would not be necessary to hold a third meeting of the General Committee.

3. CLOSURE

After the customary acknowledgements, the CHAIRMAN declared the work of the Committee closed.

The meeting rose at 17:25.
COMMITTEE A

FIRST MEETING

Tuesday, 6 May 1997, at 9:00

Chairman: Dr R. CAMPOS (Belize)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 16 of the Agenda

The CHAIRMAN expressed his gratitude at having been elected and welcomed those present, particularly the delegates of the new Member State, Andorra, which had joined the Organization since the Forty-ninth World Health Assembly, thus becoming the 191st Member State.

He then drew attention to the third report of the Committee on Nominations (document A50/27), in which Professor H. Achour (Tunisia) and Mr K.R.C. Pillay (Mauritius) were nominated for the offices of Vice-Chairmen of Committee A and Dr S. Zobrist (Switzerland) for that of Rapporteur.

Decision: Committee A elected Professor H. Achour (Tunisia) and Mr K.R.C. Pillay (Mauritius) as Vice-Chairmen and Dr S. Zobrist (Switzerland) as Rapporteur.

2. ORGANIZATION OF WORK

The CHAIRMAN, drawing attention to the unusually heavy workload of the Health Assembly, called on speakers to be brief. He suggested that the normal working hours should be from 9:00 to 12:30 and from 14:30 to 17:30.

It was so agreed.

3. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999: Item 17 of the Agenda


Mr CLERC (France), speaking on a point of order, said the documentation relating to the proposed programme budget had been made available in languages other than English only on 5 May 1997, the starting date of the Fiftieth World Health Assembly. Such inequitable treatment, whereby some countries received documentation in good time in their chosen working languages, while others did not, undermined the basic

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1 See page 236.

2 Decision WHA50(4).

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principles of equality among Member States and linguistic diversity of the Organization. He called on the Secretariat to ensure full respect for the regulations regarding official and working languages.

Mr AITKEN (Assistant Director-General) conveyed the Secretariat’s regrets regarding the failure to provide documentation in all working languages simultaneously. Every effort would be made to ensure that all documents were available in all the languages before the start of future Health Assemblies.

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation), illustrating her introductory remarks on the proposed programme budget for the financial period 1998-1999 with overhead transparencies in both English and French, said that its predecessor had marked the first step towards strategic budgeting. Strategic budgeting allowed for great flexibility, in that adjustments in the proposed programme budget could be made using the advice of the governing bodies, as had already been the case with the proposed programme budget now before the Health Assembly. Cost increases were presented separately, facilitating comparison with previous programme budgets. Major resources were shifted to priorities identified by Member States and the governing bodies. The Organization’s tasks were presented in terms of “products”; plans of action detailing the specific activities needed to generate such products were elaborated at a later stage. In approving the general concept of strategic budgeting, the governing bodies had adopted a number of resolutions requesting certain improvements, some of which had already been incorporated in the proposed programme budget for 1998-1999.

The priorities selected with the participation of Member States must result in a reorientation of resources. Targets must be realistic and measurable, and evaluation must be improved and based specifically on those targets. The Executive Board had requested data on expenditure for the most recently implemented biennial programme and had stressed the need for improved efficiency and transparency. In response, targets had been quantified and, for the first time, products had been described in terms of where they were generated in the Organization: at country, regional or global level. Finally, a number of improvements in plans of action had been suggested. They were now geared to products, provided detailed costings, facilitated the monitoring of movement towards quantified targets and allowed for regular collection of data to be used for evaluation. In 1998-1999, the plans of action would be integrated into WHO’s management information system.

Resolution WHA48.25 emphasized “the need for greater harmonization of budget policies and programme budgeting procedures”. The approach to programming used in all areas and at all levels of the Organization involved elaboration of general programmes of work, each covering a six-year period, the development of three programme budgets to implement each programme of work, annual plans of action for implementing the programme budgets, and monitoring of programme implementation with a view to evaluation at all levels.

Turning to the programme budget itself (document PB/98-99), she drew attention to the introduction by the Director-General, which outlined the major policies, management principles and restructuring efforts that had gone into the elaboration of the budget. The document differed from the previous programme budget document in several ways.

Firstly, at the start of each chapter, a “grey box” detailed the major changes affecting regular budget resources and the reasons for such changes. The grey box for chapter 5, for example, explained how the 2% shift in funding called for by resolution WHA48.26 had been broken down. Secondly, the tables on proposed resources by source of funds incorporated a new column providing data on actual expenditure for the most recently completed biennium, as requested in subparagraph (3) of resolution WHA48.25. Following the tables were lists of WHO targets quantified specifically for the period 1998-1999, in contrast to the targets set out in the general programmes of work, which covered longer periods and activities carried out by Member States as well as WHO. That innovation, requested by the governing bodies, should facilitate more accurate evaluation of the products for each programme budget. Products were listed at the level at which they were generated: country, regional or global. Finally, in response to requests from the governing bodies, Table 7 provided an indicative comparison of funds allocated to each programme.

In January 1997, the Executive Board had considered the proposed programme budget for 1998-1999 and had welcomed the substantial efforts made for budgetary reform, the improvements in the structure and transparency of the document, which made it possible to focus on programming aspects and to formulate comments on specific programmes, and the progress made towards development of a strategic approach to budgeting. At the same time, in its resolution EB99.R13, it had suggested a number of improvements which the Director-General had concluded could be usefully implemented before the financial period 2000-2001. The
“Report of the Executive Board to the World Health Assembly on the proposed programme budget for the financial period 1998-1999 and response by the Director-General” (document A50/4) showed that some of those suggestions had already been taken into account in the form of modifications to the proposed programme budget for 1998-1999.

Resolution EB99.R13 called for clarification of targets, a task addressed in document A50/4; the extension of evaluation mechanisms, concerning which some proposals had already been made in January 1997, and more precise ones would be developed by January 1998; and the strengthening of critical analysis of constraints, some of which were discussed in the proposed programme budget. Above all, the resolution emphasized the need to ensure that the priorities recommended by the Board and the Health Assembly were reflected at all levels of the Organization’s activities. The changes made in the proposed programme budget in response to that resolution were described in document A50/4.

The resolution called for administrative savings and requested the development of a savings target. It was intended to effect such savings during the implementation of the programme budget for 1998-1999. Finally, the resolution proposed the improvement of coordination with other United Nations bodies, inter alia through greater use of common services where appropriate, with a view to making additional savings; that was already being done.

Document A50/4 thus contained the Director-General’s detailed responses to resolution EB99.R13, and should be read in conjunction with the proposed programme budget during the discussion of the latter.

Finally, she noted that resolution EB99.R15 gave an overview of the policy basis for programme budgets, linking WHO policy to the general programmes of work, the programme budgets and plans of action, and evaluation.

Mr AITKEN (Assistant Director-General), also illustrating his comments with overhead projections, said that thanks to the new strategic budgeting approach it was now possible to provide a complete overview of the programme budget under 19 major headings, which helped Member States to understand how priorities were changing and where the Organization’s resources were actually spent.

“Other communicable diseases” was the major item of extrabudgetary expenditure, as in the past, and also of regular budget expenditure. The breakdown of expenditures also showed that regular budget expenditure was relatively well balanced between the programmes, particularly when compared with extrabudgetary resources, which tended to be diverted primarily to the major priorities. That was due to the need to provide an adequate operating budget for each programme.

The proposed programme budget for 1998-1999 showed a number of major changes in real terms when compared with the budget for the previous biennium. It was proposed to increase expenditure on the eradication or elimination of specific communicable diseases by US$ 6 million. There was also greater focus on the control of other communicable diseases, for which an additional US$ 4.2 million had been allocated. Finally, after due consultation, resources totalling US$ 7.4 million had been switched to other priorities identified by the Executive Board, as described in document A50/4. Regional allocations were based on the proposals which had been received from the regional committees and eventually consolidated, with some amendments, into the overall budget.

Referring to the cost and exchange rate changes for the 1998-1999 budget as compared with the figures for 1996-1997, he emphasized that the proposed budget was based on “zero real growth”. This meant that, in order to deliver the same level of services, it was necessary to add the cost increases borne by WHO since the previous biennium into the overall proposed budget. Those cost increases reflected the combined effect of inflation and exchange rate fluctuations and also incorporated elements of cost absorption.

The achievement of zero real growth in the budget, taking into account the cost increases and the favourable exchange rate fluctuations, required an increase in appropriation of 0.4%, or nearly US$ 3.5 million. That amount would not be reflected in full in increased contributions by Member States, thanks to certain other sources of income, such as the payment of arrears by Member States, income from investments, and programme support costs from UNDP. Total contributions would therefore have to rise by 0.3%, or nearly US$ 2.5 million over two years.

Dr ANTEZANA (Deputy Director-General ad interim) emphasized that the budgetary reforms were designed to give sharper focus to programme content. Although the overall programme budget appropriations were considered separately, after completion of discussions on the technical content of programmes the
important link between financial allocations and the level of activities they could support must not be overlooked. The programme budget for 1998-1999 was a further step in the implementation of the Ninth General Programme of Work and included both the normative functions of WHO and technical cooperation activities. Any reduction in the level of the programme budget would have major adverse implications for those activities at the country, regional and global levels.

Professor ABERKANE (representative of the Executive Board) reported that, in its general review of the proposed budget for the financial period 1998-1999, the Board had expressed its satisfaction with the format and presentation of the budget. Strategic budgeting implied a programme budget with a greater degree of flexibility, while allowing for the further refinement of strategic orientations in specific plans of action at a later stage. The continuing predominance of extrabudgetary funding had been noted with some concern by Board members. Although extrabudgetary resources were welcome, their use should be consistent with the Organization’s mission and priorities. The matter had been discussed by the Board’s Programme Development Committee and Administration, Budget and Finance Committee, in the context of the uncertainty surrounding the Organization’s budgetary situation for both regular and extrabudgetary funds. It had been felt that programme priority-setting should be clearly reflected in regular budget allocations, a procedure that should encourage the provision of additional extrabudgetary donations. The Organization’s priority-setting was not designed to preempt national or regional authority, but rather to take a global view in calling for action on particularly severe health problems.

There was clearly a need for innovative approaches to the mobilization of resources for the Organization’s activities. In developing the new partnerships that would be required, consideration should be given to expanding the role of WHO collaborating centres. In the current budgetary situation, the Secretariat must achieve increased effectiveness and productivity and consider every possible measure to save on administrative and other costs. New methods of work, such as those adopted within the United Nations system, offered another option for more efficient use of the collective resources of the specialized agencies.

A proposal had been made to establish a panel at WHO headquarters, consisting of senior staff and one or more Board members, to examine the question of programme priorities and the use of extrabudgetary resources. The panel had started working immediately, and had considered the question of the use of extrabudgetary contributions in the context of the overall priorities of WHO. Its findings would be reported to the 100th session of the Executive Board.

Mr ÖRTENDAHL (Sweden), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), considered that the principal challenge facing the Organization was the development of the health-for-all strategy for the twenty-first century. As the Director-General had said in his introductory statement to the Health Assembly, a new vision was needed for global health cooperation, involving a new basis for partnership for health development, with strategic leadership by WHO.

The programme budget was the most important instrument through which Member States could exercise their influence on the direction taken by the Organization in implementing the health-for-all strategy. Health systems development was a particularly important component of the strategy and must be a well-integrated and coordinated activity within the Organization.

Important steps had been taken to provide all Member States with the necessary instruments to fulfil their governance role; the manner in which the concept of strategic budgeting had been developed since its introduction was particularly commendable. Nevertheless, the Organization was still at the beginning of a process of adapting to new management principles. A strategic budget was only one element of a process: it presupposed that Member States would ensure that internal monitoring, evaluation and reporting procedures were satisfactory, an area where further improvement was still needed.

The decisions to be taken by the Health Assembly concerned only the regular budget, which accounted for about 50% of the resources available to the Organization. The recent trend of giving priority to selected extrabudgetary programmes while calling for a reduction in the regular budget would need to be balanced by closer links in the use of regular and extrabudgetary funding in order to respect the fundamental principle of global membership and universal partnership in the governance of the Organization. An open and transparent budgeting process based on strategic aims would allow all Member States to participate on an equal basis.

Internal borrowing should be seen in the context of the overall budgeting process. It was essential that once the budget had been approved, the Secretariat could consider that the general direction adopted for each programme was fully valid. Every effort must therefore be made to strengthen the budgeting process and the
Committee A: Second Meeting

The concept of strategic budgeting. At the same time, Member States must take full responsibility for their decisions: they had to be prepared to accept the funding implications of the budget they had approved; and they must pay their assessed contributions in full, on time and without conditions. Internal borrowing must not be allowed to become a solution to problems resulting from arrears in payments.

Budgetary discussions were increasingly focusing on the figures rather than on programme content - an unfortunate and potentially dangerous development. In principle, the budget of WHO, as for that matter of the United Nations system as a whole, was not too high; indeed, it was small considering the Organization’s mission and functions. However, there was still room to consider savings in administrative areas. In January 1997, the Executive Board had requested the Director-General to implement a systematic policy for savings resulting from improved efficiency. Such resources should be reallocated to priority programme activities.

The Nordic countries supported the proposed programme budget.

Dr KHOJA (Saudi Arabia) commended the efforts that had gone into the development of the proposed programme budget and the selection of priorities. However, to meet the needs of the countries in his Region greater support must be given to the promotion and protection of health, in particular adolescent health and development, and to oral health activities especially among schoolchildren. Allocations to programme 4.2 (Healthy behaviour and mental health) appeared to have been reduced (document A50/4, paragraph 32) although some national programmes in the Eastern Mediterranean Region needed further technical support in that area. There was also a reduction in the budget for the control of noncommunicable diseases in the Region, despite the fact that further support was needed in that field, and that allocations had been increased in other regions. Nevertheless, the proposed programme budget was ambitious and he welcomed it.

Mr CLERC (France) noted that the budget document combined a certain textual elegance, which was commendable, with great obscurity as to items of expenditure and staffing. It provided for the transfer of funds between large programmes but made it difficult to monitor implementation and undertake any analytical review in accounting terms. The only tables provided on the main programme areas showed the very marked regionalization of the Organization and the importance of extrabudgetary resources, although no details were given as to the precise sources of extrabudgetary funding, the reliability of the information provided concerning pledged voluntary contributions, the division of activities and responsibilities between regular and extrabudgetary programmes, or the criteria upon which such divisions were based. It was also impossible to identify the structure of established posts, which was not explicitly approved in the appropriation resolution. The cost of any programme changes that might be made was impossible to determine, since no specific amount was allocated to any particular activity within the 19 major programmes. For example, within programme 2.3 (National health policies and programmes development and management) no figures were given for strategic support to countries and peoples in greatest need. There was therefore no information permitting a comparison with the funding allocated to emergency and humanitarian action. It was even more difficult, within the latter programme, to compare the appropriations allocated respectively to emergency preparedness, to relief operations, and to safety promotion and injury control. Moreover, there was not the slightest indication of the allocations for particular items of expenditure, such as travel, mission expenses, printing, consultancy or telecommunications.

The originality of the text of the proposed programme budget lay more in the description that it contained of the past or permanent achievements of the Organization than in its role as a document setting out the nature of the products to be delivered by the Organization during the coming biennium. It was designed for a broad readership that was uninitiated into the financial aspects of budgeting. It was easy to read and constituted a good tool for the dissemination of information, but was of no help for choosing between alternative programme orientations or identifying measures to achieve greater administrative efficiency, since it offered few figures. The document in its current form should be accompanied by a more traditional budget document that provided detailed figures for the proposed items of expenditure.

Mrs PERLIN (Canada) considered that the proposed programme budget document showed considerable progress in the development of a strategic budgeting process with clear objectives and priorities. It was more transparent in the allocation of resources to the priorities and included targets and evaluation mechanisms for the achievement of results. She particularly welcomed the identification of products at the country, regional and global levels, with the respective time frames and the comparison of projected expenditure for 1998-1999 with
the level of funding for the previous biennium. She commended the Director-General on the efforts made to respond to the issues raised by the Executive Board in January 1997. However, as noted in document A50/4, there was a need for further refinement in the definition of objectives, targets and products, clearer links between products and plans of action, and improved programme evaluation. The Director-General should continue along the same lines in order to build on the significant progress achieved in the development of a strategic approach to budgeting, which allowed Member States to fulfill more effectively their role of setting WHO's policy orientations and programme priorities and ensuring that resources were used efficiently and effectively to meet the needs and emerging challenges of global health.

The new United Nations Secretary General had shown determination to achieve savings through greater efficiency in order to ensure that high-priority programmes received adequate funding and to seek new and more efficient ways of programme delivery in order to free resources for high-priority activities. That would require sharper focusing of priorities, strengthening of financial and personnel management, a review of programmes based on an evaluation of their impact, greater efficiency in programme delivery, a significant reduction of overhead costs and broader collaboration with other organizations. WHO must move in the same direction if it was to meet the challenges of the new health-for-all strategy in the twenty-first century. In that context, it was unfortunate that there had been no reduction or reallocation in respect of appropriation section 6 (Administrative services) since the Executive Board's discussion. Indeed, the proposed cost increase for inflation was higher than that approved for the 1996-1997 programme budget, despite the trend in the United Nations and other agencies to absorb cost increases and despite national budgetary restraint. In effect, therefore, administrative and overhead costs had been increased at the expense of vital programme activities, including country-level activities. That was not acceptable in the current climate, which required optimal use of the limited resources available, including greater efficiency in programme delivery. The proposal for a 0.4% increase in appropriations masked an increase of 4% in costs due to inflation, offset by an improvement in the exchange rate. The Health Assembly was faced with a choice. It could spend an additional US$ 33 million on salaries, travel costs, office equipment, supplies, furniture and other administrative items - the option set out in the proposed programme budget. The alternative was to use the benefit of an advantageous exchange rate for other purposes, including a reduction in the assessments on Member States and the allocation of increased resources to special programme initiatives. As had been done for the 1996-1997 biennium, Member States should call on the Director-General to absorb the increased costs through further efficiency measures and to look into innovative ways of ensuring that high-priority programmes had sufficient funds.

Mr LIU Xinming (China), while commending the efforts made to take account of requests concerning priority areas and budget reform in preparing the proposed programme budget, warned that, at a time of increasing global concern for human health, WHO would find it difficult to fulfil its responsibilities with a shrinking budget. The Organization needed to undertake a careful study of how it could achieve its objectives under such financial conditions. Developing countries had been hoping for greater support in fields of health policy and management, health services development, promotion and protection of health and integrated control of disease, whereas the actual support provided would be at a lower level than in the previous biennium. Clearly, WHO could not permit a large increase in its budget; it could only aim at improving its efficiency and using its limited resources where they were most needed.

Mr MOEINI (Islamic Republic of Iran) said that, in priority-setting and resource allocation, full account should be taken of the need to reduce the difficulties experienced by some countries in obtaining access to technology and the necessary equipment and facilities. The divergence in priorities at the global and national levels, referred to in paragraph 7 of document A50/4, might mean that countries did not feel that the global priorities always corresponded to their own needs, and if so that should be reflected in the 1998-1999 programme budget. As far as technical cooperation was concerned, WHO's budget should be expanded and devoted to more specific issues, such as the provision of technology and equipment. WHO should take an active role in operational activities, rather than just setting guidelines and policies. Evaluation mechanisms should be transparent and open to all Member States, not restricted to a limited number of countries.

Dr BOUFFORD (United States of America) believed that budgetary difficulties, which faced almost every country present, had important implications for WHO's long-term financial stability. A thorough review of the
Director-General’s proposal was therefore extremely important at three levels: presentation and format, data presented, and appropriation levels for the 1998-1999 biennium.

As far as format was concerned, she expressed her appreciation of the modifications made since the presentation of the first revised budget in 1995. New tables made it easier to judge the detailed allocations of funding and compare them with actual expenditures in the preceding biennium. Some difficulty remained in tracking whether and how the resources were shifted from one budget category to another, but the current document was much improved. She also commended the effort to define targets and specific outcomes for budgetary investments as a step towards strengthening the overall management culture at WHO.

As to the data provided, she welcomed the reallocation of resources undertaken since the ninety-ninth session of the Executive Board in January 1997, giving greater emphasis to the priority programmes identified by the governing bodies.

Stressing that discussion of WHO’s budget appropriations for the 1998-1999 biennium could not be divorced from domestic budgetary trends, she said the United States of America could not accept the Director-General’s proposal. Her Government, like many others, was required to balance its budget, and expected WHO to do the same. On the basis of realistic projections of income from Member States, a reduction of 5% from the level of the budget of the current biennium was the minimum acceptable. While recognizing that incomplete payments to WHO from the United States were part of the problem and that its payments to WHO and other agencies of the United Nations system were no longer adequate to cover the country’s assessments, she warned that the situation was likely to persist as long as assessments remained at or above 1996-1997 levels. It was not a short-term problem, and was likely to extend into the next century. The criticism levelled at the United States, while understandable, would not help to eliminate the political reality.

The United States recognized its obligation to WHO and wished to be able to pay in full. While it believed there should be a change in the scales of assessment, it was fully prepared to continue its status as the largest contributor to WHO. In fact, the elements of a budget package for the United Nations system that would pay arrears in full and sustain a reduced assessment were currently going through the legislative process. Nevertheless, the assessments resulting from the Director-General’s current proposals would require payments by the United States far in excess of the level of funds expected to be appropriated.

However, the United States’ payment situation was only one element of WHO’s cash-flow problems. The financial report showed that 63 Member States had made no payment whatsoever to WHO in 1996; at the end of 1996, 41 countries had paid nothing to the Organization for more than two years; WHO had a shortfall in the collection of its 1996 contributions of more than US$ 93 million; the Working Capital Fund was totally depleted, even though it had been nominally increased; excessive internal borrowing had been necessary to maintain some of the programmes in operation; and planned expenditure of US$ 21 million had not been implemented in 1996. The United States proposal for a reduction in the forthcoming budget was not intended as a criticism of WHO, but to help it out of its serious financial predicament. WHO was still one of the most important agencies of the United Nations system; the United States had been heavily involved in its creation and remained a major supporter. The world required an effective multilateral mechanism to deal with the numerous, complex and growing problems of international health. WHO could make a difference to the situation, but only by prioritizing its activities and optimizing the use of resources.

The Director-General’s proposal sought a 4% increase in the budget to cover the higher cost of programmes in the next biennium. Exchange rate improvements in the currencies used by WHO to conduct its business amounted to almost 4% and could be used to offset the cost increases, thus enabling it to pay higher prices for its programmes and administrative services while avoiding an increase in assessments for Member States. In view, however, of the expected shortfall in receipt of contributions, the Health Assembly should request the Director-General to absorb the 4% increase in costs through efficiency adjustments, giving a nominal reduction of 4% from 1996-1997 levels. A number of specific suggestions for savings had already been made, for example in the report of the External Auditor (document A50/22). Moreover, reform was already taking place in the United Nations system: the United Nations and the World Bank had announced reform plans and ILO had tentatively reached agreement on a 3.75% budget reduction, with further cuts to be considered later. Absorption of the 4% cost increase was one very logical step WHO should take in that direction. As a second step, it could simply absorb 1% more. The resulting total nominal reduction of 5% was prudent in the light of cash-flow trends and feasible with little or no damage to the high priority programmes, especially in the countries of greatest need. The Director-General had been requested by the Board at its ninety-ninth session, and
at other times, to prepare for the Health Assembly a document showing exactly how a 5% reduction could be implemented, and she again urged him to do so.

She regretted the need to outline such a serious picture, but WHO was at a crossroads. Both the costs of its operations and Member States’ assessments must be lowered if the operations were to be sustainable. The current evolution of exchange rates offered an opportunity to do so, without adversely affecting the core programme and with a net gain in efficiency that would improve WHO’s cash flow. That opportunity should be seized.

Ms INGRAM (Australia) said that since 1993 there had been continuous improvements in the presentation of the biennial programme budget, resulting in a more transparent budget process and making possible more effective examination by the governing bodies. That process was, of course, evolving and there was still room for further improvements. While the explanatory text was well presented, the content - particularly targets and products - was still not sharp enough to permit a quantified assessment of outcomes. She welcomed the addition of objectives in document A50/4, but observed that they were not generally “strategic” objectives in that they largely focused on inputs or processes rather than desired outcomes. Objectives should continue to be redefined in all programme areas until they were truly strategic.

The current documentation still did not permit easy comparison over time of expenditures with approved budget activities. Statement 1 of the Interim Financial Report for 1996 (in document A50/8) provided only a very general, aggregated indication of expenditure patterns. Its main use was to show transfers between sections made by the Director-General under his discretion to make shifts of up to 10%, and none was shown until the end of the biennium. She called for a more detailed breakdown to the 19 main programme levels.

On programme allocations and administrative costs, she felt that the reallocations effected by the Director-General since the meeting of the Executive Board in January 1997 did not go far enough. The Executive Board had sought to inject funds into priority programmes, to limit administrative costs and to focus on content. The changes implemented had been at the margins only, involving a certain amount of window-dressing and redefinition rather than a change of function. In particular she was concerned at the limited response concerning programme 6 (Administrative services).

As to the other measures to implement resolution EB99.R13, paragraph 31 of document A50/4 suggested that a comparison of budgetary allocations with expenditure had been made possible, but that was true only at the level of broad programme categories or appropriation sections. Comparison by major programme and specific programme was essential and financial statements should be broken down accordingly in the future. The intent of resolution EB99.R13 was not to make programme cuts, but to achieve efficiency savings by managing activities more effectively. Paragraph 35 of document A50/4 said that an effort was being made to do so, but it gave no clear commitment to or timetable for putting an efficiency savings mechanism in place; she urged the Director-General to institute one as quickly as possible.

As to priority-setting, she welcomed the work already undertaken, as described in paragraphs 34 and 35 of the report, to develop the analytical framework called for in resolution EB99.R13. Noting the link drawn with the Organization’s major planning process, she thought it useful to consider the relation between priority-setting and planning. Priorities should inform the planning process, not vice versa. A strategic approach to global health work should yield real improvements in the global health status. Strategic budgeting went well beyond the preparation of a strategic budget document; further work remained to be done.

Mr VAN REENEN (Netherlands) expressed appreciation of the presentation of the draft budget, which provided more useful information than in the past, particularly on expected outputs. There were, however, some shortcomings: the transfer of a number of activities from one section to another of the budget meant that the current draft was not always fully comparable with the budgets and actual expenditures of previous bienniums, and the description of constraints on the implementation of programmes often failed to take account of nonfinancial factors. He therefore welcomed the Executive Board’s recommendation, in resolution EB99.R13, that the Director-General should “strengthen the critical analysis of nonfinancial factors that impede or foster achievement of objectives, outcomes, programme delivery, or products”.

Document A50/4 gave a clear survey of the strategic objectives of all activities. Nevertheless, he regretted that the matrix in paragraph 21 showing the different elements of primary health care failed to allow for a clear comparison with the programme budget and that the table in part III setting out further shifts in the programme
Regarding the budget level, the position of the European Union, on whose behalf he had been authorized to speak, was that the reform of the United Nations system, including the specialized agencies, was not about cost-cutting, but about strengthening the system and reasserting its pivotal importance in the social and economic fields.

Speaking on behalf of the Netherlands, he expressed full support for the proposed 0.4% increase in the budget for the 1998-1999 biennium. He commended the Director-General for heeding the advice of the Forty-eighth World Health Assembly and basing estimated cost increases on data from authoritative sources, such as the international financial institutions. He regretted, however, that the Executive Board's request that the Director-General propose a systematic policy for savings stemming from improved efficiency with a view to ensuring that, **inter alia**, maximum funds were allocated to priority programmes had not yet been implemented.

The European Union took the position that there was scope for such savings within the administrative part of the budget and for reallocation of resources from the administrative and governing-bodies areas to priority programmes.

Turning to the Secretariat's proposals for the reallocation of funds to priority areas, he welcomed the proposed shift of resources towards appropriation section S, at least under the regular budget. However, he regretted that a number of priority areas in primary health care and other fields such as essential drugs, intensified cooperation with countries in greatest need, reproductive health and nutrition had not received the resources they deserved. He noted with concern that the Regional Offices for Africa, Europe and the Western Pacific had not contributed to further shifts towards priority programmes as requested by the Executive Board.

Observing that a number of donor countries had already begun to report on implementation, in their bilateral assistance programmes, of performance under the 20:20 Initiative, contained in the Programme of Action adopted by the World Summit for Social Development, he said that difficulties were being encountered in reporting on contributions to multilateral organizations because of the lack of data on their 20:20 performance. The Netherlands, in close consultation with other interested donor governments, wished to discuss with the Secretariat, immediately after the Health Assembly, ways in which WHO might provide, in future programme budgets and financial reports, the necessary data on the allocation of resources to basic social services.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland) welcomed the progress made in budgetary reform, which had provided documents that were considerably easier to work with than past proposed programme budgets and should lead to a more productive debate. He fully supported previous speakers' comments, in particular those of the Australian delegation on the scope for further budget improvements.

The request in resolution EB99.R13 had been that the Director-General should propose a systematic policy for savings stemming from improved efficiency; the Director-General’s response in paragraph 35 of document A50/4 to the effect that there was no need for additional mechanisms had been disappointing in that respect. The fact that such savings were achieved in the normal run of business was no substitute for a systematic policy similar to that adopted by the United Nations with the creation of the Efficiency Board. He welcomed the more positive note sounded in Dr Chollat-Traquet’s presentation on the subject. He reiterated the importance of a conscious policy and commended the example of the United Nations and the Universal Postal Union in that regard.

In conclusion, he endorsed Sweden’s statement on behalf of the Nordic countries on the importance of a careful examination of the role of extrabudgetary funds, expressed appreciation of the efforts made in that regard under the leadership of Dr Shin of the Executive Board, and looked forward to the Board’s report.

Mr HURLEY (Ireland), thanked the Director-General for his focused presentation of the budget. As Chairman of the Programme Development Committee, which had examined the proposed programme budget and had reported to the Executive Board in January, he himself had commented on the improved layout and presentation of the budget, which had greatly facilitated the Committee’s task. He was pleased that the Director-General had adopted many of the important points made during the discussion in the Board.

The programme budget was developing into an important management tool. While further progress was necessary, it was crucial, in the examination of the programme budget and the general approach to the cost increases in particular, to acknowledge what had already been achieved. The programme budget was being presented at a crucial time in the Organization’s history. The Health Assembly would shortly be debating the
renewed health-for-all strategy, a matter that was central to WHO’s future. No organization could continue to function effectively in a climate of continuing financial uncertainty. The Board and the Health Assembly had made significant progress in their earlier tasks of reorienting WHO to introduce the concept of strategic budgeting and ongoing evaluation. The task ahead was to build on that process rather than to restate previous positions, and to support the Organization, while at the same time continuing to demand a more focused and priority-based approach, particularly with regard to linkages between programmes and activities. It was true that further savings were possible, but they should be directed to priority programmes. The approach of acknowledging the achievements made thus far and encouraging the Organization to make further advances and efficiency savings would be enhanced by the concept of zero real growth. The windfall gains in foreign exchange had made that easier. In conclusion, he fully supported the overall figure of the programme budget as proposed.

Dr SILWAMBA (Zambia) while commending the clear and detailed accounts presented, felt that they portrayed an Organization reluctantly adjusting to the new reality that fewer resources were available to it and to development aid in general, and that other multilateral organizations were playing an increasingly active role in assisting developing countries with policy formulation and technical matters. While commercialization of advisory services increased professionalism, it also increased vested interests in their provision, thus creating a vacuum that WHO could fill if it were prepared to adjust.

The most remarkable change in the overall budget was the expected 12.04% drop in income from other sources, leading to an overall reduction of 6.78%, which was attained by cuts in the "business areas" (i.e. appropriation sections 2 to 5), leaving overhead costs unaffected: the provision for governing bodies was reduced by a mere 0.31%, while that for administrative services was increased by 5.21% in absolute terms. The largest shift in relative resource allocation between the 1996-1997 budget and the proposed budget for 1998-1999 was an increase of 1.3% for administrative services, which hardly constituted a reform.

With the drop in the country level’s share of the budget from 25.9% to 21.84% and in that of the intercountry level from 21.7% to 19.7%, it appeared that resources were being shifted from the country level to the global and regional levels rather than the reverse as had been intended. Although, as explained in the footnote to Table 4 of document PB/98-99, such expenditures also benefited country programmes, if the budgets were kept at the higher levels, those levels would obviously also determine how the resources were spent. A key feature of health reforms in countries was the shift from a command-driven to a demand-driven system by devolving authority and responsibility for budgeting and priority-setting to districts and hospitals. If WHO were serious about reforms and its response to country needs it would do the same, enabling the countries, inter alia, to purchase services from the Organization and pay for participation in intercountry activities.

Mr GUN (Democratic People’s Republic of Korea) while welcoming the proposed major changes in real terms, especially in provisions for the elimination or control of communicable diseases, was concerned that the role of the regular budget was being continuously diminished, making important WHO programmes dependent on extrabudgetary resources, at the risk of their becoming unstable and unpredictable.

Given the growing cost of health care, WHO should pay more attention to strengthening national programmes for enhancing vaccine and medicine production as an important component of WHO’s health-for-all strategy. Since budget restraints affected some important programmes, greater attention should be paid to ensuring that the approved budget was suitably implemented. In conclusion, he welcomed suggestions that extrabudgetary funds should be directed to priority areas in order to cover the costs of programmes affected by reductions in the regular budget and to alleviate the consequences for priority activities.

Mr KOVALENKO (Russian Federation) said that, on the whole, the proposed programme budget was an improvement on that adopted for the previous biennium and reflected the changes made in strategic programming. He also appreciated the work done, since the ninety-ninth session of the Executive Board, to adjust the levels of expenditure proposed for the different appropriation sections. However, the Executive Board’s proposals for a greater reduction in administrative expenditure had not been fully taken into account.

Given the budgetary difficulties and restrictions experienced by many countries, it was essential for international organizations to devise means to achieve greater savings, a reduction in administrative expenditure and the reallocation of financial resources to priority programmes. In that context, and taking into account the marked tendency within the United Nations system to reduce budgetary levels, he considered that the projected
inflation-related cost increases of about 4% should be fully absorbed within a budgetary envelope that would allow the 1998-1999 programme budget to be kept at the same level as for the previous biennium in absolute terms.

Any budgetary adjustment as a result of the favourable change in the dollar exchange rate (+3.6%) should be effected in relation to an overall budget level of US$ 842 654 000. Those additional resources could then be allocated to priority programmes and should permit a further possible reduction in Member States' contributions. Further measures to achieve savings and increased efficiency in the implementation of WHO programmes would also be welcome.

Dr ITO (Japan) said that the improved structure of the programme budget properly reflected the discussions of the preceding Health Assembly and Executive Board sessions. The inclusion, for the first time, of strategic objectives and products for each budget item would certainly be useful in assessing the impact of programme activities. Compliance with the governing bodies' requirements had made the budgeting process more transparent and increased the Member States' sense of ownership of WHO programmes.

He welcomed the increase in the 1998-1999 allocations for programmes on emerging and re-emerging infectious diseases and hoped that future budgetary discussions would focus on ensuring sufficient funding for that area, given the severe problem that infectious diseases represented throughout the world and the modest budget originally allocated for tackling them. He applauded the Director-General's decision, in response to the discussions at the last session of the Executive Board, to make further reallocations to the priority areas of primary health care, reproductive health, essential drugs, nutrition and food safety, and environmental health.

While appreciating the efforts made to reduce the cost-increase multiplier for calculating the overall budget to 0.4% from the original 2% proposed to the Executive Board, Japan was not in a position to agree to any cost increases, but only to a zero nominal growth budget, in its belief that further effective management would yield more cost containment and that zero nominal growth would symbolically provide the best basis for reconciliation in consideration of the financial problems facing the entire United Nations system. Should the Member States urge WHO to take a stringent budget option, however, it would be incumbent upon all of them to pay their assessments in full and without delay, as required by the WHO Constitution.

Professor GRANGAUD (Algeria) agreed with previous speakers that the presentation of the proposed programme budget was a great improvement compared with previous years. The statement of clear targets made possible a better appreciation of the different programme activities. The matter of extrabudgetary resources clearly called for more in-depth study in the light of the views expressed by previous speakers and Professor Aberkane’s presentation. The growth of such resources in relation to regular budget funds created problems only if they were not allocated to priority areas. Regrettably, that had been the case, thus raising questions about the Secretariat’s capacity to manage those resources.

Delays in the payment of regular contributions threatened to handicap and undermine the Organization. Substantial savings could be made by using the skills existing in the various countries.

There were other areas that called for imaginative thinking. In defining priorities account must be taken of the fact that the gap between the rich and the developing countries was widening and that the epidemiological transition taking place in the world was experienced differently from country to country. With regard to resource management, ways must be found of tackling emergencies while avoiding wastage. One example was the problem of meningitis in the African Region: how were vaccines to be kept available without becoming out of date owing to overstocking? He hoped that those two concerns regarding the definition of priorities in resource management would be dealt with by the international community.

Dr DURHAM (New Zealand), while welcoming the improved presentation of the proposed programme budget, shared the views of other delegations, particularly those of Australia and Canada, regarding further improvements that could be made to demonstrate rigour of analysis, transparency, and comparability with expenditure. Her Government viewed efficiency as more health gain per unit of resource and shared the European Union's view that the purpose of WHO reform was improved performance rather than cost-cutting. Performance must be achieved by systematic evaluation against measurable targets. Efficiency meant doing the right thing well, and a clear focus on agreed priorities would enable the Organization to steer towards that objective.
She strongly supported the Secretary-General’s recently announced plans to reallocate 33% of United Nations funds from administration to economic and social programmes by 2001, and advocated the development and implementation of a comparable specific proposal for WHO along the lines indicated by the United Kingdom.

Dr SHISANA (South Africa), after expressing appreciation for the improved presentation of the proposed programme budget, urged Members in arrears to pay their contributions, which were an essential resource for use in WHO’s priority programmes. The Organization played a key role in advising the developing countries on ways of dealing with major public health programmes, a case in point being tuberculosis control and health informatics in South Africa.

She was concerned about the handling of essential drugs in the proposed programme budget. Section 3.3, paragraph 63 of document PB/98-99 stated that one-third of the world’s population - 60% in Africa - lacked secure access to essential drugs, and two-thirds of the funds under that head were allocated to country support in policy development, implementation of comprehensive programmes and technical assistance. However, the essential drugs regular budget showed a substantial decrease from US$ 14.2 million in 1994-1995 to US$ 12.9 million in 1998-1999, a matter of great concern for the countries of Africa. South Africa supported zero growth, but not a reduction, inasmuch as The world health report 1997 showed that chronic diseases increasingly existed side by side with communicable diseases in much of the developing world, in addition to increased threats of emerging and re-emerging diseases. WHO and those countries should not be let down by a reduction in the Organization’s budget.

Dr BOUAMGA (Congo) considered that further efforts should be made to improve the programme budget. Mobilization and strengthening of financial resources were needed if countries were to be able to implement their programmes and activities. The control of emerging and re-emerging infectious diseases and epidemics posed a constant challenge in Africa. Accordingly, efforts should be made to reduce WHO administrative costs in the interest of an improved budget. Congo was doing its best to pay its assessments and arrears and hoped that WHO would continue to provide technical support to Member States on an equal footing and in accordance with each country’s expressed needs.

Mrs MANYENENG (Botswana) supported the zero real growth budget proposal. It was strategic budgeting, as a component of strategic planning, that could steer WHO towards the implementation of the health-for-all strategy for the twenty-first century, together with all the critical nonfinancial factors, such as WHO leadership, while Member States also had a role to play in honouring the agreements entered into. The countries of the African Region were currently faced with emerging and re-emerging infectious and other diseases and a changing pattern in the occurrence of diseases. Botswana had also now become a malaria area, in addition to the fact that diseases like HIV/AIDS were negating all the gains achieved, while tuberculosis and malaria were becoming increasingly resistant to treatment. It was to be hoped that the 3% increase in contributions, coupled with the zero growth budget, would make it possible to tackle emerging health problems while also sustaining existing programmes.

Dr PHILLIPS (Jamaica) commended the improvements in the presentation, transparency and manageability of the proposed programme budget and in the budgetary process as a whole. Supporting the programme budget as presented, he said it was important that the work of WHO should not suffer any setbacks, given the important challenges to the health status of the globe and the political and social crises that affected the developing countries for the most part. There was, however, scope for greater efficiency, and he joined with those who wished to see developed a programme for achieving gains in efficiency within the Organization, particularly with a view to reducing overhead costs and increasing the resources spent on programmes, especially priority programmes.

Professor ABERKANE (representative of the Executive Board) noted that the comments of Member States mirrored the concerns of the Executive Board and the resolutions it had adopted in its desire to ensure optimal use of increasingly scarce resources. The credibility of WHO and its ability to respond to change were determined by the quality of its resource management. Efficiency might be difficult to achieve at each of the many levels of programming and policy implementation in WHO, as a number of delegates had indicated.
Discussions about programming and implementation at WHO headquarters, in the regions and in countries had been the basis for making concrete proposals for improvement. The activities of WHO were difficult to evaluate. There had been much discussion in the Board about how to strike the right balance between the consideration of highly technical data and detailed figures and the debating of broader policy issues, both in the Programme Development Committee (PDC) and the Administration, Budget and Finance Committee (ABFC). A recent example had been the discussions in ABFC of the External Auditor’s report.

Dr ANTEZANA (Deputy Director-General ad interim) commented that optimal budgetary reform could not be achieved in one biennium. The present proposed strategic budget was the second to be prepared by WHO; perhaps by the year 2000 the budget would fully reflect the concern of Member States with regard to efficiency, management and allocation of resources.

Mr AITKEN (Assistant Director-General), responding to comments made by delegates, noted the difficulty in striking a balance between a strategic and a more detailed budget. That had been attempted by the issuance of information documents on the proposed programme budget. Reference to those documents could be made during the coming discussions. Document EB99/INF.DOC./1 was very comprehensive, giving for example detailed figures on travel, consultancy and staff costs. Reference should also be made to the different presentations of accounts.

The policy for use of extrabudgetary resources had changed over time. The Executive Board at its 100th session would receive a report which represented a first attempt to analyse the use of extrabudgetary resources in relation to those of the regular budget, as a step in the development of a WHO policy on extrabudgetary resources that would assist in orienting use of that growing source of funds. A more advanced version of the document might be available for discussion at the Fifty-first World Health Assembly.

The comments of Member States had shown that reporting of progress in improving efficiency should be more detailed, in order to clarify past, present and future action, including the building of such measures into the daily work of WHO, in order for instance to allow WHO to pay for priority programmes without requesting extra funds. He suggested that a comprehensive report on efficiency measures could be presented to the Executive Board at its 101st session. It would include clearer definitions of the measures that had been and were being taken, of targets and of how those measures would be implemented across programmes in 1998-1999. Document A50/4, meanwhile, was a step in that direction.

Evaluation was a critical element in ensuring the transparency of the Organization’s activities and was a fundamental part of the strategic budgeting process.

Responding to suggestions that the proposed 4% increase in costs might be absorbed, he noted that the proposed budget did not include any items that could be cut. It was an honest, transparent, realistic budget. The total requested to cover cost increases by the seven major administrative centres that made up the Organization had in fact come closer to 8%. Thus, almost half of the cost increases were already absorbed by WHO in order to balance the budget.

The cost increases did not fall only in administrative areas; most were for delivery of the priority programmes of WHO. It had been mentioned that the United Nations was taking steps to reduce administrative costs from the current level of 30%-35%. In contrast, WHO’s administrative costs represented only 10.5% of the overall budget and comprised expenditure at headquarters and at the six regional offices. The budget proposals received from the six regional committees, and effectively approved by the 191 Member States of WHO, had requested US$ 4 million more for administrative costs than had finally been incorporated in the proposed budget. The Director-General had thus decided not to present the entire cost increases that had been approved by the regional committees as the minimum necessary to run WHO.

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation) remarked that most of the comments that had been made re-emphasized the points addressed in resolution EB99.R13. She noted the necessity of improving the quantification of goals, strategic objectives and definition of products but echoed the comment made by Dr Antezana that an optimal strategic budget would be achieved only after several attempts. One of the difficulties was that many programme directors, who had to define goals, products and strategic objectives, were not trained to do so. A series of internal courses was to be organized to improve their performance in that respect.
The Director-General would present the Executive Board at its 101st session with an analytical framework for setting priorities within the programmes of WHO. It was proving a complex matter to establish a framework that would be acceptable to all. The scheme had not only to include the priorities of the various governing bodies but also to analyse and take into account priorities at the country level. An analytical framework that could fulfil those different functions was difficult to set up and would be difficult to use subsequently in order to meet those priorities.

The Secretariat had made a number of proposals to PDC concerning the role of evaluation in the management and implementation of the programmes of WHO, through the programme budget and the more detailed plans of action. Resolution EB99.R13 requested evaluations of efficiency and impact that were linked to a financial evaluation. The Secretariat would provide the Executive Board at its 101st session with a framework for evaluating implementation of the programme budget and its products in relation to a financial analysis.

**Appropriation section 1: Governing bodies**

Dr AL-SAIF (representative of the Executive Board) said that the Board had approved the proposed restructuring measures outlined in the “grey box” under appropriation section 1 in document PB/98-99, including the shortened durations of the Health Assembly in 1998 and 1999 and the payment of travel costs for one representative each from the least developed countries only. Some members of the Board had considered that costs would increase despite restructuring and had suggested that certain technical committees should meet biennially instead of annually. Others had said that the cost increase appeared to be due to work in two regional committees. While it had been felt that the concept of zero growth should be maintained in forthcoming budgets, it had also been argued that resources for priority programmes in the regions should be increased.

Dr VAN ETTEN (Netherlands) inquired whether renewal of the strategy for health for all would be discussed under appropriation section 1. He also asked to what extent the budgetary allocations for regional governing bodies were comparable, noting that they seemed to vary considerably.

Ms INGRAM (Australia) noted that the proposed appropriation section 1 still showed real growth. The amount had been decreased by US$ 316 200 since consideration of the allocation by the Executive Board at its ninety-ninth session, but a small increase remained. It was important in a time of fiscal restraint, when resources should be directed to priorities, that the governing bodies should set an example, reducing spending on their meetings.

Mr AITKEN (Assistant Director-General), in reply to the delegate of the Netherlands, said that renewal of “health for all” was considered in appropriation section 2.1 of the budget and was referred to in several sections on planning. A meeting on the subject was to be held at the time of the next Health Assembly and would be financed under section 1. The costs of regional committees differed, as shown in document A50/4, partly because the number of Member States varied markedly by region. Furthermore, the structures of governing bodies differed, for instance with regard to meetings of subcommittees and standing committees. One of the reasons for the proposed increase in section 1 was that the European Region intended to fund the relatively new structure of its governing bodies, which included meetings of standing committees. In reply to the delegate of Australia, he said that an effort to maintain zero growth had been made in discussions with those regional committees that proposed increases in appropriation section 1. It had been the judgement of those committees, however, that their proposals represented the best means of governing their regional structures. The Secretariat had tried to offset those increases by reducing the costs of the meetings of the Executive Board and the Health Assembly.

Dr LARIVIÈRE (Canada) said that his delegation was in full agreement with the strategic orientation set out in the proposed budget. In improving the methods of work of the Health Assembly, management should be left to managers. The shifting of responsibility increasingly from the Health Assembly to the Executive Board should be analysed in the context of reforming and strengthening the work of the Board. The Health Assembly would in future have to take greater account of the output of the Board.
Bodies equivalent to the Executive Board which existed in the Regions of the Americas and Europe reduced the work of the regional committees, increased efficiency and reduced costs. A similar approach could be taken in other regions where the number of Member States warranted it.

The CHAIRMAN drew the Committee's attention to the draft resolution contained in document A50/4, concerning the cost of travel to the Health Assembly.

The draft resolution was approved.\(^1\)

The meeting rose at 12:20.

\(^1\) Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.1.
SECOND MEETING

Wednesday, 7 May 1997, at 9:00

Chairman: Dr R. CAMPOS (Belize)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999: Item 17 of the Agenda (continued)


Appropriation section 2: Health policy and management

2.1 General programme development and management
2.2 Health, science and public policy

Professor ABERKANE (representative of the Executive Board) said that, having heard the views of the Programme Development Committee on appropriation section 2, the Board had emphasized that the Organization should maintain its core normative functions in several fields, while ensuring that they were conducted with maximum efficiency. It had placed particular emphasis on the importance of doing so in connection with the management information system, which fell within major programme 2.1. It had also raised the question of the cost of the installation of the system and had expressed concern at the current allocation of resources for its future development. It was understood that the Secretariat would supply a financial plan for the installation and operation of the system.

Turning to major programme 2.2, the Board had noted with concern the abolition of the four posts under the specific programme Health in socioeconomic development. It wondered how that reduction could be reconciled with the maintenance of activities in such important fields for future policy as women, health and development, which was covered by the Global Commission on Women’s Health, and human rights and health. The Board had been informed that every effort would be made to ensure that the activities concerned were continued by being integrated into the work of other programmes within the Organization. It had also been informed that extrabudgetary resources had been found to maintain a post on human rights and health for a limited period.

Mr ESKOLA (Finland) said that the work of the task force on health in development had been reviewed by the Executive Board in January and had been highly appreciated. However, the proposed programme budget did not give any clear indication of how the work of the task force would be continued, although it was stated that it would have completed its mandate by 1999. He therefore requested clarification on how the Task Force would be funded and its continued existence secured.

Dr BOUFFORD (United States of America) endorsed the comments of the previous speaker and requested further clarification concerning the extent and implications of the extrabudgetary funding available for human rights and health. She expressed concern at the abolition of the focal point on women’s health and development and requested an indication of how WHO would follow up the work of the Global Commission on Women’s Health. It was not necessary to fund individual units on each of those issues, but a focus had to be provided for each until they could be incorporated into the mainstream of WHO’s activities.
Dr LARIVIÈRE (Canada) noted that there were several matters affecting different programmes in “Health, science and public policy”, including women’s health, human rights, ethics and the coordination of research. WHO had already been giving attention to those matters and would certainly continue to do so. Its increasing involvement in ethical issues might affect its excellent and long-standing relations with CIOMS, and he hoped that there would be no duplication or tension between the two organizations.

Concerning the implications of health reform for the proposed programme budget, the recent Meeting of Commonwealth Health Ministers was evidence that all countries were concerned by the issue to varying degrees. WHO could play a useful role as a clearing-house for the very many national experiences of health reform and should provide leadership to support national reform efforts. He asked how activities would be organized to provide such support.

He emphasized the importance of the work of the task force on health in development and of its recommendations on the future of global health development and on WHO’s contribution to that development. He hoped that the work and recommendations of the task force would be taken more fully into account in the process of renewal of the health-for-all strategy and redefinition of the role of WHO in the twenty-first century.

Dr SHAMLAYE (Seychelles) emphasized that the activities under major programme 2.2 were vital to WHO’s global leadership role in such areas as promoting and protecting the centrality of health in development, addressing the situation and needs of vulnerable and disadvantaged groups and ensuring their access to and participation in the development process, promoting and developing human rights in health, and addressing the policy aspects of health reform. He commended the contribution made by the task force on health in development and the Global Commission on Women’s Health, as well as WHO’s other related work. It had therefore been with some concern that he had read in paragraph 9 of document A50/4 the Executive Board’s question as to “how the maintenance of important policy areas of health in socioeconomic development could be reconciled with the discontinuation at headquarters of all posts in health policy in development”. He welcomed the Director-General’s response in paragraph 23 that health policy in development was indeed a priority, and that it would be integrated and reinforced in all the programmes of the Organization. However, he wondered whether such important work did not merit a more sharply focused approach in order further to develop WHO’s activities on health policy and human rights, enhance its global leadership and provide Member States with further assistance in pursuing health policy development.

Dr SILWAMBA (Zambia) said that WHO’s work in the field of health policy and management was of great importance and should be one of its core activities. Although health and development were closely interrelated, it was notoriously difficult to give effective operational expression to their linkages. The problem had been addressed for years by various agencies, including the programmes concerned with HIV/AIDS and many United Nations and other multilateral organizations, with which WHO should maintain close collaboration. WHO had a specific mandate in the health sector, and staff and tools to implement its policies, but they did not function as they should. Health politicians and health professionals had an obligation to make them function efficiently through dialogue to bring health on to the agenda of economic and development sectors. That provision of a service that was responsive to local needs and managed so as to make the best possible use of the meagre resources available. Carefully selected interventions were needed that were cost-effective and aimed at the most urgent problems. In view of that, it was puzzling that in the African Region it had been decided to transfer the funding of work in such a key policy area from the regular budget to extrabudgetary sources. He would have expected the Organization to use its own resources to protect and control its core activities.

Regarding major programme 2.1, he noted that paragraph 8 of document PB/98-99 referred to WHO’s mission but gave the reader no indication of what that mission was. WHO needed to distinguish itself from all the other operators in the health sector by emphasizing its unique features, such as its global membership and its specific mandate. WHO should be a leader, not a follower, in health.

With reference to major programme 2.2, paragraph 18 of the document mentioned a “minimum package” of public health measures and essential clinical services that could reduce the burden of disease by 25% and went on to say that a large proportion of the population lived below the level at which such an essential package could be afforded; no indication was provided, however, of how the Organization would seek to address that problem. It also appeared to be contradictory that, while the Organization recognized the importance of providing balanced essential health packages, the exhibits displayed in the corridors during the Health Assembly
suggested a trend towards more narrowly defined vertical programmes or campaigns - extending even to the promotion of toothpaste. It remained to be seen how the excellent sentiments expressed under the heading “Health policy and management” were reflected in the overall organization of WHO’s work.

Ms INGRAM (Australia), commenting on WHO research activities under major programme 2.2, referred to the report on cooperation for health development prepared some years previously by Australia, Norway and the United Kingdom of Great Britain and Northern Ireland, which had noted the high value placed on WHO research but also the very small investment in research under WHO’s regular budget. Indeed, over the past 10 years regular budget research funding had fallen every biennium, from US$ 9.7 million in 1988-1989 to a proposed US$ 3.4 million in 1998-1999 at global and interregional level; thus, less than half of 1% of the regular budget was allocated to research. While the extrabudgetary funding for research was much higher in financial terms, amounting to about US$ 236 million in 1996-1997, the proportion of total extrabudgetary funds allocated to research had also declined, from 33% to 23%, over the same 10-year period. She stressed that the Organization’s first function under the Constitution was “to act as the directing and coordinating authority on international health work” and that another function was “to promote and conduct research in the field of health”.

The bulk of scientific research capacity and investment was concentrated in the industrialized countries and although there had been some growth in research investment in recent years in middle-income countries, progress in research in the poorest countries was only modest. That did not augur well for the future. High-quality research was essential to effective health action, and there was an enormous wealth of research material available, which could and should be shared. As the directing agency for international health work, WHO had to be central in its evaluation and dissemination. Reference had already been made to the importance of adopting a systematic and analytical approach to the setting of priorities within the Organization. The same principle applied to the determination of research priorities. In that respect, the report of the Advisory Committee on Health Research provided a useful benchmark and the same type of approach should be extended throughout the work of the Organization.

Mr MOEINI (Islamic Republic of Iran) said that he would appreciate greater clarification than was contained in section 2.1 of document PB/98-99 about the means WHO would use to mobilize financial and intellectual resources for health.

Dr DURHAM (New Zealand), commenting on women’s health and development under major programme 2.2, acknowledged the value of WHO advocacy in the full integration of women’s health in the development process. However, she believed that WHO should act as a role model in terms of the allocation of resources to the work, the participation of women in WHO’s activities and the incorporation of “gender analysis” in its development activities and policies at the global and regional level. She did not consider that WHO’s rhetoric was matched by investment or action. That represented a very significant missed opportunity in terms of WHO’s capacity to improve global health and reduce inequality in health.

Professor LEOWSKI (Poland) said that the products and projections in the two major programmes under review were well expressed in general terms, but he regretted the lack of any yardstick for evaluating their implementation in the next biennium. Noting that the provision under the regular budget for the two programmes was some US$ 10 million less than in the previous biennium, with extrabudgetary funding unchanged, he asked for some indication as to the fields in which problems could be expected as a consequence of the cuts.

Professor ABERKANE (representative of the Executive Board) observed that it had frequently been stressed in discussions in the Board that activities for women’s health, security and rights should play a strategic role in the development of community health care. The budget cuts that had been made in certain areas arose from the Organization’s financial difficulties and the consequent problem of giving adequate budgetary expression to agreed priorities.

Dr HAMMAD (Health Policy in Development), responding to comments, explained that a programme area named Health in public policy had been established in pursuance of the Ninth General Programme of Work.
It had contained a programme element on Health in socioeconomic development, whose main task had been threefold: to establish the extent to which health was fostered or compromised by development policies, to advocate the inclusion of health components in development, and to articulate human rights implications for health in concrete terms. The unit concerned had been disestablished in consequence of the budgetary reductions, but some of its activities were to be incorporated into WHO's existing programmes. The Global Commission on Women's Health would come within the purview of Family and reproductive health and the task force on health in development would report to the Deputy Director-General ad interim. Human rights questions had been handled in response to need with extrabudgetary funding but there was no specific programme for that topic.

Mr AITKEN (Assistant Director-General) added that the Health in socioeconomic development programme had traditionally been financed through a mixture of regular and extrabudgetary funding, with the latter recently predominating. The difficult decision had been taken to integrate the activities in question into the other work of the Organization so far as staffing was concerned, and an amount of approximately US$ 300 000 was available for allocation by the Director-General to assist the mainstream programmes involved. As was said in document A50/4, paragraph 23, funds from the Director-General’s Development Programme could also be used, as appropriate, to finance certain necessary activities. The fact was that, at the request of the governing bodies, 2% of the headquarters budget, including the funding for the posts under discussion, had been transferred to country programmes. However, the Director-General intended, subject to availability of funds, to “unfreeze” certain existing posts in areas to which responsibility had been transferred, in order to maintain some of the “intellectual memory” necessary. A review of the new modus operandi would be carried out at the end of 1998.

Answering the delegate of the Islamic Republic of Iran, he said there was only a small focus under major programme 2.1 concerned with external coordination and resource mobilization and that in fact the whole range of the Organization’s work was devoted to those tasks. The strategy was to involve all potential associates - governments and civil society - in the work of the Organization, not necessarily as donors, but as partners in the work with Member States. More and more partners in civil society should be regarded as potential beneficiaries, inputs and resources of the Organization.

Dr KONÉ-DIABI (Assistant Director-General), said that health systems reform was an integral part of the activities of all health systems in order to render them more efficient and effective as well as more equitable and sustainable for the populations concerned. WHO had already taken steps in recent years to strengthen its capacity in that respect. The first of those, taken in 1995, had involved placing under one Assistant Director-General the division concerned with health infrastructures and the initiative on intensified cooperation with countries. A recent evaluation had shown that reorganization of the work had led to more than 80% of the activities benefiting the countries in greatest need. The second step had been the reorganization of three other divisions in 1996, and the strengthening of programming missions in the regions to ensure that headquarters planning took account of the priorities of the countries and regions and reflected the complementary nature of the three levels of WHO. A common strategy on health systems throughout the Organization had been sought in order better to focus WHO’s efforts on health systems. Furthermore, discussions had been held with the technical programmes with a view to achieving horizontality between the health systems development programme and the technical programmes and to eliminating fragmentation and a vertical approach at the country level. As a third step, the Executive Board had set up an ad hoc working group on health systems development for the future, which had looked into ways of strengthening WHO’s capacities. Important recommendations on analyses, studies and operational initiatives would be submitted to the Executive Board at its 100th session. Clearly, no strategy, however excellent, could be successful without a commitment on the part of the principal players and without adequate financial and human resources. If WHO was to contribute to the changes necessary in health systems in the countries, those resources would have to be made available to its health systems team.

As to the mobilization of national resources, the commitment of the international community had to be matched by a commitment at the national level. There was no country, however small, in which resources, even human resources, could not be mobilized. It was intended to carry out an evaluation of the quantity and quality of resources available in national health systems and to develop a participatory approach designed to involve not only those in positions of responsibility in health systems, but the whole of the civilian population.
In the implementation of health system programmes, priority would be given in all countries to making use of national resources and encouraging the private sector to become involved in efforts to develop health systems.

Dr MANSOURIAN (Office of Research Policy and Strategy Coordination) said that the apparent contradiction in paragraph 18 of document PB/98-99, to which the delegate of Zambia had drawn attention, was probably due to the editorial need for concision. The package of public health measures and essential clinical services was certainly favoured but, even so, more research was needed to bring down the cost of technology and reduce the gap between rich and poor.

The points made by the delegate of Australia were well taken. In fact, taking trends over the previous 20 years, the proportion of the regular budget devoted to research and related activities had fallen from 5% to 0.5%. Yet, over the same period, the amount of extrabudgetary funds had risen from a few million to over 200 million US dollars. It was important to take that into account, as well as the greater involvement of the WHO regions in research. Regarding her comment on the enumeration in the Constitution of WHO’s functions, he observed that the relatively little-quoted Article 18 (k) - on the functions of the Health Assembly - seemed to indicate a way of promoting research partnerships between WHO and many other institutions. He agreed with her remarks on the wealth of knowledge and capacity for research available in the world. About US$ 450 000 million was spent worldwide each year on research and development, of which about 12% was health-related. Approximately half of that amount was spent by industry and half by national institutes of health. Clearly it was essential to establish some form of association with all such partners.

Regarding priorities, there was considerable debate between the advocates of priority-setting in research and those who favoured grasping opportunities as they arose. However, WHO had institutional mechanisms at the global and regional levels to deal with such issues, namely the global and regional advisory committees on health research, a network which harmonized research activities with the Organization’s programme delivery.

Research was an inseparable part of WHO’s programmes, serving their promotion and implementation.

Dr ANTEZANA (Deputy Director-General ad interim), responding to comments on the task force on health in development, remarked that there was generally agreement about the importance of having an external group thinking about WHO’s future policies and strategies. The time had come to reflect on the views expressed by delegates and consider ways of achieving the requisite improvements in the Secretariat’s structure and functions, especially with regard to human rights and other matters such as the Global Commission on Women’s Health and women’s health and development, not only in the next biennium but in the more distant future. The task force and the activities in programme 2.1 would be given a new look, using the resources mentioned by Mr Aitken and in the light of the discussions in the Health Assembly and further consideration by the Director-General.

He assured the delegate of Canada that there was no intention to duplicate CIOMS work on ethical issues but rather to strengthen its activities and encourage its continued collaboration with WHO. In response to the comments of the delegate of Zambia concerning paragraph 8 of document PB/98-99, he explained that the matter of WHO’s mission would be explicitly addressed during discussion of the renewal of the health-for-all strategy under item 26.1 of the agenda. Whereas the programme budget discussion did not necessarily reflect all the concerns of Member States, the future policy which would influence the Tenth General Programme of Work and future programme budgets would do so.

Professor ZAHRAN (Egypt), welcoming Dr Antezana’s comments and the spirit of openness of the programme budget procedure which still left room for accommodation of various viewpoints, noted that specific programme 2.2.1 (Health in socioeconomic development) was extremely complex owing to its multidisciplinarity. Over the years WHO had been developing the technical skills needed to deal with the topic. For instance, since women’s issues had been placed on the policy agenda only at the 1994 International Conference on Population Development, most countries had not finished formulating the necessary policies. The task force should therefore continue to follow up on its recommendations. Since it would be wasteful to disperse the valuable expertise in WHO by integrating it into other programmes, he considered that that programme and its staff should be maintained and suggested that it should be funded from resources provided by savings on other activities, such as the Organization’s liaison functions.
2.3 National health policies and programmes development and management
2.4 Biomedical and health information and trends

Dr AL-SAIF (representative of the Executive Board) said that the Board had noted with concern the budgetary changes proposed for major programmes 2.3 and 2.4 in 1998-1999. Specific programme 2.3.1 (Technical cooperation with countries) received a substantial budgetary increase, whereas specific programme 2.3.2 (Collaboration with countries and people in greatest need) suffered a considerable decrease. That could have a significant impact on Africa and, more generally, on countries in greatest need. Given that specific programme 2.3.2 had been identified as a major priority policy area by the Executive Board, the Board had wondered whether it would be provided with the resources to continue its activities. It had been explained that changes in resource allocations were taking place in the countries of some regions owing to the improved capacity of health infrastructures. However, the Board believed it was essential for WHO to develop its collaboration with countries, particularly those in greatest need, where the strengthening of self-reliance in health development required more resources. Furthermore, all the regions had requested more support for WHO country offices and the regional committees had approved a projected increase for that purpose.

Regarding major programme 2.4, the Board had discussed in detail the importance of WHO’s work on the International Statistical Classification of Diseases and Related Health Problems (ICD). Some members of the Board believed that the severe budgetary restraints proposed would disrupt work in that field. Assurances had been given that the ICD programme enjoyed close and fruitful cooperation with some 10 collaborating centres and it had therefore been possible to maintain activities while exploiting the opportunities provided by new information technologies. Nevertheless, the Board was concerned that sufficient resources should be made available in order to coordinate work with the collaborating centres and to promote ICD development.

Mr MOEINI (Islamic Republic of Iran) noted the reference made in the table in section II.1 of document A50/4 to the necessity, in providing strategic support to countries and peoples in greatest need, of mobilizing all national and international resources. Although recognizing that, as a specialized agency, WHO could play a major role in that respect at the international level, he wondered whether it was possible to achieve that objective at the country level in view of the great differences in national circumstances and regulations. In the same table, in connection with supply services, he noted that the objective was to “provide, at the lowest possible cost, appropriate equipment and supplies”, and asked for clarification concerning the criteria for deciding what supplies or equipment were appropriate for what countries.

Dr LARIVIÈRE (Canada), referring to major programme 2.3, welcomed the new emphasis on preparedness and coordination for emergency and humanitarian action, which was consistent with his country’s long-standing request. His concern about WHO’s efforts to respond to the countries in greatest need and to further the development of health systems had been allayed by the data contained in document A50/4 and the clarification provided by Dr Kone-Diabi.

Turning to programme 2.4, he said that one of the Organization’s most visible products was The world health report. Its excellence clearly depended on the availability of timely and accurate health information, as did that of the many valuable printed products of other WHO programmes. Such excellence could be manifest only if it remained based on strong programme activities. He also welcomed the work done with regard to biomedical and health information and trends, which, although essential for programme support, had not always been given the visibility and recognition it deserved.

Dr MOREL (Brazil), while praising the efforts made to publish and disseminate relevant biomedical and health information, such as The world health report and the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), sought clarification regarding the policy governing the distribution and sales of such basic WHO reference material and information. The printed and diskette versions of ICD-10 were currently available at 300 and 600 Swiss francs respectively, whereas they should be actively disseminated, possibly on the Internet, free of charge.

Dr VAN ETTEN (Netherlands) expressed his concern about the proposed budget for specific programme 2.3.2 (Collaboration with countries and peoples in greatest need). Since the Director-General had been unable
to maintain the budget at the current level, he suggested that additional funds should be made available for that programme from elsewhere within appropriation section 2.

Regarding specific programme 2.3.1 (Technical cooperation with countries), the new text contained in document A50/4 was not entirely convincing. He stressed the importance of such technical cooperation and endorsed the Canadian delegation’s view that emergency and humanitarian action was vital, although not all countries needed that type of support. It was also important for WHO to work with other agencies at the national level, especially in the area of technical cooperation. In short, there should be a better balance between specific programmes 2.3.1 and 2.3.2.

Dr BOUFFORD (United States of America) recalled that members of the Executive Board had expressed serious concern about the dramatic reduction of resources earmarked for work on the International Statistical Classification of Diseases and Related Health Problems (ICD) and had been reassured that a core professional staff would be retained. However, she had subsequently been informed by members of the collaborating centres in her country and elsewhere, who were extensively involved in the technical work on ICD, that they were still concerned about WHO's ability to sustain its leadership role as convener and coordinator of the expert collaborating centres to maintain the internationally agreed classification of diseases which was fundamental to all countries' health services research and planning. She therefore requested clarification and reassurance regarding the status of support for ICD.

Dr THIERS (Belgium), referring to programme 2.3, regretted that the figures provided did not indicate what proportion of the budget would be devoted to strategic support to countries and peoples in greatest need and what proportion to emergency relief operations and humanitarian action. He would like to see higher priority accorded to the former; that would be consistent with the United Nations vision of lasting and sustainable development and with the major role that WHO should play in long-term, rather than short-term, health development.

Professor WHITWORTH (Australia) referred to specific programme 2.3.1 (Technical cooperation with countries), which largely financed the operation of country offices. Expenditure on that programme would be doubled to a proposed US$ 78 million in 1998-1999, which represented the largest single increase in the budget document. There might be some reduction of that sum in the revision in document A50/4, but the tables there were not sufficiently detailed to be enlightening. Data provided at the ninety-ninth session of the Executive Board had shown that financing of country offices accounted for one-fourth of all funding to countries and about one-twelfth of the regular budget. In view of the cost of country offices, WHO should consider carefully where they were required and where more cost-effective alternatives, such as liaison offices, might be used. The cost of running a country office was usually over US$ 500 000 and could be more than US$ 1 million, whereas operation of the liaison offices in the European Region, for instance, cost about US$ 50 000 per biennium. Country offices clearly played an important role in countries in greatest need, where the health systems required considerable support and where resources for health had to be marshalled and coordinated. They might no longer be required, however, in middle-income countries or, for instance, in a member State of OECD. It might be fruitful, both strategically and financially, to consider the continuing need for WHO representation, or rationalization of the level of that representation, as the status of a country developed. Close technical assistance in the field might evolve to simply drawing on WHO's expertise in specific areas, and the nature of the link with WHO might change from a country representative to a locally recruited liaison officer or even to contact through a regional centre.

One of the products, mentioned in paragraph 25 of document A50/4, of the specific programme for technical cooperation with countries was regular monitoring of the criteria for establishing WHO country offices. She suggested that the wording should be modified to include criteria for the retention or reduction of such offices or a change in the level and type of national presence. She also recommended that the roles of country offices be reviewed, so that their functions and costs could be adapted as countries developed and their needs became less pressing.

She agreed with the delegate of the United States of America about the essential global function of the International Classification of Diseases.
Professor ZOUGHAILECHE (Algeria) noted with regard to programme 2.3 that in paragraph 31 of document PB/98-99 mention was made of the difficulty of devising innovative strategies to involve more policy-makers, leaders within civil society, and the media. In his country, where the intersectoral approach had predominated in health policy for several years, health professionals were often discouraged by finding themselves working alone in seeking solutions to health problems. For example, it was difficult to mobilize local communities for the control of water-borne diseases and zoonoses. WHO should promote the concepts of coalition and intersectoral cooperation among groups with shared goals; each group gained from such collaboration and disseminated information about successful projects widely to other countries, particularly within the same region but also outside it where there were similar problems.

Referring to programme 2.4, he suggested that, although the information provided by WHO was invaluable, the information policy of the regional offices might be reoriented towards health priorities defined at the regional level, by providing training in information techniques within regional projects through a network of regional reference centres, “observation” or “sentinel” posts and early-warning and intervention systems. Such a network could not only assist WHO in acting rapidly but would also ensure a more active role for the regional offices.

Mr POINSOT (France) noted that the proposed budget for specific programme 2.3.2 (Collaboration with countries and peoples in greatest need) showed a reduction of nearly 50%, from US$ 13 499 000 in the current biennium to US$ 7 452 000 for 1998-1999. He asked for an explanation of that drastic cut in a priority area and urged that the Director-General should consider maintaining the current level of financing.

Dr SULAIMAN (Oman) said that country offices played a fundamental role and could not be replaced by liaison offices. The latter served to facilitate certain missions and activities but were not essential. Country offices were crucial for assisting ministries in implementing WHO programmes.

Dr MAJORI (Italy) commented that poverty was a growing global problem. WHO should help countries to find solutions, as research had shown that the health sector played an important role in reducing poverty. His country had always supported the WHO initiative for intensified cooperation with countries in greatest need and wished to see work in that area expanded to address the needs of the poorest in all countries, especially those involved in wars and internal conflicts.

Dr SAMBA (Regional Director for Africa) expressed his gratitude for the assistance given in response to emergencies in Africa by WHO headquarters, multilateral and bilateral organizations including those of the United Nations system, nongovernmental organizations and civil society. The disease outbreaks in Africa were not limited to the classical infections such as poliomyelitis, meningitis and yellow fever but were complex epidemics necessitating emergency action. Africa now had the greatest number of refugees - more than five million - and the greatest number of internally displaced persons - more than 27 million - of any region. The role of WHO in Africa had thus become extremely important. During the early health crises in Ethiopia, WHO had been told to concentrate on long-term development and not to concern itself with emergencies. Now, the majority of countries facing emergencies were in Africa and WHO was very closely involved. Teams from most of the rapid intervention systems of the United Nations arrived after an emergency had begun, the time taken often being related to the extent of media coverage. WHO was constantly present in all 46 countries of the Region, in the form either of a country office or of a liaison office. Representatives were therefore present before an emergency; they could sometimes predict it and thus help the countries, other United Nations agencies and bilateral organizations to prepare for it. That had been the case in Zaire. WHO assisted during an emergency by providing the health component, which often did not arrive at the same time as food supplies and other equipment. The Organization was also present after the emergency, to assist in reconstruction and rehabilitation and to ensure that the situation did not become chronic. Emergencies generally started suddenly but they tapered off slowly. Specific programme 2.3.4 (Emergency and humanitarian action; relief and rehabilitation operation and emergency preparedness) should therefore be given prominence both in the regular budget and in activities financed from extrabudgetary resources.

As Africa contained the largest number of countries in greatest need and the largest number of least developed countries, the usefulness there of WHO country offices was not in doubt. Liaison offices in Africa, however, were different from those elsewhere in the world. They were usually just as expensive and complex
technical cooperation, providing advice to ministries. In what was known in the African Region as "micro-technical" cooperation, WHO liaison officers were sometimes the only medically qualified personnel available. They might be involved in procurement and even in direct action. He himself had had to perform an emergency operation recently, although he had not practised as a surgeon for many years. Country and liaison offices were vitally important in Africa.

Dr BASSANI (Division of Emergency and Humanitarian Action) said that a good balance had been struck in the work of his division between the normative aspects of preparedness and operational relief activity. WHO should not duplicate the effective actions of other United Nations agencies but complement them in the field of health. When it intervened in an emergency, development also had to be considered. His division was working in close collaboration with the initiative for cooperation with countries in greatest need, which were those most heavily affected by emergency events. In order to ensure external coordination with the United Nations system, WHO was involved in the Interagency Standing Committee of the Department of Humanitarian Affairs and in the discussions and resolutions of the Economic and Social Council of the United Nations; a memorandum of understanding had been signed with the Office of the United Nations High Commissioner for Refugees. His division had been reorganized several months previously in order to respond better to the needs and concerns of Member States.

Dr VARET (Assistant Director-General), replying to questions concerning major programme 2.4, thanked the delegate of Canada for his recognition of the work of the Divisions of Health Situation and Trend Assessment and of Publishing, Language and Library Services, which was carried out in order to fulfill constitutional obligations but which had been affected by large budgetary reductions. Work connected with the Tenth Revision of the International Classification of Diseases (ICD-10) was to be carried out with the help of two consultants and an expanded Secretariat, in association with 10 collaborating centres, internal WHO programmes and the regional offices, with four objectives. The first was to make ICD-10 available as widely as possible, since it was an essential tool for comparing the results of WHO programmes; without it, the collection of data would be meaningless. In the coming months, ICD-10 would become available in Russian and Arabic, in addition to the versions in 27 languages that had been prepared by Member States. A second objective was to provide training in the use of ICD-10 at collaborating centres in Australia, Sweden and the United Kingdom and at the regional offices for the Americas, the Eastern Mediterranean and the Western Pacific. The third aim was to promote wider use of ICD-10. The International Classification of Diseases was used for mortality classification in 68 Member States and the Tenth Revision had been adopted by 28. The goal was to ensure that the majority of the Member States of WHO were using ICD-10 by the year 2000. The fourth objective was to prepare a long-term strategy to define priorities. That strategy would be presented at the next meeting of the ICD collaborating centres in Copenhagen in October 1997, so that the resources necessary to implement it could be decided upon. With regard to the price of ICD-10, WHO's long-standing policy was to facilitate dissemination of its publications to the countries in greatest need, so a reduction of 30-50% was accorded in such cases. The classification was to be made available on Internet and CD-ROM, but paper versions were needed so that it could be used in the countries in greatest need.

With regard to the surveillance of diseases, the delegate of Algeria had suggested that the setting-up of regional "observation" or "sentinel" posts to collect information might be a useful complement to the existing arrangements. It was the responsibility of each country to collect data, and regional offices had epidemiological consultants who could assist in validating them. Regional databases provided comparative data at the regional level. In order to develop a global health policy, databases had also to be maintained at headquarters, to ensure their comparability and their validation by the same methods. Such tools were necessary to ensure publication of The world health report. The volume to be published in 1998 would include an evaluation of implementation of the strategy for health for all by the year 2000 at country, regional and global levels, which would be related to the global health situation and thus provide WHO with a strategic overall view.

Mr AITKEN (Assistant Director-General), replying to a question from the delegate of the Islamic Republic of Iran, said that WHO had two approaches to the provision of supplies. In the case of what was called "reimbursable procurement", a Member State used WHO's expertise and advice but provided the money for the purchase of supplies; the final decision on which materials were bought was made by the country. When WHO
used its own funds to purchase supplies for a country, a decision about which materials were necessary was reached by WHO itself after full discussion with the national authorities.

Replying to the delegate of France concerning the reduction in the budget for specific programme 2.3.2, he said that it was mainly due to the transfer of some allocations within regional budgets to other regional items, after consultation with the regional committees and regional directors. As the heading was seldom or never used in some regions, the funds had been transferred, for instance, to direct country support. The work on collaboration with countries and peoples in greatest need would, of course, continue.

(For approval of draft resolution, see summary record of the ninth meeting, end of section 1.)

**Appropriation section 3: Health services development**

3.1 Organization and management of health systems based on primary health care

3.2 Human resources for health

Professor ABERKANE (representative of the Executive Board) said that when considering appropriation section 3, the Executive Board had noted with concern a substantial drop in regular budget allocations and extrabudgetary resources both at headquarters and in certain regions for major programmes 3.1 and 3.2, both of which were deemed to be priorities for the Organization. In some regions, the reduction was attributed to the allocation of funds to other primary health care sectors. The Board had indicated that the Secretariat should find more efficient methods of concentrating funding on areas identified as priorities by the Board itself and by the Health Assembly.

The Board had noted that, in the Eastern Mediterranean Region, primary health care was seen as a comprehensive programme covering not just health systems but also health education, nutrition, sanitation, essential drugs, maternal and child care, the Expanded Programme on Immunization and many other activities. Consequently there had been no real reduction in the budgetary package allocated to primary health care. Programmes in that area had been successful, with sufficient national resources being devoted to it so that there was less need for WHO's support. In the African Region, the Board had noted that activities connected with essential drugs were handled mainly at country level, and that since the country-level budget was decentralized, the programme budget document did not fully reflect all the activities envisaged. In the South-East Asia Region, much progress had been made in the provision of essential drugs; accordingly, some of the funds usually allocated to that programme could be channeled to other elements of primary health care. The European Region also had a reduced budget for essential drugs, owing to success with the mobilization of voluntary contributions over the two preceding biennia. A 25% increase in allocations to major programme 3.1 was envisaged, and the Region had obtained a fairly satisfactory level of voluntary contributions for primary health care at country level. In the Western Pacific Region, the reduced allocation for major programme 3.1 corresponded to a change in requests for funding during the next biennium for country-level activities relating to district health systems.

At global level, efforts had been made to improve: the coherence of programmes connected with the development of health systems for primary health care, including appropriate development of human resources; to promote interregional coordination of country support; and to strengthen the strategic function of research and development in responding to the long-term consequences of transformations in health systems.

Professor BERTAN (Turkey) said that programme 3.1 provided detailed and welcome information on the world situation and targets, the main achievements, and constraints connected with the organization and management of health systems based on primary health care. Though many meetings had been organized and activities undertaken, their impact had not been evaluated. WHO should be active in helping countries to select the most appropriate approaches or interventions, based on the lessons learned from previous activities. Evaluation of the results of seminars, conferences and research in specific areas would be helpful in that regard. She hoped an impact evaluation of various activities would appear in future documents.

Dr KILIMA (United Republic of Tanzania) noted that most countries were at present involved in health sector reforms focusing on the installation of organizational and management structures to respond to the health needs of communities while promoting equity in health for all. As such structures - particularly for
strengthening district-level services - required resources beyond the means of most countries, WHO should work closely on the reforms with Member States. More resources would definitely be needed at all levels for that purpose. Health care packages, whether public health or clinical, could yield the required products only if they were delivered within the right environment, meaning the right organizational set-up. The overall reduction in resources under appropriation section 3, especially at the current juncture, was therefore inexplicable.

Dr VARGA (Hungary) said that Hungary supported WHO's efforts to elaborate and disseminate guidelines for quality assurance in hospitals and health centres, but thought it equally important to broaden that work to cover primary health care, including home care and other basic activities.

Ms McCOWAN (United Kingdom of Great Britain and Northern Ireland) said there was increasing recognition that restructuring, decentralization, health insurance and cost recovery were key issues facing all health systems, and that sector-wide approaches and health sector reforms were being increasingly emphasized by countries themselves, bilateral donors and multilateral institutions. The United Kingdom considered it vital for WHO to play its full part in such initiatives, but was not convinced the Organization needed to spend precious funds on helping countries to analyse the major policy options when there were so many other potential sources of funding, such as the European Union and the development banks, which had built up a considerable body of expertise. Though both the regular and the extrabudgetary proposals envisaged cuts for the current biennium, WHO should review the portion of the overall appropriation earmarked for health sector reform. At the very least, assurances must be given that the Organization was not duplicating work being done elsewhere.

Dr BOUFFORD (United States of America) expressed her conviction that WHO needed a robust programme for research and development, exchange of experiences, advocacy and technical assistance to ensure adequate information sharing in support of ministries of health and governments, especially those of countries in greatest need, as they sought to cope with the dramatic changes in the health sector throughout the world. The Executive Board had emphasized the need to ensure sustained WHO leadership by establishing an ad hoc working group on health systems development for the future. The integration of disease-specific or population-specific programmes into a conceptual and operational framework at country level that was consistent with a country's preferred model for personal care as well as with its public health structure was vital to success in developing health systems infrastructure. The importance of such infrastructure in achieving success with other, more eye-catching programmes was often overlooked. Vigilance was needed to ensure that WHO retained leadership in ensuring that countries had the support they needed to develop the kinds of health sectors and systems they wished for their populations.

Dr LARIVIÈRE (Canada), referring to major programme 3.2, pointed out that the overall regular budget allocation for human resources development represented roughly 7% of the total regular budget, reduced from about 10% a decade previously but still an extremely significant share. The main modality used by WHO in that area was fellowships, which in recent years had been closely scrutinized by the External Auditor and the Executive Board. The gradually decreasing level of resources available for fellowships was offset by better planning, improved selection of candidates, interregional training and efforts to ensure that newly acquired skills were put to good use within countries upon the return of the fellows, all of which ensured better value for money. There was always room for improvement, but his delegation was pleased with the progress made in effective use of fellowship resources.

He stressed the vital role played by WHO in respect of nursing. Some progress, though not as much as could have been hoped for, had been made in implementing the full provisions of resolution WHA45.5, and an important contribution had been made by the Global Advisory Group on Nursing and Midwifery.

Dr SIKOSANA (Zimbabwe) noted with concern the real reduction in funding for programme 3.1. Countries in greatest need were currently undertaking health sector reforms with a view to maximally and efficiently providing access to quality care for their populations. Those reforms would entail additional responsibilities and leadership requirements for WHO, as well as a need for increased technical assistance. His delegation therefore called for the intensification of support to the programme.
Mrs DHAR (India) said that her country had made substantial progress in health reform, especially through a development project aimed at the strengthening of district and subdistrict health systems and initially covering a population of over 200 million. India was also working on a project to strengthen capacity in the drugs, pharmaceuticals, food safety and vaccine sectors. On health financing, it had taken a policy decision to open the health insurance sector to private enterprise. Two public sector companies currently offered a package of health insurance services. India would like guidance, however, from other developing countries on their experience with health insurance. When vast numbers of people were still too poor to afford health insurance, other means had to be found.

On human resource development, she noted that there were WHO collaborating centres and centres of excellence in India. In order to ensure that they were put to good use, fellowship training within the South-East Asia Region and perhaps also in the Eastern Mediterranean Region could be organized. India was also prepared to open up its own excellent institutions as a way of implementing fellowships.

Mrs AL-RIFAI (United Arab Emirates) remarked that paragraphs 57 and 58 of the proposed programme budget outlined WHO's efforts to assist the development of health personnel, particularly midwives and nurses. Such assistance by WHO had yielded positive results in many countries. Yet a reduction in funding for such activities was now being suggested. She called on WHO to pursue its efforts to benefit nurses and midwives: otherwise the momentum and experience gained might be lost.

The meeting rose at 12:30.
THIRD MEETING

Wednesday, 7 May 1997, at 14:30

Chairman: Mr K.R.C. PILLAY (Mauritius)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999: Item 17 of the Agenda (continued)


Appropriation section 3: Health services development (continued)

3.1 Organization and management of health systems based on primary health care (continued)
3.2 Human resources for health (continued)

Dr PHILLIPS (Jamaica) observed that in the experience of certain countries, including his own, the health reform process, to which WHO assigned priority, often encountered the constraint of inadequate human resources. It was therefore with some concern that he noted the reduction in the budgetary provision for programmes 3.1 and 3.2. It was to be hoped that adequate resources would be made available “to modify the scope of practice of existing categories of health-care workers and to experiment with new combinations of workers to meet needs more effectively” (paragraph 55 of the proposed programme budget), an urgent task at both national and regional levels. Little mention had been made of the possibility of achieving a balance between countries with a surplus of human resources in some professions and others with a deficit. WHO could effectively help to put countries in touch with each other to achieve such a balance, perhaps through short-term training assignments. However, if the budgetary provisions for meeting specific human resource needs were inadequate many efforts to achieve health reform would result in disappointment.

Ms CANNON (Brazil) stressed the importance of information systems in the organization and management of health systems, notably as a reliable basis for planning, evaluation and decision-making, to ensure that the most appropriate policy options were taken. WHO could play a key role in helping countries to organize their own health information systems, especially those countries that were in the process of decentralization and health economic evaluation and that were seeking higher levels of efficiency. It could also provide valuable support for human resources development.

Dr KALITE (Central African Republic) spoke of the need in Africa to reorganize and restructure health services so as to increase their efficiency and their accessibility, especially to the rural populations. The implementation of the new policy was however, encountering difficulties: lack of financial resources, quantitative and qualitative inadequacies in human resources, and training which was often ill adapted to the new functions required. He joined with the delegates of the United Republic of Tanzania, Zimbabwe and other Members in calling for more sustained attention to programmes 3.1 and 3.2 with a view to achieving effective consolidation and restructuring of the health services in African countries.

Professor LEOWSKI (Poland) suggested that the section of the proposed programme budget under discussion appeared to be more concerned with the development of medical than of health services. It did not
cover the whole spectrum of health care services, which was extremely broad, ranging from such areas as immunization, health promotion, preventive care, food handling and school health to social and medical care of the elderly and the chronically ill, diseases related to age or unhealthy lifestyles, etc. Within that spectrum, public health services had an important part to play in the provision of health care, and health professionals, in determining their current and future obligations, must find an appropriate balance between individual and community health care and between curative, preventive, promotive and restorative care.

Dr OTTO (Palau), referring to programme 3.2, said that in small and developing island nations, capacity-building in human resources for health was one of the most pressing needs: he therefore noted with some disappointment the decrease in the allocation for fellowships, even though the need for budgetary constraint was understandable. He expressed gratitude to the WHO Regional Office for the Western Pacific for its assistance to his country in that area, and welcomed the recognition of the Fiji School of Medicine as a centre of excellence in the Region. He also wished to acknowledge the assistance given and contributions made by the Governments of Australia, New Zealand and the United States of America.

Professor GRANGAUD (Algeria) referring to programme 3.2, said that there always tended to be a discrepancy between the model proposed to staff during their training and the reality which they subsequently experienced in their professional lives. In fact the dominant model was often hospital-focused, emphasizing the technical aspects of training rather than the socio-anthropological and psychological aspects. His country was therefore in the process of introducing socio-anthropological aspects into training, particularly in maternal and child health. The relevance of training, which was one of WHO’s main concerns, should be further improved in the future.

Dr ABDUL WAHAB (Bahrain) said that although there had been some success in the development and management of Bahrain’s primary health care programme, there was much to be done before the objectives for the Eastern Mediterranean Region were attained, particularly in human resources development, which was still dependent on imported expertise. As a result of the economic crisis, Bahrain was still in need of technical and financial assistance from WHO to meet needs and to implement health programmes, especially with regard to human resources.

Dr KONÉ-DIABI (Assistant Director-General) thanked speakers for their comments. Replying to the delegate of Turkey, she said that impact evaluation was an important component of WHO’s work. The Health Systems Development Programme, together with the Division of Health Situation and Trend Assessment, had established and would refine indicators which could be used to measure the impact of WHO’s programmes at the country level and a monitoring and evaluation unit had been set up which worked in close collaboration with the Division of Development of Policy, Programme and Evaluation. The importance of achieving the balance between individual and community health care referred to by the delegate of Poland, was being borne in mind in establishing the essential strategies for health systems development.

Dr TARIMO (Division of Analysis, Research and Assessment) said that many agencies were involved in health sector reform, and WHO would cooperate with countries in ensuring effective complementarity of the assistance provided through those agencies. In looking at ways of financing health services, for example, WHO had been working in collaboration with countries and regions to document different types of health insurance, and a number of guiding principles had been established. Moreover, ILO and WHO had produced a guidebook on social health insurance and WHO was working with the regional offices to document the various ways of providing adequate health insurance for vulnerable sections of the population in developing countries, in particular in rural areas and in the non-formal sector, with a view to disseminating relevant information to individual countries. WHO had proved successful in conducting that type of analysis, which was not generally carried out by other agencies.

WHO recognized the importance of integration of primary health care with other health programmes, and numerous joint activities were under way, for example in the areas of maternal and child health, malaria, leprosy, tuberculosis, HIV/AIDS and vector control; an integrated approach to medical care and public health was also essential. Programme 3.1 was aimed at enhancing organizational arrangements to ensure such integration.
Dr GOON (Division of Organization and Management of Health Systems) added that WHO recognized that health system reform must change the scope of practice of the health workforce. It was establishing a core of experts in each region to deal with the broader issues of human resources at the regional and country levels.

WHO was striving to provide better value for money in the fellowships programme, and a report on fellowships would be submitted to the Executive Board in January 1998. With regard to the offer by the delegate of India to open up the country’s institutions as a way of implementing the fellowships programme, he recalled that the Regional Directors had indicated in the past that they would give priority to the placement of fellows within their respective regions.

Dr UTON RAFEI (Regional Director for South-East Asia) said that, in order to assess the efficiency and effectiveness of WHO’s input to national health development through programme 3.1, the Regional Office had launched an evaluation exercise with the full involvement of the Member countries of the Region and cooperation from headquarters. The findings, which would be reported to the Regional Committee in September 1997, would serve as a basis for developing detailed action plans for the 1998-1999 biennium and for formulating the 2000-2001 programme budget.

In his Region, fellowships were integral components of the various technical programmes, thus ensuring their relevance to programme needs. The budget allocation of approximately US$ 300 000 was used to support staff and coordinate activities relating to the management of fellowships and other training activities. In that context, the policy was to promote and encourage intraregional and intracountry training in order to minimize expenditure on sending fellows outside the Region. WHO collaborating centres and national centres of excellence were also involved in training WHO fellows within countries and within the Region. A regional meeting of WHO collaborating centres was scheduled for August 1997 to discuss strategies and workplans for human resources development in the areas of reproductive health and emerging and re-emerging diseases. The Regional Office had also promoted and facilitated bilateral intercountry cooperation with a view to establishing a joint action plan to promote human resources for health.

3.3 Essential drugs
3.4 Quality of care and health technology

Dr AL-SAIF (representative of the Executive Board) said that, although programme 3.3 was a recognized priority programme, the proposed regular budget allocation had decreased in most regions for a number of reasons: the significant progress made in many national procurement and quality control programmes for essential drugs had made some shifting of resources possible, extrabudgetary funds had been obtained for some priority programmes, and essential drugs activities were being conducted as part of primary health care in several regions.

With regard to programme 3.4, the Board had discussed the role and input of WHO collaborating centres and the way in which the programme worked with national health technology assessment programmes. The Board had heard that the expertise of the collaborating centres and the results of national health technology assessments were used extensively and effectively, particularly in Europe and the Americas. Programme 3.4 coordinated the information and made it available, particularly to developing countries. The Board had noted that new technologies were not always suited to local needs and that quality of care in relation to health technology had been a matter of concern in some contexts.

Mr COLLA (Belgium) referred to a draft resolution which Belgium was submitting for discussion under agenda item 19 (Implementation of resolutions and decisions), but which was nevertheless relevant to programmes 3.3 and 3.4. It concerned the growing practice of selling pharmaceutical products direct to patients over the Internet. Belgium was not seeking to prevent that means of selling, but had evidence of a number of abuses connected with it, including the sale of time-expired or prescription-only drugs and of products which were potentially dangerous or had actually been banned in many countries. In other cases, incorrect information was supplied with the product. Such practices had obvious implications for quality control of pharmaceutical products and patient safety. The draft resolution called for the establishment of an ad hoc group to examine the

1 See summary record of the seventh meeting, page.
problem and submit draft guidelines for the prevention of abuses; Belgium would cover most of the costs entailed.

Referring to programme 3.4, Dr ITO (Japan) said that the setting of norms and standards in important areas such as food and drugs was an essential function of WHO and required a steady and consistent effort.

Dr LARIVIÈRE (Canada), noting that programme 3.4 had one of the lowest levels of extrabudgetary funding, welcomed the strategic approaches outlined in the proposed programme budget, but expressed concern at the lack of regular budget resources available for the important normative functions of WHO in relation to drugs and biologicals. An area which deserved further attention was that of medical devices.

Dr DINARVAND (Islamic Republic of Iran) expressed concern at the drastic reduction in the regular budget allocation for programme 3.3 in the Eastern Mediterranean Region, since access to high-quality and effective drugs was one of the most important elements in ensuring good health.

Ms STEGEMAN (Netherlands) also expressed concern at the substantial decrease in the allocation for programme 3.3, particularly in the African Region. With regard to programme 3.4, she called for greater attention to the urgent question of blood safety.

Speaking on programme 3.4, Dr SHE Jing (China) welcomed WHO's support for traditional medicine in national health policies. China had over 2500 traditional medicine clinics, and Chinese traditional medicine was accorded equal status with western medical techniques. Traditional medicine was a vital part of primary health care, particularly in rural areas, where it accounted for one-third of all consultations.

Traditional medicine was invaluable in the prevention and treatment of chronic and noncommunicable diseases, which were the theme of The world health report 1997. She hoped that WHO would continue its support for programmes of traditional medicine, and perhaps convene a world conference on the subject.

Dr LUETKENS (Germany) observed that the Action Programme on Essential Drugs had successfully combined bilateral measures, which directly supported individual countries or regions, with a global approach. He welcomed confirmation by the Programme's Management Advisory Committee that the strategies relating to national drug policy, health economics and drug financing, drug management and supply, rational use of drugs, and regulations and quality assurance would be maintained. He was pleased to note that additional activities in the areas of development of financing systems and promotion of rational prescribing practices were planned for countries which were adjusting to changing health structures, that activities in the area of traditional medicine were under consideration, and that the Management Advisory Committee would consider an evaluation of the suitability of the present selection criteria and an analysis of the efficiency of the Action Programme's global measures at its next meeting.

Dr AL-MADI (Saudi Arabia) said that health services must be designed to meet the needs of patients and must be suitable for the health professionals who provided care. In recent years, with the assistance of the Regional Office for the Eastern Mediterranean, Saudi Arabia had introduced programmes to develop health care and improve its quality in a number of specific areas. A special programme for monitoring and quality control of pharmaceutical products had been under way since 1993; a handbook of essential drugs had been produced and training courses held. He called upon WHO to provide more technical and moral support for the countries of his Region, particularly in the important area of training for health professionals.

Mrs SHONGWE (Swaziland) expressed her support for programme 3.4. The demand for higher-quality health care was growing all over the world, including the developing countries. WHO should give more support to the training of human resources for quality assessment, which could be linked with general human resources training. Swaziland had introduced a national quality assurance programme and a scheme for monitoring health care with WHO support, which it hoped would be maintained.

Dr ANTEZANA (Deputy Director-General ad interim), replying to the points raised, noted that most speakers had emphasized the importance of availability to all countries of safe and effective drugs, a matter
which had always been a WHO priority. WHO's normative functions in that area were largely financed from the regular budget, as it was essential to safeguard the interests of all Member States without any discrimination. In the area of food safety, the Organization had recently introduced activities which came under the direct responsibility of the Deputy Director-General. As the representative of Swaziland had noted, the demand for such activities came directly from countries themselves. Some speakers had expressed concern at reductions in the regular budget allocations in various regions. The Secretariat would investigate the matter further. WHO-sponsored activities in the field of traditional medicine were mostly undertaken by individual countries and WHO collaborating centres; the Organization was grateful for their efforts. The delegate of Canada had referred to quality control of medical devices. WHO had begun the process of classification, recommendation and assessment of such items, with the assistance of one of its collaborating centres and the Government of the United States of America. WHO greatly appreciated the contribution of Germany to the Action Programme on Essential Drugs. As the delegate of Germany had noted, the strategies were very effective, but the programme needed to adjust to countries' new challenges and needs.

Dr EMMANUEL (Blood Safety), answering the delegate of the Netherlands, said that, despite a limited budget, headquarters had cooperated successfully with regional offices to improve blood safety throughout the world. Distance-learning materials had been developed as a cost-effective way of training human resources. All WHO regions had now held workshops, and a total of 120 trainers from more than 70 countries had been trained in blood safety techniques. Efforts to raise additional extrabudgetary resources would continue.

Dr UTON RAFEI (Regional Director for South-East Asia) said that the proposed programme budget before the Committee showed that the allocation for programme 3.3 in his Region had been reduced by some US$ 400 000. However, after discussion by the Executive Board at its ninety-ninth session in January 1997, the allocation had in fact been increased to a figure approximately US$ 25 000 higher than that for 1996-1997. The regional allocation for programme 3.4 had been reduced by US$ 1 million because the assessments of specific health technologies were to be conducted by the individual programmes concerned, and the figure shown was only intended to cover the development of generic guidelines and standards. The regional allocation for traditional medicine activities had been reduced by US$ 150 000, since they were now mostly included within primary health care.

Appropriation section 4: Promotion and protection of health

4.1 Reproductive, family and community health and population issues
4.2 Healthy behaviour and mental health

Professor ABERKANE (representative of the Executive Board) said that the Board had requested a clearer definition of priorities in certain programme areas in appropriation section 4. There had been satisfaction that budgetary allocations to programme 4.1 were largely unchanged, particularly given the importance accorded to reproductive health, as demonstrated by the recent International Conferences on Population and Development (Cairo) and on Women (Beijing). The Board had questioned the wisdom of the proposed budgetary cuts in specific programme 4.1.7 (Occupational health), which might affect WHO's capacity to maintain the coordinating function required to implement resolution WHA49.12. Following a request from the Programme Development Committee to review the matter, the Director-General had explained that, given current constraints, it was hoped that the new approach to occupational health would be largely covered by the excellent network of collaborating centres and through effective cooperation with other programmes.

In considering programme 4.2, the Board had observed with satisfaction the progress made in health promotion, particularly through the model programme in schools and the healthy-city networks. It therefore welcomed the proposed increase for health education and promotion. The Board had expressed concern at the growing number of people affected by mental disorders arising from domestic or ethnic conflicts, unemployment and other stress-related situations, and had therefore welcomed the expansion of the mental health programme, in close cooperation with other organizations, within and outside the United Nations system, that had relevant activities linked to health education and promotion.
Dr LARIVIÈRE (Canada), while commending the improved internal coordination of reproductive health activities within the Organization, which was the result of restructuring undertaken during the previous year, voiced concern over external coordination in that area, in particular with other agencies of the United Nations system. He requested further information on action under the plan of cooperation among United Nations agencies arising from the Cairo Conference.

Programme 4.2 was a broad area which included control of tobacco consumption, clearly identified in *The world health report 1997* as the most important determinant of noncommunicable diseases and conditions. Canada had on a number of occasions urged WHO to strengthen its involvement in and support for national tobacco control strategies, and in resolution WHA49.17 the Health Assembly had requested the Director-General to support relevant activities at country level through the elaboration of a framework convention on tobacco control. He hoped that 1998 action plans would reflect the importance Member States attached to the role of WHO in that area.

Indicating his surprise that WHO's public relations activities, which supported all programme areas at all levels, had been classified within one specific programme area (4.2.4), he asked what was the strategic value of that decision.

Dr MALYŠEV (Russian Federation) expressed general support for appropriation section 4. Referring to programme 4.1 and to resolution WHA49.12 on a WHO global strategy for occupational health for all, which had been welcomed by countries, he said that the time had come for the strategy to be implemented. Additional efforts were required from WHO to that end, yet one year after the adoption of the resolution the Health Assembly was being asked to approve a programme budget that proposed cuts in specific programme 4.1.7 of 75% at headquarters level and 50% overall. While he welcomed the modest increase in allocations to programme 4.1 proposed in response to Executive Board concern, further resources would be needed to implement the strategy. He supported the coordinating work done by WHO in the area of occupational health and called for further integration of occupational health activities in other WHO programmes.

The Russian Federation fully supported programme 4.3 (Nutrition, food security and safety), and promised both active cooperation and the provision of technical and scientific resources. Further, it was prepared to participate fully in programme 5.3 (Control of noncommunicable diseases), which should remain a priority area over the coming biennium.

Mr ESKOLA (Finland) commended the efforts made to improve the proposed programme budget as requested by the Executive Board. However, he shared the concern expressed by both the Board and the previous speaker with respect to programme 4.1. Its importance had been demonstrated by the unanimous endorsement of resolution WHA49.12 on a WHO global strategy for occupational health for all. The resolution had been greeted with enthusiasm by professional associations, by the 58 members of the global network of WHO collaborating centres in occupational health, and by numerous countries and international bodies. Collaborating centres were valuable and potentially active partners, but needed proper coordination in their efforts to promote the well-being of workers worldwide. Insufficient capacity and resources prevented them from assuming responsibility for such overall coordination, which was clearly the duty of WHO. It was therefore surprising that in the programme budget presented to the Executive Board total allocations for occupational health were cut by 50%, from 4 to 2 million US dollars, and allocations to headquarters by 75%. In response to the Board's doubts as to the ability of WHO in those circumstances to implement resolution WHA49.12, the Director-General had proposed the transfer of US$ 100 000 to specific programme 4.1.7 (Occupational health). That was a welcome, albeit insufficient, step. He sought clarification as to how the proposed reduction would affect activities, including support to the extensive and highly effective global network of collaborating centres. Concerned about the credibility of WHO as a guiding body in occupational health matters, he viewed the reconsideration of budgetary allocations in that field as both a responsibility and an opportunity for the Organization.

Commenting on programme 4.1, Professor AKIN (Turkey) observed that, particularly since the International Conference on Population and Development in 1994, strategies to ameliorate reproductive health in countries had been better defined and the links between family and community health on the one hand and population questions on the other had become much clearer. The result had been a wider concept of reproductive health, covering adolescence and the period beyond menopause, i.e. defining it in relation to the
individual's entire life-span. Turkey acknowledged the leadership role of WHO in shaping guidelines and new
concepts which would assist and guide countries in regard to their perspectives, plans and activities.
She emphasized the value of the safe motherhood approach in promoting maternal and child health.
Despite statistics indicating an overall drop in infant mortality in developing countries over a number of years,
closer examination revealed that the bulk of that reduction was in the postnatal rather than the perinatal period.
The rates for stillbirths and for early neonatal and maternal deaths had remained unchanged in developing
countries for quite some time. Safe motherhood programmes therefore remained a priority and should continue
to receive support at country level.

Dr VAN ET TEN (Netherlands), while endorsing the proposed increase to programme 4.1, asked for
information on the figures for specific programmes. He would not like to see any cuts in the allocations to
specific programme 4.1.1 (Reproductive health). He expressed satisfaction with the proposed allocation to
specific programme 4.1.4 (Women's health).

Mr PRADO (Nicaragua) remarked on the importance of major programmes 4.1 and 4.2 for the countries
of Central America, the former being crucial to peace, investment and job creation.

Pointing out that Sweden had been providing substantial voluntary funds to specific programme 4.2.5
(Rehabilitation) for a considerable time, Mr ÖRTENDAHL (Sweden) praised the achievements of the
community-based rehabilitation programme. However, in the absence of a long-term rehabilitation plan in many
countries, community-based rehabilitation often depended on dedicated but ad hoc support from organizations
and individuals. As a result, insufficient coverage for disabilities led to suffering and placed demands on
families and taxpayers that could have been averted through timely rehabilitation. The benefits of investment
in such areas were obvious. WHO should intensify its related activities, guiding the national production of
technical aids at country level and introducing rehabilitation into the mainstream of WHO programmes.

Rule 14 of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted
at the 1993 General Assembly of the United Nations, stated that countries should initiate and plan adequate
policies for persons with disabilities. He therefore called for a WHO policy on disability to aid Member States
in fulfilling that task. Absence of a coherent policy was reflected in the modest allocations proposed for
rehabilitation and the many valuable but fragmented activities in that field under other programmes.

He welcomed the substantial documentation recently issued by WHO on blindness and deafness. In face
of the impressive challenges outlined in The world health report 1997 in respect of ageing, chronic disease and
disability, care and rehabilitation to facilitate the proper integration into society of persons with disabilities were
as important as disability prevention. Sweden therefore proposed that the Director-General and the Global
Policy Council should prepare a coordinated disability policy for WHO to guide relevant programmes. Clear
directives should be issued for monitoring the implementation of the United Nations Standard Rules as they
related to WHO's programmes and in close cooperation with the United Nations Special Rapporteur on
Disability. Finally, the Director-General should report to a forthcoming Health Assembly on WHO's action for
equalization of opportunities for persons with disabilities.

Speaking on specific programme 4.1.7 (Occupational health), Ms VOGEL (United States of America)
agreed that the network of collaborating centres was of high calibre but, like Finland and the Russian Federation,
fearred the impact on that network due to the absence of an effective leadership and coordinating function of
WHO, particularly at headquarters. She was concerned about the proposed cuts of 75% at headquarters and 50%
overall. Occupational health affected a great number of people and was crucial to the well-being of workers'
families. A more appropriate allocation of resources should be considered.

Mr LIU Xinming (China) said that, despite the Director-General's additional proposals, there remained
a substantial decrease in the budget allocation for programme 4.1. With its rapid urbanization and
industrialization, China, like the developing countries, was encountering many still unresolved problems with
regard to occupational health. It was also facing severe resource problems and needed to strengthen its work
in the field. The decrease in the regular budget allocation did not favour joint international action and
coordination or the development and promotion of occupational health. As for programme 4.2, China considered
that the best place for promoting health was the schools. Good health habits established at an early age played
a very important role in the elimination of diseases and increased both life expectancy and the quality of health. It was to be hoped that health activities in schools would receive adequate financial resources in the next biennium. An increasing number of people were now suffering mental health problems as a result of social and work-related stress; mental health programmes should be emphasized in the new biennium. WHO should strengthen and consolidate its activities in the field of mental health, at the global and country levels, with particular attention to the need for epilepsy control programmes in developing countries.

Professor WHITWORTH (Australia) said that in recent years the Executive Board had identified and reaffirmed five priorities for WHO, three of which came under appropriation section 4. The priorities concentrated on those areas where inequity in health outcomes was most marked. Many speakers had emphasized the link between health and development. With its commitment to equity, WHO should be aiming at achieving a minimum global standard of health and at raising that standard progressively. Some of the most cost-effective public health interventions included management of the sick child, prenatal and delivery care, tobacco and alcohol programmes and micronutrient programmes. At its ninety-ninth session, the Executive Board had been particularly exercised about the failure of the 1998-1999 programme budget adequately to reflect the priorities it had identified. Despite subsequent proposals, the allocations to programme 4 remained below those of the previous biennium and were unsatisfactory, especially in respect of programme 4.1. The priorities identified must be respected; it was by concentrating activity in areas which could yield real, cost-effective benefits for the less developed countries that real health gains globally would be achieved.

Dr MACHADO (Brazil) said that his country had in the past three years been developing a family health programme that had received general public approval. It involved the deployment of teams comprising a doctor, a nurse, a medical technician and between four and six community health agents. Each team was responsible for the health care of 1000 families. Currently there were 850 such teams caring for 850 000 families, and in all municipalities where the programme operated there had been a rapid reduction in child mortality and almost all health indicators had improved, including those relating to women’s health. The initiative was worthy of support by other countries. It was a priority programme for the Brazilian Ministry of Health, which planned to have 3500 teams operating by the end of 1998 and responsible for the health care of 3.5 million families, or 17.5 million people.

Dr EL SHAFEI (Egypt), expressing her support for the regular budget allocation for programme 4.1, said the developing countries were beginning to implement their strategies for women’s health, taking a holistic approach. Reproductive health did not concern only women, but also men and adolescents and the early detection of cancers in both sexes.

Dr STAMPS (Zimbabwe), referring to specific programme 4.2.4 (Communications and public relations), said he had become greatly concerned at the inability of health departments to get their message across through the popular press. There seemed to be an international cartel which determined the sort of news that was to be disseminated on health, and it was usually news about some exotic, unusual or perversely exciting activity or abstruse research. News of local health successes was rejected in favour of defects and mistakes. Few countries, and even fewer news organizations, had specialized reporters who could understand and properly report on health matters and achievements of genuine concern and value. The world had recently been shown degrading and dehumanizing television news footage of Africans dying in the Great Lakes Region but it had never been stated in the reports that the great majority of those deaths had been due to untreated malaria; the image of an incompetent continent had been perpetuated and the activities of WHO had not been projected at all. WHO, perhaps in collaboration with another United Nations agency such as UNESCO, should devise a system of providing general reporters and editors with the mechanisms by which they could communicate the true facts about health to lay audiences.

Professor GUIDOUm (Algeria) said the world had seen important achievements in family planning, assisted childbirth, prenatal care and screening for sexually transmitted diseases. He firmly supported programme 4.1 and its priorities, but the efficiency of the services provided was often too low when compared with the resources allocated. There were many causes, but the main ones were lack of an overall vision of the health system and, consequently, lack of any assessment of the delivery process, resulting in demotivation and
lack of interest in preventive action at the decision-making and professional levels. The solution was not just a financial one, although it was the element that was most decisive; it was also a question of strategic reorientation, based on the primacy and unity of public health and on giving priority to improving the efficiency of existing services and to local health development, particularly through projects of research and action that were more readily assessable and were often better linked to the realities on the ground. Algeria had good experience in the field of occupational health, where there had been a recent change of emphasis towards an approach that was more epidemiological than clinical.

Mrs AL-RIFAI (United Arab Emirates) welcomed WHO’s efforts to support women’s health activities under programme 4.1 and hoped that the Organization would make it possible for all regions to acquire the necessary technical and financial means to improve women’s health, especially through the establishment of collaborating centres.

Mr WASISTO (Indonesia) said that the status of reproductive and community health was reflected, among other things, by the rate of maternal mortality, which was still very high in developing countries and was largely determined by the level of education of the population and the accessibility of modern health services to girls, women and mothers. Better education for those groups was very important, and health services had to be expanded to reach them all. Improved training and supervision of nurse-midwives was also essential. WHO and its Member States should pay greater attention to providing budgetary resources for the improvement of maternal health.

Dr BIKANDOU (Congo), referring to programme 4.1, supported the initiatives and measures that had been taken in respect of reproductive health. With the support of WHO, UNFPA and other bodies, Congo had undertaken a number of activities in that area since 1981, and had participated in the first regional forum on teaching the subject in medical schools and faculties in central and western Africa. An awareness-building programme was under way, with a view to establishing a national committee to draw up a national action plan during the current year. A national action plan on adolescent health, with particular emphasis on early sexual activity, was also being drawn up and would be the subject of a national seminar.

Dr DLAMINI (Swaziland) believed that reproductive health should be strengthened, and that more collaboration was needed with other sectors regarding adolescent reproductive health. There was still a high rate of teenage pregnancy in her country, with consequent curtailment of women’s education and economic empowerment. With regard to ageing and health, in her country, as in others of the subregion, the extended family system had broken down as families moved to look for work further afield, so that the elderly were no longer as well cared for. Swaziland would welcome more assistance in establishing a formal health care system that would help in looking after the elderly rather than displacing them from their environments. Her country would also welcome more training in the area of perinatal care and safe motherhood programmes with a view to raising standards at all levels. Finally, there was a general feeling in Swaziland that not enough was being done for its communities in protecting them and preventing occupational accidents and hazards. More human resources were needed in the area of occupational health, which still came under the auspices of ministries that were not health-related.

Referring to programme 4.2, Dr DURHAM (New Zealand) welcomed the move from vertical programmes to a “settings” approach to health promotion. New Zealand would like to see WHO working with indigenous populations to facilitate the development of health promotion settings that had relevance for them. With regard to programme 4.1, she joined other delegates in emphasizing the importance of its component specific programmes in relation to the identified priorities, but was concerned to note that several regions were said to have limited funding available for women’s health and development. Funds were limited in relative rather than absolute terms, and by giving due weight to the crucial matter of women’s health the available funds could be appropriately allocated; allocative efficiency was as important as technical efficiency. New Zealand would welcome information regarding the time-frame for the introduction of “gender analysis and women’s perspective into health research, policies and programmes”, referred to in paragraph 98 of the proposed programme budget.
Dr FARSHAD (Islamic Republic of Iran), noting that 2500 million people in the world were working in small-scale industries, strongly recommended that more support should be given to the occupational health programme.

Dr FLACHE (World Federation for Mental Health and World Association for Psychosocial Rehabilitation), speaking at the invitation of the CHAIRMAN and on behalf of 12 presidents of international nongovernmental organizations concerned with mental health, paid tribute to the Director-General for his support to the world mental health community and for the work performed in 1996 by the new Division of Mental Health and Prevention of Substance Abuse. The restructuring was bearing fruit in providing better coordination and programme impact. It was regrettable, however, that the regular budget allocation for mental health remained very low for the next biennium — indeed, below the minimum required by WHO’s constitutional aims of promoting the mental as well as the physical well-being of the world’s population. Fortunately, the problems could be somewhat alleviated by extrabudgetary resources. In pledging full cooperation to the global initiative “Nations for mental health: an initiative for mental health in underserved populations”, he urged WHO to give it the much wider scope envisaged in the original plan which had, for various reasons, been abandoned. That broader plan, with close involvement of the United Nations, UNESCO, UNICEF, UNHCR, UNDP and the World Bank, as well as international foundations, universities and nongovernmental organizations, would give it a far better chance of ensuring more efficient coordination and integration, and of attracting larger voluntary contributions.

Ms CANNON (Brazil) said that, despite recent progress, support was still needed for the implementation of adolescent health care programmes within countries and to train health professionals working in that area, particularly in relation to adolescent reproductive health. In Brazil in 1996, 18% of adolescent girls aged 15-19 years had had at least one pregnancy, over half of the women who gave birth in hospital were aged between 10 and 24 years and some 10% of them were under 19. WHO should therefore continue to stress the importance of adolescent health care at regional and country level.

Speaking on programme 4.1, Dr KILIMA (United Republic of Tanzania) found it difficult to relate the resources available to such a broad issue. He pointed to the relative absence of activities geared to the under-fives, a very vulnerable group in most countries and subject to relatively high mortality.

Ms McCOWAN (United Kingdom of Great Britain and Northern Ireland), also referring to programme 4.1, expressed her concern at the lack of clarity in regard to the relationships and coordination between WHO and other United Nations organizations working in the field of reproductive health, particularly UNFPA and UNICEF operating at country level. She was especially interested in the local use of project appraisal committees in that context and the extent to which the comparative advantages of the various agencies were decided at the project and programme level.

Dr OTTO (Palau) agreed with the priorities as elaborated in appropriation section 4 and was encouraged by the increase in the amount allocated to health promotion. He shared the concern expressed regarding tobacco use and suggested that WHO should assist in collecting and disseminating information on the chewing of tobacco, particularly with reference to its effect on fetuses and on breast-feeding infants.

Dr MAJORI (Italy), speaking on programme 4.2, welcomed the initiative on mental health in underserved populations, which could represent an important medium for making people, communities and governments more aware of the implications of mental and behavioural problems for the psychological well-being and physical health of underserved populations throughout the world.

Mr SHAHARE (India) attached great importance to programme 4.1 and was therefore particularly concerned at the drop in the amount allocated for it. Reproductive health was a central element of human development, as had been globally acknowledged at the recent International Conference on Population and Development in Cairo and at the past two World Health Assemblies. The new reproductive health approach emphasized the importance of ensuring that fertility could be regulated and that pregnancy, childbirth and sexual relations could be embarked on in safety. India had organized workshops and joint sector reviews and had
established a task force on that subject. Referring to programme 4.2, he asked for information regarding the source of the figures regarding India cited in paragraph 111 of document PB/98-99.

Mrs HERZOG (Israel) said that, while all the areas covered by programmes 4.1 and 4.2 were very important, she believed that investment in the young should be given priority if future generations were to be healthier and have a better quality of life. WHO should therefore strengthen existing frameworks, such as health-promoting schools, healthy cities and healthy communities. The special needs of women in mid-life should be given particular attention.

Dr TÜRMEN (Family and Reproductive Health) assured all the speakers on programme 4.1 that their concerns had been noted. Recognition of the shortcomings of existing health programmes had resulted in an expansion of maternal and child health and family planning to the broader concept of reproductive health. The adoption of a comprehensive approach to the topic was now seen as a necessary response to expanding needs in that field, including the threat posed by the HIV/AIDS pandemic, and the recognition of sexuality and sexual health as a component of reproductive health.

Replying to questions raised, she said that WHO worked closely with other United Nations agencies, in particular UNFPA, UNICEF, UNDP and the World Bank, in following up the internationally agreed plans of action of the Cairo and Beijing conferences and, more generally, in pursuing both formal mechanisms for interagency coordination and interagency activities, which contributed greatly to consistency in the strategies adopted by the various agencies. WHO also worked closely with a number of national and international nongovernmental organizations. Regarding the budget allocation for the reproductive health programme, in which it had been pointed out that there was a small increase, she noted that WHO reproductive health programmes were funded mainly from extrabudgetary resources.

In regard to the time-frame of activities relating to gender perspectives and analysis, the work was carried out through a network of focal points in the regions together with women's groups around the world and was a long-term process. At global level, a gender advisory panel had been established to help guide the process in respect of research and programme planning. At national level, a series of training courses on "gender and reproductive work" for health programme managers was being launched in collaboration with academic institutions and nongovernmental organizations in the hope of stimulating the introduction of a gender perspective in that area. The plan of work for the women's health activities at WHO would also be made available to interested delegations. On the question of activities for under-fives, she suggested that satisfactory answers would be provided during discussion of programme 5.2 (Control of other communicable diseases). In answer to the question on external coordination of reproductive health programmes, she explained that WHO executed UNFPA country projects, was part of the country support system aimed at providing interagency technical support at country level, participated in high-level intersecretariat mechanisms between agencies to identify strategies for improving collaboration at country level, and gave joint briefings to country representatives.

Dr NAPALKOV (Assistant Director-General), in response to the interest expressed in the programme for the promotion of mental health in underserved populations, assured delegates that the work would continue and that the programme had good prospects for further development.

In regard to specific programme 4.1.7 (Occupational health), he stressed that, the Director-General considered the topic of great importance and shared the concern voiced regarding the budget decrease. Efforts were continuing to facilitate the development of the programme and to re-allocate internal resources for that purpose. Efforts were also being made to mobilize extrabudgetary resources through WHO collaborating centres, governments and nongovernmental organizations. In fact, several countries, in particular Germany, had offered material support for activities. Although the Executive Board had not decided to include it in the list of five priority activities, he hoped that it would be possible to stimulate support for the programme. Referring to paragraph 22 of document A50/4, he was pleased to report that the Director-General had decided to increase the 1998-1999 allocation for the programme by US$ 100,000 in response to the request of the Executive Board.

In regard to the development of national tobacco control strategies, the project proposal required in order to finalize an international framework convention for tobacco control had already been prepared and a draft convention would be submitted for consideration by the Health Assembly in the year 2000. The preparation of the convention involved close consultation with Member States and with experts on public health, international
law and convention administration, and was dependent on extrabudgetary funding. Several governments had indicated their readiness to support that activity; initial funding had already been made available by Canada, Finland and Switzerland, while France, Norway and Sweden had also shown interest. A meeting to establish a consultative group to work on the framework convention was planned for June 1997. In addition, WHO was planning to call a special anti-tobacco conference in Moscow, in the hope of improving tobacco control in many of the countries with economies in transition. He assured the delegate of Sweden that the activities mentioned in regard to rehabilitation programmes had already found support from certain extrabudgetary sources.

Dr KICKBUSCH (Division of Health Promotion, Education and Communication) assured the delegate of Sweden that many of the activities he had touched upon in relation to specific programme 4.2.5 were well under way. WHO worked closely with the United Nations Special Rapporteur on Disability in matters concerning the Standard Rules for Equalization of Opportunities for Persons with Disabilities and was keen to take on the task of monitoring the rules; it was awaiting a specific request to do so which should be received in the near future. Secondly, WHO was actively expanding the community-based rehabilitation approach to include extremely vulnerable populations in slums and refugee camps and also indigenous populations and had been able, as Dr Napalkov had mentioned, to attract considerable additional voluntary funds to the programme. Thirdly, a major consultation process had begun through the creation of a strategic programme support group for specific programme 4.2.5, with the participation of major nongovernmental organizations, disability groups, other United Nations agencies and other programmes within WHO, in order to develop a new coordinated approach to rehabilitation and disability. She hoped that its work would form the basis for the policy paper which had been proposed. The Government of Sweden had been supporting the specific programme for many years, thus allowing it to go through a number of developmental phases and to raise awareness of the importance of rehabilitation and disability. More funds were being made available and she believed it was time to give the programme a higher profile, thus enlisting greater support.

Dr UTON RAFEI (Regional Director for South-East Asia) said that, following the International Conference on Population and Development, WHO had launched a special effort to support Member countries in the Region in formulating country action plans on reproductive health within the framework of regional strategies and global action plans. Most of the countries had now completed their formulations and special activities had been launched to reduce maternal mortality rates. In addition, on the research side, the regional Advisory Committee on Health Research had recommended in 1996 that a scientific working group should be convened to identify priority areas for operational research in reproductive health and mechanisms for its implementation. The group had been established and had held its first meeting in August 1996.

Dr ALLEYNE (Regional Director for the Americas) noted that the delegate of Brazil had referred to the need to intensify programmes on adolescent health at the regional level. There had been a change in emphasis, to encourage adolescents to be agents for change in health behaviour. In that context, it was essential to link programmes for or with adolescents to those on mental health, as it was generally agreed that adult behaviour was essentially generated during adolescence. The Government of Italy gave valuable support to many of those programmes. Finally, he hoped delegates would not get the impression that programmes for the benefit of women related only to reproductive health: in fact, issues of “gender”, and of “gender equity” in particular, permeated all the programmes of the Organization.

The meeting rose at 17:55.
Fourth Meeting
Thursday, 8 May 1997, at 9:10

Chairman: Professor H. Achour (Tunisia)

Proposed Programme Budget for the Financial Period 1998-1999: Item 17 of the Agenda (continued)


Appropriation section 4: Promotion and protection of health (continued)

4.3 Nutrition, food security and safety
4.4 Environmental health

Dr Al-Saif (representative of the Executive Board) said that the Board had reaffirmed the priority of nutrition and "food security and safety", considering the budget cuts in the area regrettable. It had reiterated the importance of WHO's role in the setting of standards for food safety and nutrition and its continued support for international food safety regulations. It had also received confirmation that WHO was honouring its contractual commitments to the Codex Alimentarius Commission. The Board had also considered the need for WHO to establish guidelines on the provision of food aid, taking into account the informal guidelines that already existed.

The Board had expressed satisfaction with the proposed allocation for environmental health, another priority area. There was growing awareness of the links between health and the environment and every effort must be made to ensure that WHO continued to provide leadership in the area, particularly in the setting of vital norms and standards at the global level. WHO's promotion of chemical safety, the identification of chemical carcinogens by IARC, WHO's follow-up to Agenda 21 of the United Nations Conference on Environment and Development and the work performed by the Intergovernmental Forum on Chemical Safety had been cited as examples of crucial international work on environmental health.

The Board had considered that in developing countries facing a multitude of environmental problems the provision of sanitation and a safe and adequate water supply remained a top priority requiring leadership from the health sector and collaboration with other sectors. WHO should also consider the health consequences of industrial development. In that context, the Board had been given an assurance that the closely related activities of specific programmes 4.4.2 (Environmental health in urban development) and 4.4.4 (Promotion of chemical safety) were being coordinated so as to avoid duplication and ensure cost-effectiveness at the operational level.

Several members of the Board had referred to the national environmental health action plans recently developed in various regions as a good example of how much could be achieved with minimum resource investment. The plans involved devising national policies in line with health-for-all policies and relied on intersectoral and interministerial collaboration. They had proved highly successful in achieving their goal and attracting extrabudgetary funding. Although the Board had questioned the general desirability of increased dependence on extrabudgetary funding, the plans were thought to demonstrate how donors could be attracted simply by the quality of the Organization's work. Initiatives such as those for healthy cities and healthy villages were also cited as examples of WHO's effectiveness in promoting environmental health.

Dr Van Etteng (Netherlands) said specific programmes 4.3.1 (Nutrition) and 4.3.2 (Food safety) were priorities for his country. He favoured maintaining their appropriations at the same level as in the current
biennium, particularly in view of the discontinuation, which he supported, of specific programme 4.3.3 (Food aid). He requested clarification of the substantial increase in specific programme 4.4.2 (Environmental health in urban development) at the apparent expense of specific programme 4.4.1 (Water supply and sanitation in human settlements).

Dr AGGARWAL (India) gave a brief survey of recent action initiated by his Government in the area of environmental health and described some of the measures planned under the Ninth Five-Year Plan launched on 1 April 1997. The Supreme Court of India had ordered the installation of incinerators and other hospital-based disposal mechanisms in all government and private sector hospitals of more than 50 beds. On a pilot basis, a programme had been launched in collaboration with WHO to turn Delhi into a healthy city. Environmental health and sanitation were important topics in the negotiations between the Government of India and the World Bank and other external donor agencies.

Ms NGHATANGA (Namibia) reported that her country had drawn up a plan of action for food and nutrition in 1996, thanks to the support of WHO and FAO. Nevertheless, severe drought over the previous five years had caused food insecurity to persist at the household level. Although the rains had been good in the current year, drought was likely to remain a problem. She described the health and other problems experienced by many families as a result of the unavailability of food, compounded by extreme poverty and social hardship. Improving nutrition remained a priority for many drought-stricken, food-deficit countries like her own, and external assistance was essential. Expressing her appreciation for the support received, she appealed to WHO, working with agencies such as FAO and WFP, to provide assistance through community-based health and development programmes that would enable the poor to engage in activities that would improve their economic, and hence their food and nutritional, status.

Professor AKIN (Turkey) thought the problems relating to nutrition and food were well stated under programme 4.3 in document PB/98-99, but wished to draw special attention to three major ones, all of them preventable. The first was malnutrition in children, which contributed substantially to childhood diseases and death but often went unrecognized; almost one third of the world’s children under five years of age were underweight. Secondly, micronutrient malnutrition affected at least 2000 million people of all ages, with children particularly vulnerable; iodine and vitamin A deficiency continued to be a serious public health problem. The third problem was anaemia in pregnant women, which was well known to be the main underlying cause of maternal deaths in many countries.

She commended WHO on the many intervention strategies it had developed at the global, regional and country levels. While the promotion of breast-feeding management and the development of criteria for implementing baby-friendly hospital initiatives were progressing well in many countries, including her own, she called on WHO to make the programme more comprehensive by establishing criteria for “mother- and baby-friendly” health units, or even communities. Without a healthy mother it was hard to produce a healthy baby. The magnitude of the problem of anaemia in pregnancy was such that research was urgently required to establish the most cost-effective type of intervention and assist countries in introducing the most appropriate technology. User compliance being a major problem, new technologies should be developed to minimize or eliminate the difficulties. The development by WHO of new global growth reference values for infants and children was timely and would be of widespread value. With regard to iodine deficiency, she called on WHO to provide advocacy activities in addition to technical support, in order to publicize the problem better and help in convincing policy-makers and the public to generalize interventions.

Dr KORTE (Germany) welcomed the excellent progress of the programmes under review, for which support and budgets should be maintained at least at previous levels. He thanked the Director-General for his initiative on urban health, an area to which Germany attached particular importance and which would determine the well-being of many millions of people. With the liberalization of trade, food safety would grow in importance. WHO should continue to exercise its leadership in that field and draw up recommendations and standards to prevent health problems associated with unsafe food. He welcomed the timely initiative to set new growth standards, which would form a new reference framework for measuring over- and undernutrition.
Dr SANOU IRA (Burkina Faso) said that problems of nutrition, food security and safety were a cause of growing disquiet in the developing countries. Malnutrition was compounded by other problems connected with imported foods, and the safety of both farm and processed products left much to be desired. However, it was difficult to get the message across to the people. Given that poverty was the largest determining factor, it was difficult to know where to start tackling the problems. At the global level, there was collaboration between WHO and other international bodies, and she paid tribute to WHO's work in the field. WHO's support in setting up an effective system of hygiene management in general and food safety in particular was a matter of real priority in her country. She, too, regretted the budget cuts and urged that every effort should be made at local level, with the support of the regional offices, to ensure that the programmes already launched in her country and others were truly strengthened.

Dr ABEDNEGO (Indonesia) described some of the measures being implemented in his country in the areas under consideration, in particular those benefiting schoolchildren and concerned with environmental quality, micronutrient deficiencies, school health and poverty alleviation.

Professor GRANGAUD (Algeria) was concerned at the budgetary restrictions on nutrition programmes in view of the lack of progress in overcoming protein-energy malnutrition and the seriousness of micronutrient deficiencies highlighted in the documentation. It was important to mobilize new resources through an intersectoral approach designed to link food production, community development and food supplementation for the populations at risk. Algeria planned to launch such a project in the southern part of the country and to enlist the cooperation of various international agencies. He warmly endorsed the remarks of the delegate of Burkina Faso regarding food safety.

Dr AL-JABER (Qatar) said there was no doubt that environmental health and nutrition were of paramount importance to general health, that many diseases stemmed from lack of environmental health, that production of chemicals had a direct impact on human health and that additives had adversely affected human health. After outlining some of the action being taken in his country to tackle the problems, he urged WHO to continue its support to programmes relating to environmental health and nutrition.

Mrs HERZOG (Israel), observing that the topics under review were interrelated, said that the efforts made, within the budgetary constraints, were to be commended. Nutrition and food security and safety were matters of universal concern. While the WHO guidelines for travellers were most useful, food hygiene and safety were not a concern only of travellers, as increasing numbers of people ate outside the home. Alongside WHO's commendable achievements on surveillance and evaluation at the global, regional and country levels, guidelines should continually be sent to Member States on hygiene in all aspects of food processing and sale.

The quality of food in health terms was another important issue in both industrial and developing countries. Prepared food contained too much salt, saturated fat and sugar. There too WHO could act as a catalyst in providing guidelines to Member States, lay people and nongovernmental organizations. Education at all levels was clearly an important factor in bringing about changes in practice and behaviour and to that end, again, WHO should use other existing frameworks such as health-promoting schools and healthy cities.

Professor LEOWSKI (Poland) noted that environmental protection had been intensified in the five years since the United Nations Conference on Environment and Development (UNCED), greater emphasis being put on environmental health risks in WHO as elsewhere. He welcomed the fact that the scope of the joint WHO/UNDP initiative to support countries' sustainable development planning had expanded from 6 to 16 countries between 1993 and 1996. Subject to further developments and according to the criteria decided for country selection, Poland might be interested in cooperating on the project.

All Member States were interested in international cooperation on environmental health action plans, as emerged from the two conferences organized by the Regional Office for Europe in the wake of the Second European Conference on Environment and Health (Helsinki, 1994), and Poland would welcome implementation of the bilateral agreement signed with that office for the current biennium. The report of the WHO Commission on Health and Environment, entitled Our planet, our health, presented to UNCED had been crucial in determining the high priority assigned to health in the context of sustainable development. He also supported the idea of producing a report on health and environment in sustainable development that would give a
conspectus of the situation five years after UNCED. The report should demonstrate the links between environment and health and analyse the impact that implementation of sustainable development policies had had on environment and health. Since Poland could claim positive results in those areas, it would be willing to cooperate with the high-level panel recommended by the Director-General’s Council on the Earth Summit Action Programme for Health and Environment.

In view of the growing amounts of chemicals and the dangers they posed, further intensive efforts for promoting chemical safety were essential.

Professor SHAFI QURAISHY (Pakistan) expressed appreciation of the continued support for food safety, community health and the environment. Pakistan had made great strides over the past two years in dealing with environmental hazards and had passed legislation to tackle industrial and hospital waste, including the requirement that all hospitals with over 50 beds in large cities should use incinerators, which would be fully met by the end of 1998. Industrial safety and control of chemical waste were also on the agenda.

Under major programme 4.3, he regretted the decline in WHO support for nutrition programmes; nutrition and food safety still required much support in most developing countries. To control malnutrition and ensure the health of its future adult population, Pakistan was strengthening its school health service and improving its activities for the nutrition of mothers and children.

Dr SULAIMAN (Oman) remarked that adequate resources were needed for implementing nutrition and environmental health programmes and for the attainment of long- and short-term goals. Given the growth of the food industry and the increased use of chemical additives, with their consequences, he wondered how much of the programme resources would be available for dealing with iodine and other deficiencies and for programmes to promote awareness. He welcomed the field studies and programmes on mother-and-child nutrition, which should help in assessing the true status of nutrition, particularly in early childhood.

Dr DLAMINI (Swaziland) thanked the Director-General for the programmes proposed, but felt that stronger collaboration was needed in certain areas.

Referring to major programme 4.3, she expressed concern at the continued budgetary constraints on nutrition activities for Africa. The severe droughts that had hit her country in recent years were still contributing to malnutrition. There had also been significant pathology from deficiencies of micronutrients. The Swaziland Nutritional Council was being revived and required considerable funding. Food contamination by insecticides was another area of major concern, as was the use of chemicals and food additives, which called for research into their effect on human consumers. Swaziland had passed legislation that required all salt to be iodized. She urged WHO to continue its funding for all those areas, despite the reduced budget.

On major programme 4.4, she called for WHO’s cooperation to combat water contaminants; countries sometimes lost sight of the need for river safety in their attempts to entice investors, thus encouraging dumping of industrial waste into rivers. When preventive legislation did exist, it was not always enforced.

Dr OTTO (Palau) was grateful for the presentation on nutrition, food security and food safety in the proposed programme budget, especially the proposed products and projections on nutrition. Since the prevalence of obesity in adults was over 50% in the Western Pacific countries, half those countries’ population ran the serious risk of a progressively reduced quality of life; consequently, he welcomed the proposed actions, particularly the development of methodology to monitor, prevent and reduce obesity and the global database and monitoring system. He looked forward to receipt of the proposed guidelines on public health policy on obesity.

Ms VOGEL (United States of America) noted that the budget proposed for specific programme 4.4.1 (Water supply and sanitation in human settlements) was substantially less than in the current biennium, but that the document did not indicate what activities would be suppressed in consequence. Although UNICEF, UNDP, UNEP and the World Bank were all involved in the overall process to ensure safe water and adequate sanitation, WHO still had an important role to play.

Dr BROOKMAN-AMISSAH (Ghana) observed that the excellent programmes presented accurately reflected the problems faced by most African countries. Many countries, especially in the developing world,
were plagued by poor environmental management capabilities, particularly for waste disposal, which called for expensive and complex state-of-the-art technology and massive engineering inputs; they lacked both the financial resources and the specialized personnel needed. Those countries could benefit from a return to older, simple technologies, suited to small rural and larger urban communities, for disposing of solid and liquid waste.

Dr BOUAMGA (Congo) called on the Organization to redouble its efforts to secure funding for concrete action to establish appropriate mechanisms for promoting chemical safety, especially in the countries most severely beset by environmental problems. He thanked the Organization for increasing the appropriations from the 1996-1997 levels and hoped that projects with multiplier effects would be implemented in the area of food safety and security. Malnutrition was a major cause of disease and mortality among Africans; accordingly, WHO must continue to play its leadership role to ensure that the goal of health for all by the year 2000 was attained jointly and equitably.

Dr PRADO (Nicaragua) considered that the budget for major programme 4.3 should be maintained at the previous level. Micronutrient deficiencies in Nicaragua posed a serious threat to nursing mothers, babies, and pregnant women and were causing a rise in neonatal and maternal disease and death rates. Accordingly, his country was expanding a number of health programmes to include health of nursing mothers and mother-and-child nutrition. However, it needed help in order to attain its goals.

Ms PAULINO (Philippines) supported WHO’s initiatives for proper and adequate nutrition and food security and safety. Inasmuch as adequate nutrition reduced vulnerability to ill-health and was therefore crucial to children’s overall development and future productivity, she was concerned about the instability of the budgetary support in nutrition and related fields and accordingly the level of activities. The Organization should take the lead in undertaking further studies to identify simple and sustainable community-level strategies for ensuring safe and adequate food for families.

Mrs NINH THI BINH (Viet Nam) welcomed the excellent presentation of the programme on nutrition and food security and safety, both of which were very serious issues in the developing countries. Viet Nam would support an increase in appropriations for that area, since it had a malnutrition rate of 42% among children under five years old and had undertaken to cut that to 32% by the year 2000.

Dr MTSHALI (South Africa) expressed appreciation for WHO’s work on nutrition and called for further support for countries in need. South Africa suffered from the myriad health consequences of poor nutrition, especially protein and micronutrient deficiencies, and was therefore evaluating various food-fortification activities and contemplating multisectoral action to ensure household food security. One major area of concern, in which WHO could be of assistance, was salt iodization: while many countries required salt consumed domestically to be iodized, control measures for exported salt were often neglected, allowing non-iodized salt to be dumped on salt-importing countries. A further possible problem related to the Organization’s cooperation with other United Nations agencies: for example South Africa’s Health Directorate dealt primarily with UNICEF on many of the activities covered in WHO’s major programme 4.3 and she wished to ensure that there was no conflict of interest or duplication of work.

Mrs MANYANENG (Botswana) urged continued support for major programme 4.3. The upsurge of food vending and institutional feeding had increased the importance of food quality and highlighted the urgency of establishing food standards and legislation and of educating food consumers and producers alike. In view of the small amounts earmarked for nutrition and related areas, she hoped that the importance of the link between malnutrition and opportunistic diseases would not be neglected. She welcomed the prominence accorded to environmental health under major programme 4.4. Given the seriousness of the problem of chemical safety and disposal of hazardous waste, she urged WHO and FAO to continue to provide support.

Dr MESHKHAS (Saudi Arabia) expressed his wholehearted agreement with major programme 4.3, particularly regarding the important contribution made by certain nutritional deficiencies to diseases that were
widespread in the industrialized and developing countries alike. Breast-feeding had been given considerable
attention in Saudi Arabia, since it had been shown to stave off breast cancer in nursing mothers.

Professor PICO (Argentina), in endorsing the contents of major programme 4.3, thanked the Organization
for its achievements in nutrition and food security and safety, and more particularly for its assistance with the
development of Argentina’s National Food, Medicine and Medical Technology Administration which made it
possible to monitor the nutritional status of the population. Argentina had a fully operational national nutrition
programme which emphasized many of the same features as those covered in WHO’s programme budget. It
was also important for all programmes relating to breast-feeding to be vigorously pursued.

Dr SIKOSANA (Zimbabwe) congratulated the Organization on its achievements in nutrition and
environmental health and joined other delegates in calling for increased funding for those programmes. The
work of WHO had resulted in an improvement in the nutritional status of the population of Zimbabwe and
particularly of children under the age of five, despite devastating droughts in the region. In order to sustain those
achievements, a food and nutrition policy was being developed. The HIV/AIDS epidemic, however, had
negatively affected policies for breast-feeding and the “baby-friendly hospital” initiative.

Since legislation had been enacted to ensure universal iodization of salt, an increase in the prevalence of
thyrotoxicosis had been seen. Technical assistance would be required to monitor that serious side-effect of the
programme.

Programme 4.4 had allowed Zimbabwe to highlight environmental problems in both urban and rural areas;
the “healthy cities” initiative was to be followed by a “healthy villages” initiative, based on competitions among
villages.

Mr ROKOVADA (Fiji) said that a plan of action was being implemented in his country against
malnutrition, micronutrient deficiencies and obesity, which were significant risk factors for a range of
noncommunicable diseases, and to cover food security and safety. Breast-feeding was promoted as part of the
“baby-friendly hospital” concept; the two major hospitals of the country and one divisional hospital had been
given that accreditation. A national health promotion centre had been established in 1996 with the assistance
of the Governments of Australia and Japan. The centre collaborated with other agencies in developing health
strategies, such as “health-promoting schools”, “healthy islands” (as a corollary to “healthy cities”) and healthy
work-sites in industry.

Dr SILWAMBA (Zambia) said that the gratitude his country felt for the guidance given on nutrition and
on “food security and safety” was tempered by concern for the apparent lack of support in the area of
environmental health. Little was said, for example, in the programme budget about assisting developing
countries to detect and dispose of radioactive material. Some years previously, a consignment of tinned beef
sent to his country from Europe had subsequently been found to be radionuclide contaminated. As the proper
means for disposal of the product had not been available, it had been placed in a concrete-lined pit, to which
people had nevertheless gained access. Similar cases of dumping of rejected material on developing countries
had been reported elsewhere.

Dr HAJAR (Yemen) noted that environmental health, nutrition, “food security and safety”, and water
supplies were areas of fundamental importance. Iron and iodine deficiencies were major problems in his
country, where an inventory of the situation was being prepared with the assistance of the Regional Office, in
collaboration with hospitals and other health services. The appropriations for environmental health should be
increased in view of the cardinal importance of good water supplies and sanitation.

Dr KHARABSHEH (Jordan) said that his country attached paramount importance to care of the
environment as a means of health promotion. Countries that lacked drinking-water required assistance, not only
from WHO but also from other international bodies, in finding adequate supplies. Equitable distribution of
drinking-water between neighbouring countries had to be assured.

The promotion of chemical safety (specific programme 4.4.4), represented a problem in many countries.
It should be kept under constant review by WHO, in cooperation with all the other competent bodies, in order
to ensure the safety of all chemicals whether produced in civilian or defence establishments.
Turning to national food programmes, he stressed the importance of continuing to monitor food security and safety, both for the control of outbreaks of foodborne disease and for the prevention of endemic diseases. Countries which were not yet doing so should introduce monitoring plans in accordance with the appropriate standards.

Mr YOUSEF (Kuwait) noted that the concept of nutrition was a broad one that included possible contaminants, additives and preservatives in food products, which might themselves be directly or indirectly hazardous to health. Like many countries, Kuwait imported most of its food and wished to ensure its safety. WHO should increase the allocations for laboratory analysis and control of food products and provide for training in that area.

Dr ANTEZANA (Deputy Director-General ad interim), responding to questions about programme 4.3 (Nutrition, food security and safety), reminded delegates that the Director-General had decided to strengthen the effectiveness, visibility and operational nature of the programme by including nutrition in all the specific programmes within major programme 4.1 (Reproductive, family and community health and population issues). A specific programme on food safety and security was required in view of recent concern with regard, for instance, to Creutzfeld-Jacob disease, problems associated with *Escherichia coli* and *Salmonella*, and chemical contamination of food. Unhealthy diets were becoming a daily problem because of changing lifestyles and intensified travel. The activities of the food safety programme had been increased, despite budgetary restrictions; with cooperation from the Government of Japan, WHO was actively participating in the Codex Alimentarius Commission and in negotiations with the World Trade Organization.

Dr KÄFERSTEIN (Food Safety and Food Aid), referring to comments from delegates suggesting a possible lack of intersectoral collaboration for “food security and safety” at the country level, said that the establishment in countries of national committees and national contact points of the Codex Alimentarius Commission could ensure such cooperation. In collaboration with UNIDO, a programme was being launched to strengthen the food industry in seven African countries, with the involvement of ministries of health. Another mechanism for improving intersectoral collaboration was the “healthy-city” initiative and the newly devised “healthy market place” initiative.

Regarding the need for more information on food preparation, he noted that WHO had already issued hygiene rules for mass catering, and “golden rules” for safe food preparation in the family had been published 10 years previously. A recent WHO publication dealt with essential safety requirements for food sold by street vendors.

Dr TÜRKEN (Family and Reproductive Health), replying to comments on specific programme 4.3.1 (Nutrition), said that nutrition was an essential element for the health and well-being of people throughout their lives. Inclusion of work on nutrition in all aspects of family and reproductive health would strengthen its impact. Nutrition was a priority for WHO, as malnutrition killed, maimed, crippled and blinded people throughout the world: 197 million children under the age of five suffered from protein-energy malnutrition, 750 million people had iodine-deficiency disorders, 2.8 million children under five were blind owing to vitamin A deficiency, 1200 million people suffered from iron-deficiency anaemia and several hundred million children, adolescents and adults were obese.

Many delegates had cited the global problem represented by protein-energy malnutrition, iodine deficiency, vitamin A deficiency and anaemia, especially in pregnant women. WHO continued to support Member States both technically and financially in pursuing the goals of the 1992 World Declaration and Plan of Action for Nutrition. The incidence of iodine-deficiency disorders was decreasing throughout the world owing to the introduction of iodized salt, and they might actually be eliminated by the year 2000; a report would be made to the Health Assembly in 1999.

With reference to the delegate of Zimbabwe’s remarks on iodine-induced thyrotoxicosis, she recalled that a warning on the subject from Zimbabwe two years previously had prompted WHO, UNICEF and the International Council for Control of Iodine Deficiency Disorders to carry out an epidemiological study in several African countries, which had led to strengthened monitoring of iodized salt programmes throughout the world.

A database on body mass index that was being established would serve as a framework for defining and measuring under- and overnutrition, a point that had been raised by the delegates of Germany and Palau. An
international meeting on obesity was to be held in June 1997. Monitoring of the growth of individuals and assessment of the extent of malnutrition at country and global levels were actively supported by WHO, mainly within the specific programme on nutrition and the Division of Child Health and Development. WHO was conducting a large international study on which to base a new international growth reference value for children under five, and was providing support to more than 140 Member States so that they could strengthen growth-monitoring activities.

In response to a comment by the delegate of South Africa, she said that many of WHO’s activities in support of national nutrition programmes were conducted jointly with UNICEF and FAO. The activities were coordinated annually at meetings with UNICEF and with all the United Nations agencies concerned with nutrition, so that the scarce resources were not used to duplicate work.

Replying to the delegate of Turkey, she said WHO considered that any initiative that was “mother-friendly” would naturally be “baby-friendly” and was preparing criteria and guidelines to move from the concept of “baby-friendly hospitals” to “mother- and baby-friendly hospitals”.

With regard to the complex issue of HIV and infant feeding, raised by the delegate of Zimbabwe, WHO had long emphasized the vital importance of promoting, protecting and supporting breast-feeding for the survival and health of infants throughout the world. The growing HIV/AIDS pandemic and evidence that HIV could be transmitted in human milk had, however, led WHO periodically to review its policies in that respect. The most recent statement had been issued in conjunction with UNAIDS in September 1996. It set forth considerations for countries that were establishing policies on the matter and for health-care workers who advised women about infant feeding.

An international study was under way with the aim of ensuring the availability of safe household food and nutrition for vulnerable groups, particularly in cities. Socioeconomic, cultural and environmental factors and the caring capacity of populations were being studied in order to develop guiding principles to be incorporated in national food and nutrition policies and plans.

Dr KREISEL (Environmental Health) said that the delegates’ comments on programme 4.4 indicated growing global concern about the implications for human health of a deteriorating environment; he reminded the Committee that 25% of all preventable disease was due to poor environmental quality.

The delegates of the Netherlands and the United States of America had asked about the potential effects of the proposed US$ 12 million decrease in the budget for specific programme 4.4.1 (Water supply and sanitation in human settlements) and the proposed increase in the allocation for specific programme 4.4.2 (Environmental health in urban development). The two programmes had similar allocations at headquarters, as in the previous biennium, but a shift was being proposed at the regional level owing to the success of the “healthy cities” (“healthy villages”, “healthy islands” and “healthy communities”) initiative within programme 4.4.2. That sort of integrated approach to environmental health management was finding increasing favour at the country level, in preference to specific support for single activities. An interregional programme for “healthy cities” had been established, in which cross-programme working groups ensured cross-fertilization of ideas. The “healthy market places” initiative that had been mentioned by Dr Käferstein in the context of food safety was a good example of that approach. Another reason for the reduction in specific programme 4.4.1 was that fewer staff worked specifically on water supplies and sanitation; countries requested broader expertise in environmental health. The approach used by WHO to tackle the problem of water supplies and sanitation was education in hygiene, operation and maintenance of water supply and sanitation systems and monitoring of drinking-water quality. The necessary hardware was provided by organizations like the World Bank, which had the appropriate investment programmes. WHO was strongly involved in interagency collaboration in that area, for instance providing the secretariat for the Global Collaborative Council on Water Supply and Sanitation. It was also fully involved in developing a global programme on water, supported by the Commission on Sustainable Development of the United Nations. WHO would supply the focus on health in relation to supplies of fresh water.

In response to the delegate of Poland, he said that more than 100 countries had incorporated health and environment components into their plans for sustainable development. Examples were the national environment and health action plans in Europe and similar initiatives in other regions. Such plans emphasized intersectoral action, which was essential in order to achieve the goal of environmental health. The report on “health and environment in sustainable development” to which the Polish delegate had referred would be published in June 1997, immediately before a special session of the United Nations to review implementation of Agenda 21 five
years after UNCED. The report would emphasize current knowledge about the links between environment and health and analyse actions that had been taken.

A number of delegates had requested information on the management of hazardous and of general municipal and industrial wastes. That was a serious health issue, which should be tackled intersectorally within the context of “healthy cities” and “healthy villages”. WHO would be pleased to support countries in dealing with the problem. Radionuclide contamination of food, referred to by the delegate of Zambia, was a grave matter. It would be necessary to determine the origin of the contamination. If it were related to nuclear waste, the problem would be the responsibility of IAEA; if it were related to food, it should be dealt with under the specific programme on food safety and the programme on environmental health, which included environmental radiation.

Appropriation section 5: Integrated control of disease

5.1 Eradication/elimination of specific communicable diseases
5.2 Control of other communicable diseases
5.3 Control of noncommunicable diseases

Professor ABERKANE (representative of the Executive Board) said that in considering appropriation section 5 the Executive Board had noted with satisfaction the increase in allocations to priority programmes 5.1 and 5.2. It had stressed the importance of availability of suitable national facilities such as laboratory services, disease surveillance and, where appropriate, WHO collaborating centres. The growing problem of emerging and re-emerging diseases and the related problem of antibiotic resistance were areas in which WHO was well placed to undertake prevention and control, as the progress made in the control of the current tuberculosis pandemic well illustrated. In order for progress to be made in other areas, however, more resources must be mobilized on the basis of confirmed political will at the national and regional levels and by exploiting special events such as World Tuberculosis Day to raise public awareness. The same could be said of the situation with HIV/AIDS: WHO must continue to demonstrate its commitment to dealing with the problem within the framework of UNAIDS.

The Board had also noted the worldwide growth of noncommunicable diseases and the need for WHO to prepare to face new challenges. It had been pointed out that programme 5.3 would face many problems of prevention, particularly in view of the link between other noncommunicable diseases and cancer. A successful battle against noncommunicable diseases connected with lifestyles could be waged through an integrated approach, which was the foundation of the international strategy currently being formulated. Serious attention must continue to be given to that issue in all countries where socioeconomic and demographic change contributed to epidemiological evolution and resulted in rapid growth in morbidity and mortality attributable to chronic noncommunicable diseases, particularly cardiovascular disorders.

Dr AL-JABER (Qatar) said his country was proud of the fact that no new cases of poliomyelitis had been recorded in recent years, thanks to a comprehensive vaccination campaign. No cases of tetanus had occurred either, because of appropriate health measures adopted. Steps had been taken to combat measles and ensure the vaccination of children under the age of five, but since some cases had been observed in children over five a policy had been adopted to deal with that problem. A few tuberculosis cases had been recorded, something that undoubtedly was linked to the fact that Qatar, as one of the Gulf States, was a major receiving country for foreign workers. A number of associations had been set up to deal with chronic noncommunicable diseases like diabetes and cancer. It was WHO's responsibility to help Qatar overcome its problems with communicable and noncommunicable diseases, and his delegation welcomed all efforts undertaken by the Organization for that purpose.

Dr SIKOSANA (Zimbabwe) thanked WHO for providing countries in greatest need with both leadership and technical assistance in the control of communicable diseases. In Zimbabwe, much had been done to prevent and control poliomyelitis and neonatal tetanus, with satisfactory results, but efforts to combat HIV/AIDS, tuberculosis and malaria were thwarted by lack of resources. Despite concerted efforts, more than 700 000 cases of malaria had been recorded during the most recent season, with over 2000 deaths. The number of tuberculosis cases had more than tripled between 1989 and 1996, obviously as a result of the HIV/AIDS pandemic. While
Zimbabwe was grateful for WHO’s assistance, it believed a more coordinated, global effort was necessary. It therefore called upon all bilateral and multilateral agencies to rally and provide much-needed assistance for the prevention and control of communicable diseases in the countries most in need. A regional approach to the problem seemed to be the most cost-effective.

The importance of an effective epidemic surveillance system could not be overemphasized. Countries in greatest need could benefit from the expansion of electronic mail to expedite data transfer in order to develop and monitor the response to epidemics. Neglecting communicable diseases on the grounds that they were largely confined to developing countries alone was not a viable option in today’s “global village”.

The availability of hepatitis B vaccine in countries with high prevalence of the disease was limited by its costliness. He would therefore welcome information on progress in developing the quadruple vaccine containing DPT and hepatitis B vaccine.

Dr HAJAR (Yemen) said his country believed that vaccination campaigns were of paramount importance and had accordingly held a number of vaccination days in 1996, spurred by the political will of its leadership and with the benefit of financial support from the Regional Office for the Eastern Mediterranean, for which it was grateful. A donors’ meeting would be held in the near future to encourage donors to fulfil their obligations for poliomyelitis control. The concerted efforts made by the Regional Office and Member States in the Region had helped to stem the spread of malaria following an unusually heavy rainy season. Additional resources were needed, especially in the least developed countries, to enable them to implement vaccination programmes.

Mr CHAUHAN (India) said that, although dracunculiasis had long been a serious problem in India, the number of cases had dropped from 40 000 in 1984, when the national eradication programme had been launched, to only nine in 1996, and there was reason to hope that there would be none in 1997. An international evaluation of India’s programme had been undertaken in 1996, mobilizing a team of international experts from WHO and UNICEF as well as national experts; it had concluded that transmission had been interrupted in most endemic villages. Action was now being initiated to obtain certification from WHO’s International Commission for the Certification of Dracunculiasis Eradication; for that purpose, surveillance was being extended to the whole country by the inclusion of dracunculiasis in the list of diseases reported by each state, the national media were being mobilized for reporting on cases, and a nationwide search for cases was being actively undertaken.

Tuberculosis remained a major challenge, with 14 million cases, to which were added 1.5 million new cases annually. The Government had mapped out a new strategy, based on evaluation of pilot projects, emphasizing the cure of infectious and seriously ill patients through administration of supervised short-course chemotherapy to achieve a cure rate of at least 85% and intensification of case-finding. The World Bank had provided funding in the amount of US$ 142 million for activities connected with the strategy, which would be applied over five years, initially in a limited geographical area and for a population of 271 million, with gradual extension to cover the entire country.

Noteworthy success had been achieved in the leprosy control programme. The figure of 4 million cases in 1981, when multidrug therapy had commenced, had been reduced to 680 000 by 1995, and the prevalence rate had declined from 57 per 10 000 to just over 6 per 10 000 by January 1997. Full assistance for the project was being provided by WHO and the World Bank. At the current rate of progress it was more than likely that by the year 2000 leprosy would be eliminated as a public health problem in India.

Poliomyelitis had been a major problem until a “pulse” immunization programme had been launched in 1995. In December 1996 doses had been administered to 120 million children, and in January 1997 to 130 million. Since the start of the programme, more than 430 million children had been covered. The number of cases of poliomyelitis was coming down drastically, giving reason to expect that the disease could be eradicated.

Under a universal immunization programme begun in 1985, about 25 million infants had been vaccinated before reaching one year of age with three doses of diphtheria/pertussis/tetanus (DPT) vaccine, three of poliomyelitis vaccine and one each of measles and BCG vaccine every year. About 27 million women had been given two doses of tetanus toxide for the prevention of tetanus. The programme was moving along well, as attested to by the fact that the infant mortality rate, which in 1985 had been 129 per 10 000 live births, was currently down to 73.
Ms FIGUEROA (Honduras), referring to the transmission of Chagas disease, congratulated the Governments of Argentina, Brazil, Bolivia, Chile, Paraguay and Uruguay for the initiatives that they had taken in the Southern Cone and the impressive progress they had made with regard to the disease. Her country had proposed a similar initiative to eliminate Chagas disease in Central America, where it was a problem of increasing magnitude. A meeting would be held in Tegucigalpa to develop control and surveillance activities and set the objectives to be achieved over the next five years. At the ninety-ninth session of the Executive Board, the member designated by Honduras had raised the question of the submission of a report on the possible elimination of Chagas disease to the Board or the World Health Assembly in 1998.

HIV/AIDS was a problem of growing importance in her country, affecting the economically active population and the population of reproductive age. Mortality among young people was rising and there were increasing numbers of children infected with AIDS through their parents and of orphans whose parents had died of AIDS. Although great efforts had been made, her country required better collaboration and fuller knowledge of the activities of UNAIDS in order to help it achieve better results. She was not convinced that it was receiving the necessary assistance at the present time. One important aspect of the re-emergence of tuberculosis was its relation to AIDS. The fact that 25% of the AIDS patients suffered from tuberculosis was causing great difficulties.

Professor LEOWSKI (Poland) said programme 5.3 dealt with chronic diseases that in many instances were attributable to demographic transition - increases in life expectancy - and for many of which there was no cure. He therefore agreed with the emphasis laid on prevention, since proper action in respect of health promotion, lifestyles and behavioural changes could prevent such diseases.

In connection with programme 5.2, he noted that not only humans but also pathogens evolved. More than 25 new pathogens had been identified over the past two decades, and humans themselves were often responsible for their appearance. Tropical diseases were not restricted to the tropics: with the ease of travel in the contemporary world, they could reach any country within hours. Vigilance and proper and early diagnosis were crucial. Programme 5.2 seemed not to give sufficient attention to the importance of ensuring adequate diagnostic facilities, not only for tropical diseases, but also for tuberculosis.

Dr MALYŠEV (Russian Federation) said his delegation endorsed the basic thrust and strategic priorities outlined under appropriation section 5 and, in particular, the strengthening of the control of emerging and re-emerging communicable diseases. WHO's warnings about the growing danger represented by communicable diseases struck a respondent chord in the Russian Federation, which considered that the goal of improving the system for global monitoring of communicable diseases was fully justified. It had substantial experience in that area and was prepared to expand its cooperation with and provide full support for WHO. Priority should be given to such diseases as tuberculosis, with improvement of the strategy for control of the disease, using direct supervision and systematic immunization. Equal attention must be paid to HIV/AIDS and sexually transmitted diseases, hepatitis B virus and the Expanded Programme on Immunization.

He welcomed the emphasis in programme 5.3 on integrated control of noncommunicable diseases, but found the magnitude of that objective to be incompatible with the proposed reduction in financial resources for the programme, both at global level and in three specific regions. If, as seemed likely, the proposed programme budget had been drawn up before completion of The world health report 1997, the contradiction should be rectified. In view of the strong interest shown by many delegations in the conclusions of that report, the Secretariat should consider elaborating a strategy for integrated prevention of chronic noncommunicable diseases, with a view to its consideration by the Executive Board.

More stress should be laid, in WHO's activities for 1998-1999, on attracting additional extrabudgetary resources for the solution of certain health problems due to noncommunicable diseases, such as cardiovascular disorders, cancer, diabetes and genetically transmitted diseases, and in general for an integrated approach to the prevention and control of noncommunicable disease.

Ms HERZOG (Israel) observed that most noncommunicable diseases were related to behaviour and therefore preventable, yet they killed millions of people in what the proposed programme budget described as neglected epidemics. Over the years, WHO and its Member States had engaged in a variety of activities concerned with tobacco, alcohol, drugs, diabetes, nutrition and physical exercise; some progress had been achieved, but overall the effort involved had outweighed the results. The time had perhaps come to ask why the
results were not good enough and to try something different. Stemming such epidemics required behavioural change, which was notoriously difficult to bring about. Nevertheless, in view of the budgetary constraints under which WHO operated, it might be better to group the various headings together and make a concerted effort to change behaviours. That would require WHO’s developing the most effective methodology for the introduction and acceptance of health-promoting lifestyles. To that end, it would be particularly important to invest in the young and work with and through the young. They needed to be involved from the initial stages of development and planning through to the implementation of the relevant activities. Only the young could influence the young. The training of trainers among the young had already proved effective and should therefore be expanded and intensified in order to develop global youth leadership for health promotion.

Dr MAJORI (Italy) said that he rated programmes 5.1 and 5.2 high among WHO’s priorities. Although well satisfied with the work and leadership of WHO in combating communicable diseases, he was nevertheless concerned at the budgetary restrictions affecting some aspects of the work and requested the Director-General to ensure that the necessary financial resources were provided to implement the planned reorganization of the Division of Control of Tropical Diseases, particularly regarding malaria surveillance and control. Despite repeated resolutions, malaria was giving rise to increasing concern in old and new endemic areas. The requisite action was still hampered owing to shortage of funds and unclear lines of responsibility between headquarters, regional offices and Member States.

Professor NURUL ANWAR (Bangladesh) commended the allocation of additional regular budget resources for the eradication or elimination of specific communicable diseases such as poliomyelitis, leprosy and neonatal tetanus. However, he expressed concern at the transfer of funding from programme 5.2 to programme 5.1. Although the infant and maternal mortality rates had declined substantially over recent years, they were still very high in his country and his region. Priority attention should continue to be given to national programmes for vaccination against preventable diseases and for immunization and disease surveillance programmes. Additional support would also be needed for national programmes to deal with the emergence or re-emergence of malaria, leishmaniasis and HIV/AIDS. Despite the budgetary constraints, he therefore urged WHO to continue to ensure adequate resource allocation to those activities.

Dr SULEIMAN (Malaysia), referring to programme 5.2, called for greater attention to dengue haemorrhagic fever, which was now occurring in many countries of the world. He acknowledged that publications on dengue surveillance and control were available and were helpful and thanked the Regional Office for the Western Pacific for its support in dealing with outbreaks of dengue haemorrhagic fever in the Region. The prevention and control of the disease required intensive intersectoral collaboration and greater investment in research if the WHO target of checking the spread of the disease by 1999 was to be achieved.

Dr PARK (Republic of Korea) commended WHO on its substantial achievements in the specific programmes on poliomyelitis eradication, vaccines and immunization, and tuberculosis control. Thanking other Member States for supporting the establishment of the International Vaccine Institute in Seoul, he announced that the Korean Government would expand its contribution to those areas of work through investment in the Institute, voluntary contributions to WHO, and various bilateral collaboration projects with other developing countries.

Like many other countries, the Republic of Korea had for a long time been using standard purified protein derivative (PPD) supplied through WHO for tuberculin skin-testing, but it had recently encountered some difficulties in its national tuberculosis control programme owing to shortage of the antigen. Close communication should be established between WHO, the International Union against Tuberculosis and Lung Disease and other competent agencies to solve the problem.

Professor MYA OO (Myanmar) noted that whereas some age-old diseases, such as poliomyelitis, neonatal tetanus and leprosy, were on the verge of eradication in the South-East Asia Region, others, such as malaria, which had almost disappeared in the 1970s, had re-emerged. Moreover, new diseases such as HIV/AIDS and new strains of old diseases like cholera had appeared. In Myanmar, the expanded programme on immunization with six antigens, including oral poliovirus vaccine, had been very successful and had resulted in a significant reduction in morbidity and mortality from the six target diseases. A meeting of officials from Myanmar and
China to discuss poliomyelitis surveillance had recently been held and he was confident that poliomyelitis and leprosy would be eliminated from Myanmar by the year 2000.

Dengue haemorrhagic fever was endemic in the country and a policy of health education, environmental management and training was being adopted to combat it. The principal health problem, however, was malaria. In accordance with the global malaria control strategy, national efforts were being concentrated on early diagnosis and prompt treatment for the prevention and control of epidemics. A high-level committee had been established for mosquito control, emphasis being placed on environmental management and a mass campaign, with the collaboration of nongovernmental organizations, for the elimination of breeding sites.

WHO's essential technical and logistical assistance was highly valued. He therefore hoped that the Organization would continue to strengthen the capabilities of Member States and intensify its efforts to combat communicable diseases wherever they were endemic.

Dr ITO (Japan) welcomed the proposed increase in the budget allocation for programmes on emerging and re-emerging infectious diseases. However, in view of the great importance of the problem of infectious diseases worldwide, and taking into account the modest size of the initial budget allocation, his country would welcome continuing efforts to ensure sufficient funding in future budget discussions.

With regard to the global efforts to combat HIV/AIDS, he noted that UNAIDS had been established as a successor to the Global Programme on AIDS (GPA) in January 1996. WHO was an influential cosponsor of UNAIDS and was expected further to develop its programme activities in HIV/AIDS-related areas. In so doing, it should play a strong promotional and coordination role. He therefore requested clarification concerning the budget allocations for those important activities, with and without staff costs.

Regarding the decision to transfer 2% of the headquarters budget to country programmes of high priority, allocating half of that amount to HIV/AIDS-related programmes, the simple redistribution of those funds to the Regional Offices did not seem to him appropriate. Deliberations were needed at headquarters level so that the activities to be conducted with the reallocated funds could be coordinated with those of other WHO programmes and of other United Nations bodies. He wondered whether sufficient budgetary allocations would be made for such coordination work.

Finally, he asked the reason for the apparent decrease in the allocation for specific programme 5.2.6 (Control of tropical diseases), recalling that a similar question put by a member of the Executive Board in January had not received an adequate answer. He understood that a number of draft resolutions were being proposed to strengthen WHO's activities in the control of tropical diseases, which he considered to be a very important area of work.

Professor WHITWORTH (Australia) noted that The world health report 1997 focused on noncommunicable diseases. While health status globally was improving, it was still very poor in the least developed countries and was actually declining in some countries. Two of the Executive Board's priorities under appropriation section 5 were the eradication or elimination of specific communicable diseases and the control of other communicable diseases. Those activities were at the core of WHO's mandate; underpinned by research, they were areas in which WHO could make an extraordinary impact through activities that were often very cost-effective. She therefore welcomed the shift in resources towards programmes 5.1 and 5.2, and would have liked to see a similar effort in other priority areas.

Dr SILWAMBA (Zambia) gave full support for the integrated approach to disease control as a prerequisite for the cost-effectiveness and sustainability of health services. However, he expressed concern at how it was described in appropriation section 5 and the way in which the concept was implemented in practice. In effect, traditional vertical programmes were being repackaged into new forms and disguised as «integrated» programmes. While commending the work of many programmes and specialized units of WHO in developing and updating guidelines, norms and technical standards, he believed that the Organization was not living up to its declared intention of promoting integration, particularly through comprehensive primary health care systems and effective public health infrastructures. The reality was that those systems were being undermined and weakened; their meagre human, financial and institutional resources were being diverted from other primary health care purposes to current «integrated» programmes. The best staff in primary health care systems were frequently being attracted by supporting organizations, which often provided better pay and conditions.
In its efforts to strengthen its health delivery systems, particularly as regards primary health care, Zambia had met with reluctance among some of its partners to participate fully in the approach that it was adopting. In particular, WHO and UNICEF advocated the maintenance of vertical programmes, probably because of the way they prepared their budgets and resource allocations. There was a danger that some activities might actually be contributing to the collapse of health care systems in the developing world. Indeed, the history of attempts to strengthen health care in developing countries was strewn with well-intentioned but failed programmes. He therefore urged delegates to bear in mind, as they called for the allocation of more resources under appropriation section 5, that the activities involved might be achieving the opposite of their intended effect. He acknowledged that many WHO programmes had developed useful standards, guidelines and training materials which, with some adaptation, could be used to strengthen integrated health services. In addition, some WHO programmes, and particularly maternal and reproductive health, had foreseen the problems and had worked with his country in an attempt to deverticalize health programming. He therefore supported a more integrated approach to health service delivery.

The meeting rose at 12:30.
PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999: Item 17 of the Agenda (continued)


Appropriation section 5: Integrated control of disease (continued)

5.1 Eradication/elimination of specific communicable diseases (continued)
5.2 Control of other communicable diseases (continued)
5.3 Control of noncommunicable diseases (continued)

Mr LIU Xinming (China), speaking on programme 5.1, said that international efforts to control neonatal tetanus and poliomyelitis had made great progress, particularly in his Region, the Western Pacific, where activities had been ably supported by the Regional Office. Realistic and adequately funded programmes could achieve a great deal: he hoped that the activities outlined in the proposed programme budget would consolidate the progress made so far. In programme 5.2, greater attention should be given to tuberculosis related to human immunodeficiency virus (HIV).

Mr VOIGTLÄNDER (Germany) welcomed the draft resolution on WHO collaborating centres recommended in Executive Board resolution EB99.R14. Collaborating centres were a valuable source of scientific and managerial expertise for WHO; the system should be further developed for that reason, and not merely as a source of additional funding. He proposed the insertion in paragraph 2 of a new subparagraph reading:

(1) to strengthen the cooperation between WHO and its collaborating centres in priority areas, the existing subparagraphs to be renumbered accordingly.

Subparagraph 2(2) called upon the Director-General to promote the emergence of “a larger number” of collaborating centres. However, it was surely the quality, rather than the quantity, of centres which was important: in Germany, many institutions applied for designation as WHO collaborating centres, but only genuine centres of excellence with an international reputation were accepted. He hoped that the draft resolution would be approved, with the amendment he had suggested.

Dr KIHUMURO-APUULI (Uganda) expressed his support for the activities outlined in the proposed programme budget. The burden of communicable disease in Uganda was considerable, although the government programme to combat tuberculosis, HIV/AIDS, poliomyelitis and dracunculiasis had proved successful. The country could not mobilize the resources needed to tackle those problems by itself. To give one example, approximately two million people in Uganda were HIV-positive and over a million children had been orphaned as a result of AIDS.

Dr ABEDNEGO (Indonesia) welcomed the increase in the proposed programme budget allocations for the control of communicable diseases, particularly in the South-East Asia Region. However, even more
resources would be necessary, given the current increase in the prevalence of new, emerging and re-emerging communicable diseases. Indonesia appreciated the guidance provided by WHO to national communicable disease control programmes.

In his own country, starting in 1997, all newborn babies would receive three doses of hepatitis B vaccine, produced within the country, in their first year of life without charge to the parents, in addition to the other vaccinations specified in the Expanded Programme on Immunization. A programme of national immunization days had been organized, in which 23 million children under the age of five years had received oral poliomyelitis vaccine. The budget for surveillance of acute flaccid paralysis, the priority programme supporting the goal of eradication of poliomyelitis by the year 2000, had been increased from US$ 80,000 to US$ 1.6 million. The country's annual budget for tuberculosis control had also been increased.

He asked for clarification regarding the large reduction in the proposed allocations for the African Region in the specific programmes for vaccine-preventable diseases, diarrhoeal and acute respiratory disease control, and tuberculosis as indicated in Table 7 of document PB/98-99.

Dr CHIESA (Uruguay) said that WHO had provided valuable research support for programmes to control Chagas disease in Uruguay and the surrounding subregion. Continued support was essential if the chain of transmission of Chagas disease was to be broken and the vector, *Triatoma infestans*, eradicated. The measures adopted could provide an example for other subregions in the Americas.

With reference to emerging and re-emerging communicable diseases, support for the control of the vector mosquitos *Aedes aegypti* and *Aedes albopictus* remained particularly important for the Americas. Uruguay had recently seen the re-emergence of *Aedes*, 30 years after its eradication, because of a reduction in surveillance measures by neighbouring countries. Fortunately, however, no cases of dengue had yet been reported. If the required standard of control and surveillance measures was to be maintained, additional resources to support the efforts of individual countries would be necessary.

Dr LEGNAIN (Libyan Arab Jamahiriya) thanked WHO for its efforts to support control programmes against sexually transmitted and other communicable diseases by means of vaccines, awareness-building and treatment. The biggest problems in her Region were tuberculosis and sexually transmitted diseases, including HIV/AIDS, all of which threatened to jeopardize attainment of the goal of health for all by the year 2000. More material support was needed, particularly in the areas of epidemiological surveillance, laboratory techniques, maternal and child health and dissemination of easily assimilated health promotion materials for both rural and urban populations. Her own country had good immunization coverage and effective programmes for the control of sexually transmitted and other communicable diseases; however, the embargo imposed upon it by certain other countries meant that the supply of drugs and medical devices was very precarious. She hoped that the international community would address that situation.

Dr DLAMINI (Swaziland) said that HIV-related tuberculosis was on the increase in her country. The main problem was lack of awareness among the population and reluctance to seek medical assistance quickly. Health education programmes needed to be strengthened and she was accordingly pleased to see the proposed increase in the allocation for health promotion in the proposed programme budget. The rate of HIV infection had also increased: people were generally aware of the risks, but it was difficult for them to change established behaviour patterns. For that reason, her country emphasized school health and adolescent reproductive health programmes. One particular danger was the aura of secrecy which often surrounded the subject of HIV/AIDS; the disease was a public health threat, so perhaps there was a case for reconsideration of the rules that generally governed public health activities in relation to how HIV/AIDS was managed.

Swaziland had achieved 97% coverage in its immunization campaigns, but cases of neonatal tetanus still occurred because not all births took place in health care facilities. The country required help to improve its telecommunications, its transport system and its provision of human resources in remote rural areas, in order to improve health education and access to health services.

Cardiovascular disease and other stress-related and nutrition-related disorders were becoming an increasing burden in her country. Sensitive health education programmes were required in circumstances where cultural factors were involved and better stress management techniques were needed to combat the effects of modern lifestyles. Diabetes mellitus was also assuming greater importance. The
equipment and skills for accurate diagnosis were not available, and the disease was difficult to control, since people often found it hard to comply with the treatment regime, and very costly to manage.

She welcomed the activities outlined in the proposed programme budget, but hoped that they would give due emphasis to strengthening of and support for activities at country level.

Dr SULAIMAN (Oman) welcomed the increase in the regional allocation for programmes 5.1 and 5.2, but asked whether it would be sufficient to guarantee, for example, the eradication of poliomyelitis by the year 2000, which would be a great incentive to other disease eradication programmes, such as those for measles and tuberculosis. Countries bore the major financial burden of such programmes and deserved more support. Members of the Gulf Cooperation Council had introduced a strategy for the control of tuberculosis in a number of countries in their Region. In Oman, the strategy had improved case detection and treatment rates as well as the control of bacterial transmission. The strategy could usefully be applied in all regions of the world. Another area of activity which deserved special attention was the malaria control programme. The epidemiology of the disease had been well understood for the last 50 years, and better control should be possible.

Dr MAYNARD (Trinidad and Tobago) commended the proposed programme budget, which was clear and which targeted major health issues. Trinidad and Tobago, like other countries in the Caribbean subregion, had made remarkable progress in its expanded programme on immunization. Poliomyelitis had been eradicated and there had been no confirmed cases of measles in five years. Crucial to those achievements had been the role of the Government, health workers and various sectors, as well as the technical support and guidance provided by PAHO. The considerable expense of the hepatitis B vaccine restricted its use in Trinidad and Tobago. She requested information on the Organization’s efforts to reduce the cost.

Professor PICO (Argentina) welcomed WHO’s continued support for the eradication of communicable diseases. Vital factors for early success were the commitment of national health authorities and, in particular, community involvement, for cultural factors often hampered the fight against communicable diseases at the local level. Argentina had intensified national immunization activities, adding new vaccines to its expanded programme on immunization, implemented mass health education campaigns and initiated joint action with the Ministry of Education to raise awareness. As a result, average coverage had reached 93%.

Technical cooperation between countries should be fostered through regional and subregional initiatives on health, since drawing on others’ experiences led to more rational use of available resources. Argentina was participating in worthwhile joint action with other countries in Mercosur (the common market of the southern cone) and the Southern Cone Initiative, for example with the Republic of Bolivia in the control of malaria and other common diseases. Progress had likewise been achieved in interrupting the transmission of Chagas disease in the southern part of the continent. He supported Uruguay’s comments on that disease. He reiterated the need for joint action to promote new epidemiological surveillance programmes, which were vital in controlling both communicable and noncommunicable diseases.

Dr KHARABSHEH (Jordan) suggested that, as a result of the significant achievements in poliomyelitis eradication, it had become necessary to redefine poliomyelitis and acute flaccid paralysis and to find new classification criteria in order to facilitate specific diagnosis. He asked whether national immunization days would be necessary in coming years in countries with zero incidence or with low incidence from wild virus transmission and whether WHO would be recommending the inactivated polio vaccine to countries with zero cases as a means of preventing vaccine-linked infection.

He called on WHO to support those countries which, after being free for decades from certain tropical diseases, such as malaria, were now faced with their re-emergence, linked to the unavoidable inflow of migrant workers. Schistosomiasis threatened to become endemic in countries, including Jordan, which had previously been free of it. Technical support from WHO was needed, particularly for strengthening disease surveillance and control and for training; access to reference laboratories was currently insufficient.

Dr OTOO (Ghana) said that dracunculiasis was being effectively tackled as part of the global eradication programme, which exemplified the value of a multisectoral approach and community involvement. The latter was of particular importance in Ghana, where hospital attendance was low on account of widespread alternative medical practices and insufficient training of health staff on disease surveillance. However, although it had
facilitated the identification and treatment of dracunculiasis, a 96% drop in cases had resulted in complacency among those involved in community surveillance. WHO support was needed for developing sustainable mechanisms to maintain community-level surveillance for dracunculiasis and other diseases even after eradication. To ensure interruption of transmission, treatment of cases should be combined with efforts to ensure safe water supplies, for example from boreholes, hand-dug wells and treated surface waters. Cooperation between the health sector, local government, community leaders and water departments would provide the human and material resources as well as the political will and expertise needed to eradicate the disease. He thanked the British Overseas Development Administration (ODA) for its assistance to date and hoped for its continued support in achieving eradication over the coming two years.

Dr MESHKHAS (Saudi Arabia), commending work done in the integrated control of disease, stated that members of the Gulf Cooperation Council, including Saudi Arabia, had achieved 90% coverage in immunization against childhood diseases and had taken measures to control hepatitis B and neonatal tetanus. Success in that area was partly attributable to the unified drug and vaccine procurement programme, which he recommended for other countries. Progress had been made in reducing morbidity, particularly infant and maternal morbidity, and in tackling intestinal parasitic diseases.

Changes in nutrition and lifestyles had resulted in an increase in noncommunicable diseases. In cooperation with other Gulf countries, Saudi Arabia had set up programmes on cancer, cardiovascular disease and diabetes mellitus. WHO should increase its efforts to combat noncommunicable diseases, in particular in the areas of training, research, and health education in schools.

WHO's continued support was crucial to ensure poliomyelitis eradication. Saudi Arabia, together with other countries of the Gulf Cooperation Council, had set up its second poliomyelitis eradication action plan and hoped to launch a third one soon. Despite local and regional efforts, the disease was still a threat and was re-emerging in many countries. Global and regional action was vital in order to eradicate it by the year 2000.

Dr ABDUL WAHAB (Bahrain) said that, although countries in the Eastern Mediterranean Region were tackling tuberculosis, HIV/AIDS and hepatitis, increased tourism and ecological changes were impairing their ability to respond to those challenges. Acknowledging WHO's support in combating communicable diseases to date, he requested further help, in particular in setting up laboratories to improve local surveillance and in detecting and reporting new diseases at a local and international level. Cases of tuberculosis, hepatitis and HIV/AIDS had been observed among migrant workers, who made up 50% of the labour force in Gulf countries. The spread of communicable diseases indicated that laboratory surveillance and documentation on the health status of migrant workers were obviously unreliable and must be improved.

Dr KONO (Chad) said that, following considerable efforts to eradicate dracunculiasis, the disease was under control in his country. Progress had also been achieved in control of leprosy, although nomadic populations posed difficulties, in dealing with which assistance from WHO and countries with similar problems would be welcome. WHO should intensify its leadership in the eradication of poliomyelitis and the promotion of immunization. The re-emergence of African trypanosomiasis in Chad was worrying. He called on developed countries to pay greater attention and allocate adequate financial resources to control of HIV/AIDS and tropical diseases, which recognized no frontiers.

Dr TEMU (Papua New Guinea), commending WHO's commitment to programmes 5.2 and 5.3, said that the fight against vaccine-preventable and other communicable and noncommunicable diseases was supported in his country by the Government, by bilateral agencies such as the Australian Agency for International Development, and by UNICEF, WHO and other United Nations agencies. Safeguarding vital programmes, continuing the current disease surveillance activities, for example on poliomyelitis and leprosy, and maintaining the 80% immunization coverage were matters of great concern in the current context of government reform and decentralization. He called for continued technical support, notably in strengthening of district-level capacity for planning, implementation, community mobilization and logistics, particularly with respect to cold-chain systems, and welcomed efforts to develop cost-effective diagnostic and treatment methods for developing countries.

In the area of noncommunicable diseases, intensified global and regional collaboration was important in protecting vulnerable countries such as Papua New Guinea, where efforts to develop legislation on, for example,
food safety and to conduct health promotion and education activities were being undermined by powerful multinationals, which flooded the country with cigarettes and inferior-quality foodstuffs and thereby caused premature deaths, especially within young, productive age groups.

Dr GHOSHEHGHIR (Islamic Republic of Iran) said some countries might have difficulties regarding the proposed observance of World Tuberculosis Day on 24 March because of religious or national holidays that fell at around the same time. It was important to raise public awareness of tuberculosis and, in order to gain the maximum benefit from World Tuberculosis Day, it might be necessary to incorporate a reference to the need to take account of the social and cultural background of each country in the resolution recommended for adoption by the Health Assembly in the Executive Board’s resolution EB99.R27.

Dr THYLEFORS (Secretary) said that World Tuberculosis Day would be discussed under item 19 of the agenda, but the proposal of the delegate of the Islamic Republic of Iran, which should be submitted in writing, had been noted.

Mrs MANYENENG (Botswana) said implementation of integrated management of childhood illness had unfortunately taken some time in the planning stages and the shift in emphasis from individual and unintegrated programmes that was envisaged could be undertaken only with the guidance and assistance of WHO. That guidance was requested as a matter of urgency, for Botswana’s infant mortality rate of 45 per 1000 live births was unacceptably high. WHO was to be commended for the importance it had accorded to the control of communicable diseases. However, tuberculosis had now re-emerged with even greater virulence and resistance to treatment, and co-infection with HIV/AIDS had made it one of the leading causes of death in Botswana. The strategy known as “directly observed treatment, short course” (DOTS) had proved very effective for treatment of tuberculosis if correctly implemented. Other sexually transmitted diseases had also re-emerged. Following recent increased rainfall, Botswana had experienced malaria epidemics even in areas that in the previous year had been non-malarious; in 1996, 214 people had died of the disease. Botswana hoped to eliminate leprosy in the near future. There had been no reported cases of poliomyelitis or neonatal tetanus for six or seven years, and measures were in place, such as monitoring and surveillance of acute flaccid paralysis, to work towards the eradication of poliomyelitis. Botswana was now also faced with all the noncommunicable diseases, some of which were related to lifestyle, and had therefore established a noncommunicable disease subunit within its epidemiology and disease control unit.

Professor AKIN (Turkey) acknowledged the efforts of WHO, together with UNICEF, regarding vaccine-preventable childhood diseases. Turkey was now in its third year of a programme of national immunization days for the eradication of poliomyelitis and coverage was increasing. However, the programme to eliminate neonatal tetanus was not being implemented as successfully; existing intervention strategies must be reviewed and the programme accelerated if elimination was to be achieved by the target date. In addition to the immunization of all pregnant women and ensuring clean and safe deliveries, consideration should be given to changing some harmful traditional practices, and additional WHO support to assist countries in overcoming the problem of medical barriers and strengthening the surveillance system would be appreciated. For best results the programme should target maternal health; where possible neonatal tetanus elimination and safe motherhood programmes should be combined.

There were many multiple vaccine products on the market that were promoted by private companies and used by most private physicians, while public health services tended to adhere to schedules recommended by WHO. She requested information on the likely impact of having two different schedules on the control of vaccine-preventable diseases.

Finally, she acknowledged WHO’s assistance to countries in implementing programmes to control diarrhoeal diseases and acute respiratory infections: as a result, 85% of children under five in Turkey currently had access to oral rehydration therapy, and diarrhoeal diseases, formerly the second most common cause of death for the under fives, had dropped to sixth place.

Dr MACHADO (Brazil) said that his country was experiencing an epidemiological transition, and was seeking ways of mitigating the suffering and high rates of disability caused by noncommunicable diseases while at the same time combating endemic communicable diseases.
There were two problems of major concern for which his country was seeking assistance from WHO. Malaria had been somewhat reduced, thanks mainly to the decentralization policy for diagnosis and treatment, but it still affected 400,000 people a year and was one of the major obstacles to socioeconomic development in the Amazon region. Brazil urged WHO to accelerate new antimalaria activities based on the genetic manipulation of mosquitoes and to increase its support with a view to developing an effective antimalaria vaccine. More than 6000 cases of dengue had been recorded in the past 12 months, and there was concern about the presence of *Aedes aegypti* throughout the country. Brazil was therefore requesting WHO's urgent support for a continent-wide strategy to eliminate the mosquito which transmitted yellow fever. Without such action it would probably not be possible to control the disease effectively.

Dr OTTO (Palau) said that his country's Expanded Programme on Immunization had achieved satisfactory coverage with welcome and timely assistance from the Regional Office for the Western Pacific and UNICEF. The bulk of assistance in that area came from extrabudgetary contributions, and Palau wished to express its gratitude in that regard to the Governments of the United States of America and Japan. Finally, he associated himself with the concern expressed by the delegate of Malaysia regarding dengue and dengue haemorrhagic fever, by the delegate of Swaziland regarding secrecy in HIV/AIDS, and by the delegate of Papua New Guinea regarding the dumping of unhealthy products on developing nations.

Dr DOSSOU-TOGBE (Benin) said that the development of communicable diseases was dependent on a wide range of factors, the most important of which was the state of the body's immune system. The Health Assembly had already discussed the significance of nutrition for the immune system; alongside prophylactic and therapeutic measures, measures to improve nutritional status were of great importance in helping to control communicable diseases. Noncommunicable diseases also deserved special attention: everyone recognized the increasing danger for humanity in general represented by certain eating habits, smoking, alcoholism, sedentary lifestyles and the development of industry. The countries of the South in particular needed coordinated action in advocacy, training and the provision of adequate information for the effective implementation of measures to prevent noncommunicable diseases. Benin supported the programmes under discussion and expressed its gratitude for WHO cooperation in those areas.

Mrs AL-RIFAI (United Arab Emirates) said her country had tried to follow WHO guidelines for the control and eradication of communicable diseases, with the result that in 1996 it had recorded only eight cases of malaria and that no case of poliomyelitis had been recorded since 1992. The focus was now on follow-up, surveillance and diagnosis; it was hoped that closer monitoring of trends would shed light on problems such as resistance to antibiotics resulting from their incorrect use.

Dr BIKANDOU (Congo) said that his country had just completed national immunization days against poliomyelitis, achieving 91% coverage, and supported the eradication goal. In Congo the campaign against communicable diseases was fraught with huge difficulties, particularly in obtaining vaccines, and he suggested that WHO should support construction of a facility in Africa to produce sufficient vaccines of appropriate quality to provide for national needs. His Government was also endeavouring to increase the budget allocated for health. A number of diseases, including malaria, tuberculosis and HIV/AIDS, were giving rise to concern and he requested WHO to mobilize other partners to assist the countries suffering from those diseases. Finally, he welcomed the proposed budgetary increases in the areas under discussion.

Dr MADUBUIKE (Nigeria) expressed his country's gratitude for WHO support in primary health care, disease control and reform of health systems throughout the world. Nigeria had carried out a number of programmes in response to WHO initiatives, including national immunization days against poliomyelitis, cerebrospinal meningitis and, in areas at risk, yellow fever in late 1996 and early 1997. National coverage of over 75% had been attained and cerebrospinal meningitis brought under control. Two more immunization cycles would be carried out in December 1997 and January 1998. The number of leprosy cases had been reduced from 200,000 in 1989 to under 14,000 in 1996 and all registered cases had been treated free of charge. In addition, the WHO-recommended DOTS strategy for the control of tuberculosis was being implemented with the aim of detecting 70% of existing cases and curing 85% of those detected. In 1996, appreciable progress had been made, with a total of over 15,000 cases treated. The Expanded Programme on Immunization had also been
restarted and coverage, which had fallen to less than 30% in early 1990, had now risen to over 90% in many areas thanks to government support for vaccine purchase.

A structure to cope with epidemics in the country now existed: WHO had assisted in strengthening laboratories and training technicians for early detection of diseases, the surveillance system had been improved and adequate stocks of vaccine were now available. Training in epidemic management was under way. Nigeria had also embarked on health sector reforms, which took into account WHO recommendations and involved private sector participation in health planning and delivery, a national health insurance scheme, and a new national health policy and plan. Continued WHO assistance would be needed to implement some of those programmes and he therefore supported an increase in the current year's budget. Nigeria, for its part, would continue to fund primary health care and disease control activities.

Dr KALITE (Central African Republic) said that his country hoped to eradicate dracunculiasis, leprosy and poliomyelitis from its territory by the year 2000 and was pleased to note the concern of WHO, from which it would continue to expect help, in regard to those diseases. Although great efforts had been made in the realm of medical technology, diseases such as malaria and trypanosomiasis continued to take a heavy toll and innovative approaches to disease control must be sought. Increased community involvement, improved planning and evaluation and concrete action were also essential.

Professor ZOUGHAILCHE (Algeria) endorsed the priorities selected and stressed that the parasitic diseases mentioned in programme 5.2, which were prevalent in his Region, had important health and economic consequences; some, particularly malaria, which had been disappearing as the result of campaigns, were re-emerging. Most of the WHO and FAO bodies studying those problems focused on features such as environmental aspects, improved surveillance and general control methods. In fact, development often forced people to penetrate unfamiliar ecosystems, resulting in the emergence or re-emergence of certain diseases. An important factor in the epidemiology of zoonoses was the presence of parasite reservoirs in wild animals, and further study was needed to elucidate the complex life cycles of the parasites concerned. WHO should pay greater attention to brucellosis and rabies, to the assessment of the social and economic consequences of parasitic diseases, and to the promotion of training and research.

Dr DLAMINI ZUMA (South Africa) supported the strategies outlined for combating emerging and re-emerging infectious diseases and endorsed the work done in the eradication of specific communicable diseases. She expressed her appreciation for the technical support offered by WHO in tuberculosis control and the introduction of the DOTS strategy, since South Africa had a very high incidence of that disease. However, WHO should match priorities with budget allocations. She therefore requested an explanation of the severe cuts in the allocations for control of tuberculosis and vaccine-preventable diseases in the African Region. Over-reliance on potential receipt of extrabudgetary resources might threaten the sustainability of programme activities.

Dr KJLIMA (United Republic of Tanzania) expressed appreciation for the assistance provided by WHO in disease control. However, greater efforts were required to control communicable diseases, which accounted for approximately 90% of Africa’s disease burden. The United Republic of Tanzania had undertaken national immunization days, with an overall coverage of 97%, and was achieving some success in introducing integrated management of childhood illness. Malaria was still prevalent, accounting for 15% of deaths in children under five years of age, and tuberculosis and HIV/AIDS were on the increase. Efforts were continuing to institute practical measures for the prevention of malaria, advocacy for the prevention of HIV/AIDS and introduction of the DOTS strategy for tuberculosis control, but further external support would be needed. As he had said at the third meeting in regard to programme 4.1 (Reproductive, family and community health and population issues), he failed to see appropriate emphasis in the proposed programme budget on the need to monitor the health of children under five years of age as a preventive measure, although some health development issues were addressed.

He welcomed the emphasis given to noncommunicable diseases. A community-based study in the United Republic of Tanzania had shown definite increases in the incidence of diabetes and of hypertension and other cardiovascular disorders. Countries like his were thus shouldering a double burden and communities must be informed of the dangers of such diseases.
Dr MUÑOZ (Chile) welcomed the proposals for combating the diseases under discussion, which had a great impact in all countries. Endorsing the views of the delegate of Argentina concerning the management of specific action to achieve those objectives, he emphasized the importance, firstly, of promoting subregional programmes, so that the countries concerned could make a concerted approach in solving the problems affecting them and of which they had first-hand knowledge, and secondly of stimulating technical cooperation among developing countries. Chile was cooperating with Haiti and a number of Central American countries, resulting in valuable mutual learning, which should lead to deeper links based on friendship and international solidarity, in keeping with the essential principles of the United Nations.

Professor MYA OO (Myanmar) said that his country was going through a period of socioeconomic development and epidemiological transition. Communicable diseases were still a major health problem, while at the same time changes in lifestyle and behaviour had brought in their wake noncommunicable diseases such as cardiovascular diseases, cancer and diabetes. Efforts had been made to combat noncommunicable diseases through health education, using the mass media to promote healthy lifestyles and diet, physical activity and anti-smoking measures. Prevention was an integral part of all programmes in both clinical and community settings. Services to combat noncommunicable diseases were costly and required high technology, for which assistance from WHO and other donor agencies was required. He expressed appreciation to WHO for its valuable contributions to date and urged the Organization to play a key role in promoting noncommunicable disease programmes in developing countries.

Ms COLLADO (Spain) observed that cardiovascular diseases, which were one of the leading causes of death throughout the world, were now moving from the rich countries to the developing world. Spain had launched a public information campaign, including a special "Heart Day", to raise public awareness of ways of avoiding cardiovascular accidents. She supported the proposed programme budget allocations but would encourage WHO to seek additional resources for information programmes in countries where those diseases were the leading cause of death. It was preferable and more cost-effective to conduct prevention programmes, for example to discourage smoking, and promote healthy diets and lifestyles, than to have to resort to curative measures.

Dr DANIEL (Cook Islands) thanked WHO, and especially the Regional Office for the Western Pacific, UNICEF, UNFPA, the Governments of New Zealand and Australia and the South Pacific Commission for their assistance to his country in disease control. He endorsed appropriation section 5 of the proposed programme budget and welcomed the increased allocations to programmes 5.1 and 5.2, but was concerned that a similar increase had not been made in other areas. In Cook Islands, morbidity and mortality due to noncommunicable diseases were increasing and rates now exceeded those for communicable diseases. While cigarette smoking was tending to be regarded as unacceptable in some larger countries, cigarettes were becoming more available and cheaper in his country. He therefore requested WHO to examine ways of stopping the production of cigarettes. He endorsed the views expressed by the delegates of Palau and Papua New Guinea concerning the problem of dumping.

Dr DA WOOD (Kuwait) commended WHO's action for communicable disease control and looked forward to success in the eradication of poliomyelitis, although additional resources might be needed to attain that goal. He asked whether, for countries which had no cases of the disease, it would be necessary to continue organizing national immunization days until global eradication had been achieved.

Dr INFANTADO (Philippines), commenting on programme 5.3, said that an increasingly large proportion of health budgets went towards the detection and management of noncommunicable disease cases, not only because the middle and older age groups were increasing in number in both absolute and relative terms, but also because the health technologies and services needed for such diseases were sophisticated and costly. Programme 3.4 (Quality of care and health technology) highlighted the growing concern for the quality, safety, cost-effectiveness and affordability of health products and technologies, and not just their availability. However, in view of the scarcity of resources and the increasing health and medical needs faced by governments, informed resource allocation decisions were required. She therefore urged WHO to take the lead in research efforts
moving beyond cost-effectiveness studies to comparative cost-benefit analyses, particularly of high-cost, sophisticated health technologies.

Mrs VU BICH DUNG (Viet Nam) said that her Government gave high priority to the eradication of communicable diseases such as poliomyelitis. As WHO's support was required to control communicable diseases, such as tuberculosis and malaria, which were still a serious health problem, she expressed concern that the resources allocated to her Region had been reduced and proposed that they be maintained at the current level.

Ms TIHELI (Lesotho) expressed appreciation of the support provided by WHO and its partners, and of the increased budgetary allocations to Africa, which she hoped would continue in future, especially in the areas of HIV/AIDS, sexually transmitted diseases, tuberculosis, and childhood diseases. Lesotho was currently implementing another round of national immunization days which it was hoped would prove more successful than in the past. Although no case of poliomyelitis had been reported in her country for the last 10 years, the surveillance system needed strengthening; she noted with satisfaction that WHO had established certain targets in the programme budget in that regard which should be of benefit to her country.

Professor ACHOUR (Tunisia) said that in his country's current epidemiological transition period the control of certain communicable diseases such as poliomyelitis and tuberculosis had been given priority and prevention campaigns organized. He expressed gratitude for sustained WHO support for those programmes. While endorsing the proposed programme budget in general, he considered that emphasis should be laid on noncommunicable diseases to the same extent as in the past.

Dr AMATHILA (Namibia) expressed appreciation for the support provided by WHO, UNICEF and the European Union, among other bodies. Her country's expanded programme on immunization had been successful, reaching 90% coverage in the previous year. However, following the re-emergence of poliomyelitis after a period of abeyance, country-wide immunization days against poliomyelitis and measles would begin in June 1997. With regard to tuberculosis, which mainly affected those aged 15-44 years, the national control programme was improving steadily. Thanks to a tuberculosis information system it was now possible to follow closely the trends of the disease within the country. The DOTS strategy had also been introduced, and as a result the default rate had fallen to 7% for new cases. Namibia was actively involved in the WHO-supported Southern African Tuberculosis Control Initiative, which she hoped would be sustained.

Dr BEGUM (Bangladesh) said that, whereas in the past noncommunicable diseases had created fewer problems in developing countries because life expectancy was very low, it was now important for those countries to give attention to such diseases. She therefore welcomed the emphasis given to them in the proposed programme budget.

Mrs HEIDET (International Cystic Fibrosis (Mucoviscidosis) Association), speaking at the invitation of the CHAIRMAN, made a statement on behalf of the International Cystic Fibrosis (Mucoviscidosis) Association (ICF(M)A), the International Clearing House for Birth Defects Monitoring Systems, and the World Federation of Haemophilia, all of which were nongovernmental organizations cooperating with WHO and its human genetics programme in particular. Genetic disorders, in particular cystic fibrosis, birth defects and haemophilia, were becoming a major public health concern, calling for concerted action to improve diagnosis, treatment, prevention and control. Giving a brief summary of past cooperation with WHO, which had proved successful and productive through joint meetings leading to the development of educational materials and guidelines on prevention and control, she turned to possible future trends in collaboration. The fact that the incidence of cystic fibrosis was considerable in the eastern as well as the western hemisphere had become apparent following the joint WHO/ICF(M)A meeting on the implementation of cystic fibrosis services in developing countries, held in Bahrain in 1995. As a result of the meeting guidelines had been produced and joint plans were under way to strengthen regional and country-level cooperation through WHO Representatives and regional offices and the ministries of health of WHO Member States. Annexes to the guidelines would include nursing and nutrition factors. Similar action was also being taken for the prevention and control of birth defects and haemophilia, with emphasis on counselling and care in developing countries. WHO's cosponsorship of workshops and international meetings did much to attract international attention to the severity of such hereditary disorders.
Cystic fibrosis, formerly an inherited condition fatal in childhood, had since developed into a chronic lifelong condition, requiring specific treatment and rehabilitative counselling for both children and adults. The same applied to birth defects and haemophilia. It was urgent that training of professional health care providers and the provision of training courses should be promoted and extended. Joint documentation had been produced in cooperation with WHO, with a view to increasing public awareness of hereditary diseases and their concomitant problems. She expressed gratitude to WHO’s Member States for their continued support and encouragement through their national institutions and health infrastructures.

Continuing at the invitation of the CHAIRMAN, she read out a statement on behalf of Mr Papageorgiou, representative of the Thalassaemia International Federation (TIF) who was unable to attend. TIF had been admitted into official relations with WHO in 1996 and had 60 member countries. Approximately 4.5% of the world’s population, i.e. about 250 million people, carried a thalassaemic haemoglobin trait. About 300 000 affected infants were born annually, representing an annual global birth rate of over two per 1000. One of TIF’s main objectives had been to assist in the establishment of national thalassaemia associations; its activities had now extended to cover the establishment and coordination of prevention and control programmes. TIF had also helped to establish and provide financial support for regular training courses and was concerned with the updating of educational materials for families and professional health care providers. International meetings and research protocols for the improvement of clinical management and eventual cure for thalassaemia were being developed and TIF was also financing fellowships for gene therapy research, an area of great promise. TIF was planning, in collaboration with WHO, to establish a global information network via the Internet. As TIF’s objectives were becoming increasingly demanding, the assistance of WHO and other institutions, especially ministries of health, would be greatly appreciated so as to encourage health officials and policy-makers to support local thalassaemia associations, scientists and medical research centres in their aim of reducing the thalassaemia burden and finally achieving a cure.

The meeting rose at 17:45.
1. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999: Item 17 of the Agenda (continued)


Appropriation section 5: Integrated control of disease (continued)

5.1 Eradication/elimination of specific communicable diseases (continued)
5.2 Control of other communicable diseases (continued)
5.3 Control of noncommunicable diseases (continued)

Professor ABERKANE (representative of the Executive Board) noted that appropriation section 5 had been extensively debated at both the current Health Assembly and the ninety-ninth session of the Executive Board and that members of the Committee had expressed support for the draft resolution recommended in the Board's resolution EB99.R14. The Board had underscored the need to encourage the emergence of collaborating centres, especially in those countries affected by the health priorities defined, and to foster capacity-building programmes in them, as recommended in paragraph 2(2). While quality was an important criterion, as affirmed by the delegate of Germany, it had been pointed out in the Board that quality considerations should not be adduced to maintain the status quo of the industrialized countries' undisputed superiority in scientific potential. Also mentioned was the fact that a crucial factor of encouragement to collaborating centres in countries most affected by the WHO priorities was the use, stabilization and upgrading of national skills, so that new collaborating centres could enhance the collection and processing of reliable data, thus helping to attain broader geographical distribution of centres and to curb the ever-increasing wastage and "brain drain" that plagued those countries.

Dr HENDERSON (Assistant Director-General) complimented delegates on their reported successes, which were being achieved by the countries' own efforts, with the support of the international health community, including donor, private-sector and nongovernmental organizations. He looked forward to the achievement of total eradication or elimination of poliomyelitis, dracunculiasis, and neonatal tetanus. There remained, however, enormous challenges, such as the continued prevalence of malaria, HIV/AIDS, tuberculosis, dengue, leishmaniasis, trypanosomiasis, schistosomiasis, zoonoses and other emerging or re-emerging diseases, and the problem on antibiotic resistance. Control of those diseases called for better and cheaper vaccines and better surveillance, which in turn could be achieved only through more accurate diagnosis, greater access to reference laboratories, and improved analysis and communication of, and response to, surveillance data. Guidance was obtainable from WHO's new surveillance manual, and delegates could request further information from the headquarters Division of Emerging and other Communicable Diseases Surveillance and Control.

There was no easy answer to the plight of Zambia, whose health sector reforms were being impeded by the very programmes that were reporting such spectacular successes. However, WHO, with Zambia and other countries, was committed to finding the best balance between short- and longer-term achievements.
In answer to questions from Zimbabwe and Trinidad and Tobago, he announced that a combined DPT-hepatitis B vaccine had been on the market for two months and had been offered to UNICEF at US$ 1.90 per dose, the sum of the separate purchase prices for each component. After a lull following the death of the previous Executive Director of UNICEF, WHO and UNICEF were again pursuing their efforts to obtain a reduced price for hepatitis B vaccine from manufacturers.

He informed the delegate of the Republic of Korea that its difficulty in obtaining purified protein derivative (PPD) for tuberculin testing had been solved and that PPD would be supplied to the Korean Tuberculosis Institute.

WHO was relying on countries' own initiatives and the continued support of the donor, nongovernmental and private-sector communities to offset the regional programme budget reductions and enhance the overall level of resources under programmes 5.1 and 5.2 regarding which there was so much concern. As Oman feared, regular budget resources alone would be insufficient to achieve established eradication or, indeed, any goals in any budget section.

The apparent decrease in allocations for the Americas must be viewed in conjunction with the PAHO budget; the combined budgets actually showed an increase for programmes 5.1 and 5.2, those most strenuously supported within the Organization. To his knowledge, no region had reduced its funds because of a desire to reduce programme activities. The reductions for the African, Eastern Mediterranean and Western Pacific Regions had generally been made because the recipient countries had access to other sources which provided funds bilaterally or through WHO. The Regional Directors would furnish any additional information required.

The delegates of Jordan and Kuwait had asked about the continued need for national immunization days in countries where poliomyelitis had been eliminated. The basic question in countries just launching immunization days was the ability of existing surveillance systems to detect a single indigenous or imported case. The "gold standard" was surveillance for acute flaccid paralysis, including rapid detailed reporting of clinical cases and the supply of adequate stool samples to an appropriate diagnostic facility. The best course was to advise countries individually about national immunization days, on a case-by-case basis. The same applied to inactivated poliomyelitis vaccine; while it could be used in addition to the live vaccine, the latter remained the basis for the poliomyelitis eradication programme. Furthermore, the benefits of the inactivated vaccine might not compensate for its additional cost. He informed Jordan that, while the recommended case definitions for acute flaccid paralysis were under review, emphasis had been placed in the early phases of the eradication programme on a definition which probably erred on the side of over-diagnosis. However, virological confirmation by a laboratory was required in each case, providing an opportunity for correction.

Turkey's point regarding private sector immunization schedules that differed from those recommended by ministries of health was less of a concern than the adequacy of the cold chain to ensure vaccine potency at the time of administration. He warned about the dangers of using inactivated poliomyelitis vaccine alone in a country threatened by the circulation of wild poliovirus, and hoped that the private sector could be persuaded to become active supporters of national disease control and eradication action, in return for which their support and contributions should be acknowledged.

He would provide further information to delegates individually on request.

Dr VARET (Assistant Director-General) said that delegates' comments on HIV/AIDS and sexually transmitted diseases (STD) had been noted. The delegates of Honduras, Zimbabwe, Uganda and Chad had raised questions about the implementation of national AIDS control programmes during the transitional period between the end of the WHO Global Programme on AIDS and the coming into full operation of UNAIDS. The two programmes embodied totally different philosophies; the former had had US$ 160 million and close on 200 staff for conducting national AIDS control programmes, while UNAIDS had terms of reference stressing coordination and advocacy and only US$ 120 million and 115 people for implementing those activities at global and national level and supporting multisectoral national AIDS programmes. It was realized that the transition might take two or three years, with consequent difficulties for health ministries. WHO had therefore selected, in collaboration with the secretariat of UNAIDS, eight priorities to speed up the process and achieve in 1997 the integration desired by Zambia and Zimbabwe; they were set out in document WHO/ASD/96.3, which described WHO's strategic five-year plan for 1997-2001. To that end, the Director-General had also mobilized US$ 20 million from the regular budget and extrabudgetary funds, and from the various WHO programmes concerned, and had reallocated three-quarters of it to decentralized activities. The Japanese Government had given support in that regard. In response to concern expressed by the Executive Board, 1% of the headquarters regular budget would
be reallocated to regional and interregional AIDS and STD control activities. The priorities for using those funds would be discussed shortly after the adoption of the programme budget. Further information would be provided under item 19 of the agenda, during consideration of the report on the implementation of resolution WHA49.27.

Dr TSECHKOVSKI (Division of Noncommunicable Diseases) replied to comments on the activities covered under programme 5.3. Most of the delegates voicing concern at the advent of noncommunicable disease epidemics represented developing countries or those with economies in transition, in virtually all regions. Attention had been drawn to the need for better dissemination of evaluated information for greater public awareness and more pertinent advice on noncommunicable diseases; the overwhelming majority of comments had stressed the priority of preventive action and health promotion. Changes in modifiable risk factors, such as smoking, diet, alcohol, lack of exercise, obesity and stress had been highlighted as key areas of action, clearly mirroring the concluding notes in *The world health report 1997*. Emphasis had been laid on the need to reinforce health education as one of the key components of health promotion, and Israel had pinpointed youth as the key target group and the most likely agent of change. The redesign of health programmes to deal with many health determinants rather than a single subject would be instrumental in altering general, as opposed to individual, behaviour patterns. It had been suggested that, in any comprehensive development programme, primary prevention measures must be supplemented by appropriate detection methods and cost-effective treatment, with WHO guidance, a solution also recommended in *The world health report 1997*.

Bangladesh, Benin, Myanmar, Poland, Russian Federation and United Republic of Tanzania had supported the control measures for noncommunicable diseases presented, but felt the urgent need for follow-up in the form of WHO’s continued guidance and its leadership of international cooperation in policy and programme development in Member States. During the current biennium WHO, using data from the INTERHEALTH global network and the regional CINDI and CARMEN networks, had actively sought and analysed experience and expertise in noncommunicable disease prevention and control programmes and had produced a first draft of a global strategy on integrated prevention and control of noncommunicable diseases, which was undergoing peer review inside and outside the Organization. A meeting was planned for 1997 to analyse the proposed strategy and prepare it for general consultation among Member States and consideration by the Executive Board at the next round of programme priority debates. The strategy was meant to contribute to the renewal of the health-for-all strategy in the twenty-first century and furnish Member States with policy advice on health care reform.

The CHAIRMAN invited the Committee to consider the draft resolution on WHO collaborating centres recommended by the Executive Board in resolution EB99.R14.

Professor BERTAN (Turkey), in supporting the draft resolution, stressed the need for new health policies and strategies for health for all for the twenty-first century which would require greater efforts and close collaboration and coordination among governing bodies, nongovernmental organizations and international agencies, and cost-effective use of country resources at all levels. While WHO had always provided technical assistance to countries on request, current budgetary constraints underscored the need for the collaborating centres to mobilize local resources for the provision of technical expertise. At the same time, the definitions of the centres’ functions and conditions of designation and redesignation needed review, with due consideration of each site’s potential. Once designated, collaborating centres, which could be single-purpose or multipurpose as required, must maintain close links with all WHO offices and with each other in the interest of technical cooperation among developing countries, and should undergo periodic evaluation of their efficiency, quality and capacity-building needs.

In response to a request by Dr LARIVIÈRE (Canada), Dr THYLEFORS (Secretary) read out the amendment proposed by the delegate of Germany at the beginning of the fifth meeting.

Dr LARIVIÈRE (Canada) supported the proposed amendment.
The draft resolution recommended by the Executive Board in resolution EB99.R14, as amended, was approved.¹

Appropriation section 6: Administrative services

6.1 Personnel
6.2 General administration
6.3 Budget and finance

Dr AL-SAIF (representative of the Executive Board) said that some members of the Board had noted a concentration of administrative functions in major programme 2.1 (General programme development and management), notably management information systems and staff and management development, and in specific programme 2.3.1 (Technical cooperation with countries), in which a sizeable administrative component existed for WHO country offices; appropriation section 6 and specific programme 2.3.1 were the only two areas of the proposed programme budget in which there were increases of more than US$ 10 million in the overall (but not the regular) budget. Those Board members had considered that the resources allocated to programme 2.1, specific programme 2.3.1 and appropriation section 6 should be considered together when any reallocation of funding to priorities was being contemplated.

Most organizations, including WHO, had made savings in administration through greater efficiency and more cost-effective services. Improvements in management, such as off-site placing of certain support services, contracting and reforms in procurement, more effective use of collaborating centres and restructuring of senior management might also result in savings.

The Board’s Programme Development Committee and Administration, Budget and Finance Committee had jointly expressed concern about increased reliance on payment of programme support costs from extrabudgetary funding. Further clarification might be needed to show how monies derived from the 13% administrative support cost charge were divided among the six appropriation sections, as it was known that some were spent on administrative support within the programmes themselves.

Dr STAMPS (Zimbabwe) recalled that, at a meeting of a subgroup to review and evaluate the programme on human resources for health during the ninety-fifth session of the Executive Board, the Director-General was reported to have responded to a question about why there were few Africans in high positions in the Organization by stating that non-Caucasians in general and Africans in particular had difficulty in adapting culturally to living in Geneva and lacked writing and presentation skills. That statement had caused a general furore among the African staff of the Organization and had been reported widely in the national and international news media.

During the Forty-eighth World Health Assembly, in May 1995, the Ministers of Health of the African Region had expressed their indignation at the Director-General’s inopportune and offensive statement and had requested him to take three corrective measures in order to include Africans at the policy- and decision-making levels of the Organization. They had requested that the vacant position of Deputy Director-General or one of the Assistant Director-General positions should be filled by a candidate from the African Region; that both the Cabinet of the Director-General and the positions of directors at WHO headquarters should fully reflect the geographical composition of the Organization; and that attention should be paid to removing inequalities between the sexes by giving women from the African Region some of the highest positions in WHO. In a response to those requests, dated 8 May 1995, the Director-General had apologized for his offensive remarks, if, as he said, they had been offensive, and stated his firm intent to continue to increase the representation of African staff, including women, in the Organization and particularly at higher levels at headquarters.

During the Forty-ninth Health Assembly, the Ministers of Health of the African Region had requested the Director-General to report on progress in fulfilling his written undertaking. Apart from the appointment of an Assistant Director-General from the African Region, there had been no significant increase in the number of African staff members at the level of director or above. The Director-General had attributed that fact to the

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA50.2.
Since his initial undertaking in 1995, the number of African professional staff members at headquarters had decreased from a total of 28 to 23. The numbers of staff at higher levels, apart from the Assistant Director-General, had either remained unchanged or been reduced. Delegates from the African Region had asked the Director-General to provide a graphic comparison of the staffing patterns of Africans at headquarters in 1995 and 1997.

An African staff member who had had a long, successful career in WHO, who was much respected by all staff members, and who had enjoyed the support and confidence of senior management at headquarters and of the six Regional Directors had been rejected for no apparent reason by the Director-General for the post of Director of the Division of Personnel, in which he had at the time been immediately junior to the Director. The post had been given to a candidate from the United States of America, currently employed by FAO. In fact, 90% of the highest posts in the administration of WHO were currently occupied by nationals of the country that was the largest contributor to the Organization but which had not maintained a clear balance in terms of its contributions over the preceding 10 years and had criticized the administration at every session. Furthermore, although the Director-General had announced to the Ministers of Health of the African Region in 1996 that a Special Adviser for African Affairs had been appointed, he was actually employed on a temporary basis, with no career prospects. There appeared to be an unwritten policy that African staff members in the general service category were not to advance beyond the grade at which they joined WHO. African secretarial staff with as much as 20 years' experience remained at their entry grade. One African staff member had been assigned duties for which others doing similar work were classified at a higher grade and had performed those duties for two years without being given the appropriate grade. When she had complained, she had been reassigned to a post at a lower grade within 24 hours; the non-African who had replaced her had been given the appropriate, higher-grade post. An eminent African professor had recently been employed by a division but had resigned within a week when he realized that the post for which he had been selected had no budgetary security, whereas the more career-orientated post of chief had been given to a much less qualified person. The Director-General should clarify the situation.

At the last three Health Assemblies the delegation of Zimbabwe had complained about the overt, blatant racism demonstrated at the highest levels of the administration of WHO, which appeared to persist. The fact that the Director-General had not honoured the written undertaking he had given to the African Region in 1995 was objectionable in the extreme and was inconsistent with transparency, sound management and effective administration.

Dr LÉPES (Hungary) said that the most important issue was the overall level of the budget, i.e. maintenance of zero real growth despite the perceived programme needs and the substantial reduction made in the 1996-1997 biennium. Maintenance of zero real growth required a 0.4% nominal increase in the budget, because the effect of the 4% inflation seen worldwide was offset by a 3.6% fluctuation in exchange rates. Zero nominal growth should be rejected. He commended the improved structure and clarity of document PB/98-99, including the use of “boxes” showing shifts in resources at all levels and tables allowing comparisons between periods. The priorities set by the governing bodies should, however, be made more visible in future. He noted that the priorities for the current biennium were the same as those for the preceding period and welcomed the fact that, in the European Region, 10% of the total regular budget resources had been transferred to priority programmes. Activities financed by extrabudgetary resources should be consistent with the Organization’s missions and priorities, and extrabudgetary funds raised centrally by WHO should be distributed equitably to the various levels of the Organization. That might be ensured by a panel of members of the Executive Board, with the involvement of the regions. He welcomed the concept of target-setting for products as it would facilitate the monitoring and evaluation of programmes.

Ms STEGEMAN (Netherlands) expressed disappointment that no proposal had been made to reduce the budget for administrative services. The allocations for administration should be reduced both in appropriation section 6 and in other relevant programme areas, and the funds transferred to priority programmes, such as reproductive health, nutrition and essential drugs.
Mr KRIEBLE (New Zealand), referring to programme 6.1, commended the appointment of a coordinator for the employment and participation of women in the work of WHO. That position was crucial to ensuring that WHO represented a role model on issues of sexual equality and provided a working environment sensitive to those issues. With regard to programmes 6.2 and 6.3 he joined the previous speaker in supporting budgetary reallocation from administrative functions to programme activities. The Executive Board had asked for improved efficiency in order to achieve savings that could be reallocated to programmes of higher priority. He was concerned that no further net shifts of funds had been proposed from programmes 6.2 and 6.3 since that request.

Mr LIU Xinming (China) said that administrative services were the basis for all the other work of the Organization and increases in administrative costs were sometimes unavoidable. While efforts had been made to keep increases as low as possible, ways should be sought in future to direct the limited resources to technical programmes. He hoped that action would be taken to redress the under-representation of China on the staff of the Organization.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) noted the concern of the Executive Board at the fact that administrative costs also entered into the proposed budgets of programmes other than 6.2, which made it difficult to calculate the total level. A more flexible, creative approach, including more decentralization and greater use of collaborating centres, could result in significant savings in administrative costs and the money could be used to support priority programmes. Administrative costs appeared to vary among the regions. He commended the European Region for the way in which it had addressed the matter of administrative overheads.

He concurred with the delegate of Zimbabwe on the important principle of equity in the appointment of staff to higher levels in WHO and in the balance both among regions (particularly Africa) and between the sexes. The principle of equity applied as much to appointments as to access to health care in the programmes of WHO.

Dr AGGARWAL (India) approved the proposed budget for appropriation section 6, as it reflected the recommendations of the Executive Board. He endorsed accommodation of a 0.4% nominal increase.

Professor PICO (Argentina) agreed with the broad principles of programme 6.2 but stressed the importance of improving the efficiency of administrative procedures in WHO. Increased horizontal technical cooperation would be useful in making more rational use of existing resources. WHO should ensure implementation of priority programmes and decentralize others in order to improve its administrative efficiency and effectiveness in the regions and in various subregional initiatives.

Professor WHITWORTH (Australia) remarked that the discussion had moved from the financial requirements of the various health sectors to the balance between administrative costs and health delivery. She was convinced that further significant savings could be made in administrative costs and overheads. Those costs, which were to be found throughout appropriation section 6 and in programmes 1.1 (Governing bodies) and 2.1 (General programme development and management), made up nearly 30% of the proposed budget. Despite concern expressed by the Executive Board, no adjustment had been made to appropriation section 6. A proposal to make a significant reallocation of funds from that section to priority health programmes would form part of a draft resolution on improving efficiency that she would submit later. Savings could be made by centralizing functions like procurement, by siting administrative functions that had already been globalized in lower-cost centres, thus using the decentralized structure of WHO imaginatively and efficiently, and by adopting optimal practices in all regions. With regard to the last suggestion, total administrative costs ranged according to region from 10% to 45% of the proposed budget, a variation which implied that considerable savings could be made. The proposed reallocation would improve health at the country level, and therefore the welfare of Member States, and would boost the reputation of WHO. She asked for support for the forthcoming draft resolution.

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1 See summary record of the ninth meeting, page 116.
Professor GRANGAUD (Algeria) called for further efforts to reduce the proposed budget for administrative services and particularly the use of extrabudgetary funds in that area. He supported the statement of the delegate of Zimbabwe concerning equity in staffing.

Dr DLAMINI (Swaziland) concurred with the comments of the delegate of Zimbabwe. Africans did not wish to make a political issue of the imbalance in staffing at the highest levels of WHO; they, and African women in particular, did not ask to be favoured or given token posts but to be afforded the same opportunities as all other nations and as men. From the viewpoint of a small country on the African continent, Africans appeared to face hurdles that were much higher than those confronting other nations. Women, and especially African women, found it particularly difficult to break through to senior management positions, no matter how high their standard of performance. She wished to be reassured that there was no bias with regard to regional representation in WHO programmes. She looked for justice and equity and hoped that the Director-General's office would display more objectivity than it had hitherto. Words should be replaced by deeds and favour by merit.

Mr AITKEN (Assistant Director-General) denied that racism prevailed among the senior management of the Organization. Africa could be defined either as the continent of Africa or as the WHO African Region, which did not include some of the countries in the north of the continent; the latter definition was generally used at WHO. However, WHO was a single, global organization and considered its geographical balance globally; at that level, it could not be bettered and more than 150 countries were represented. As reported to the Executive Board, three African countries were either under- or unrepresented in the Secretariat, most were within the proper range, and a few were over-represented. That situation compared favourably with the representation of some other regions. The issues raised recently had, he recognized, focused on the distribution of professional staff at headquarters, something that had not generally been reported on. The number of African professional staff members at headquarters had decreased from a total of 28 to 25, not 23 as had been stated by the delegate of Zimbabwe. That decrease had been due to the overall reduction in staff at WHO. In particular, two persons had been transferred from the Global Programme on AIDS to the UNAIDS programme. Although that programme was administered by WHO, its staff were not on the Organization's lists. Thus, it could be said that there was only one fewer African professional staff member in Geneva than in 1995. Although there had been a decrease in the number, the geographical distribution had been maintained because of the overall reduction. He would speak with the delegate of Zimbabwe in order to clarify the individual cases that he had cited. He assured the delegate of Swaziland that the Organization would continue to make efforts to ensure geographical equity and women's representation in WHO.

The Secretariat was aware of the need to improve efficiency throughout the Organization, including programmes in appropriation section 6. A document was available that described some measures that had been taken at headquarters, and he was chairing a panel consisting of representatives from the regions and from headquarters to find means of further improving efficiency. The ratio of appropriation section 6 to other sections of the proposed budget should be considered from the point of view of both the regular budget and extrabudgetary resources, which were also managed by the administrative services. Appropriation section 6 represented 10.5% of the total budget of the Organization. As had been mentioned earlier, other parts of WHO could also make savings in administrative costs.

(For continuation, see summary record of the ninth meeting, section 1.)

2. PREPARATION OF THE TENTH GENERAL PROGRAMME OF WORK: Item 18 of the Agenda (Resolution EB99.R15; Document A50/5)

Dr AL-SAIF (representative of the Executive Board) said that the Board and its Programme Development Committee, which had considered the Director-General's report on the preparation of the Tenth General Programme of Work (document A50/5), had recognized the need for a general programme of work clearly linked to the global health-for-all strategy and to programme budgeting and evaluation, in order to provide a clear and consistent framework for WHO activities. It was important to maintain and coordinate the flow of information
among all groups involved in its preparation so as to avoid misunderstandings, overlaps and inconsistencies. In the current period of rapid world change, the periodicity of general programmes of work should not be lengthened, but should remain at six years.

The Board considered it essential to find consistency of vision and common threads among the Organization's planning instruments. The global health policy was required for renewing the health-for-all strategy for the twenty-first century and would define long-term targets. The Tenth General Programme of Work would outline the role of WHO in implementing that policy over the period 2002-2008. It should define objectives and outcomes which could be revised every two to 10 years and should be framed in terms of targets and outputs that could be monitored and assessed. It would guide the consecutive programme budgets and plans of action for the entire period, and outcomes would be evaluated.

The Board had adopted resolution EB99.R15, which recommended for consideration by the Health Assembly a resolution that emphasized the need for synergy in the reform process and, in particular, the links between policy, planning and implementation and optimal management of WHO's human resources to enhance efficiency.

Dr LARIVIÈRE (Canada) endorsed the general orientation proposed by the Director-General for the preparation of the Tenth General Programme of Work and welcomed the emphasis on the development of clear criteria for the planning and later evaluation of products, services and functions. Paragraph 1 of the Director-General's report indicated that the Programme would be based on WHO policy for the renewed health-for-all strategy for the twenty-first century. Since that policy would not be adopted before May 1998, while the Programme had to be ready for regional committee sessions in September 1998, there would be very little time to undertake the large amount of work required.

The Tenth General Programme of Work was to include provisions to strengthen WHO's global normative activities and to give a sharper edge to the Organization's technical cooperation in response to particular national situations. Perhaps the expression "specialized" technical cooperation should be used for WHO's work in support of countries, since there seemed to be some confusion about the various types of technical cooperation by the United Nations system at different levels. Canada recognized the key role that WHO must continue to play in several areas of great importance for effective health development, such as human rights, ethics, the status of women, the promotion of peace and, sustainability in development.

Mr ÖRTEN DAHL (Sweden) said it was imperative for WHO to develop and implement a health-for-all policy for the twenty-first century. It was within that policy, not in the Tenth General Programme of Work, that the mission and functions of the Organization must be defined.

Sweden questioned the usefulness of elaborating general programmes of work now that significant changes had been made in the strategic budgeting process. Strategic budgeting provided a much improved tool that Member States could use to fulfill their governance role and a much better instrument for planning. Given the rapid changes occurring in the political and socioeconomic situation in the world and the rapid developments in health and medical science, it was difficult to plan for programme activities so far in advance. The preparation of general programmes of work was a burdensome process and was hardly the most efficient use of scarce human resources. A general programme of work would have to be evaluated and monitored on a regular basis. Considering that a similar process must be established for the renewed health-for-all strategy, there seemed to be a high degree of overlapping. He was far from convinced of the Tenth General Programme of Work's value and would like to hear the Secretariat's views on that point.

Dr PERERA (Sri Lanka) said the six-year periods for general programmes of work had been found satisfactory, as they enabled a medium-term perspective to be incorporated into WHO-led initiatives in investment for health development. The Tenth General Programme of Work should address the inequities that were root causes of poor health conditions in disadvantaged sectors of populations, with emphasis on education and empowerment of women, alleviation of poverty, and solving the problems of environmental degradation and pollution.

Current political and socioeconomic trends might nullify some of the gains already made in the health status of a number of countries. Donor-driven restructuring programmes gave cause for concern. The philosophy of providing a safety net for groups that might be adversely affected by restructuring had been found inadequate and should be reviewed. Financing of health services, with emphasis on establishment of a proper
public-private mix, was another important issue in many countries. Attempts to define that mix had not so far been successful owing to the complexity of the underlying problems. The question would best be dealt with in regional forums.

He endorsed the general orientation, general principles and schedule for the preparation of the Tenth General Programme of Work suggested in the Director-General’s report.

Ms STEGEMAN (Netherlands) had some misgivings about the general orientation sketched out in the Director-General’s report. WHO’s specific position in relation to other United Nations agencies and other actors should be taken into consideration at the current stage of the planning cycle. A European Union position paper on United Nations reform in the social and economic spheres proposed that the specialized agencies, including WHO, should focus on the areas of their comparative advantage. It was not appropriate, for example, for the general orientations enumerated in paragraph 10 of document A50/5 to include participation by the Organization in “the promotion of peace and security”. Other items mentioned could be focused more sharply on WHO’s core functions.

Quality of care was not mentioned in the resolution recommended in resolution EB99.R15, yet it was an important element of health care. She therefore suggested that in paragraph 2(3) the word “quality” should be inserted after “accessibility”.

Professor WHITWORTH (Australia) noted the constructive revisions made in the report on the preparation of the Tenth General Programme of Work since the Board’s discussion in January 1997. She welcomed the links drawn in paragraph 8 between the several planning instruments and concurred with the logical sequence outlined for them. Australia nonetheless felt some concern about the format and content of the Tenth General Programme of Work.

The current planning environment was quite different from that of 40 years previously, when the practice of preparing general programmes of work had been adopted. The Organization was using strategic budgeting and an armoury of associated planning tools. As part of WHO reform, to be discussed under agenda item 26.2, consideration was to be given to amalgamating a number of reporting exercises since much of the new reporting displaced or subsumed many of the previous requirements. In a similar vein, a critical look should be taken at the continuing need for a general programme of work. The proposed components of the Tenth General Programme of Work outlined in paragraph 15 of the report could be greatly simplified, given the other planning tools now in place, including the detailed biennial programme budget documents. The general programme of work was akin to a corporate plan of the Organization, and should accordingly be short and sharp, setting out WHO’s strategic priorities and the main objectives and directions for the upcoming period.

The strategic priorities should be derived from the Organization’s mission and functions, from overarching principles for international action such as equity and sustainable development, from the directions set out in the renewed health-for-all strategy, and from a broad analysis of disease trends. Those priorities could then be translated into broad objectives linked to measurable performance indicators. The objectives would be framed in terms of the most pressing and most achievable actions. The document should be short and succinct - not a long philosophical tract - with strategic directions receiving fuller expression in the biennial programme budget.

The general orientations listed in paragraph 10 of the report seemed to anticipate a policy development process that was not yet completed and did not seem consistently to build on the Organization’s Constitution. The targets and objectives defined in the general orientations must be within WHO’s mandate and capacity to deliver: the intention, however laudable, of alleviating “conflicts and their effects on health” seemed well beyond the Organization’s means, though it could indeed work to alleviate the effects of conflicts on health. Many of the orientations were in the realm of advocacy, whereas WHO’s work went well beyond that domain. Essential normative functions should be reflected: there were many valuable activities for which the world must have a global organization, including global disease surveillance, global monitoring of health trends, and development of standards, and while those activities did not grab headlines, they saved many lives.

The currency of a general programme of work devised some four years before its implementation could also be questioned. The report proposed that the Tenth General Programme of Work should cover only six years rather than a longer period because of the speed of change in the world’s political, socioeconomic and health situation. For that very reason, there was a danger that the Programme would fall into premature obsolescence if it were finalized three years before it was due to come into effect. If, however, the Programme were a much
simpler document, it could be developed much closer to its implementation date, and hence be much more
dynamic.

Mr CREGAN (Ireland) welcomed the way the remarks and comments of the Executive Board had been
taken into account in the document before the Committee, and supported the resolution recommended in
resolution EB99.R15. It was essential for WHO’s credibility that there should be coherence and congruence in
the statements of its policies and programmes. The Tenth General Programme of Work would be the first
indication of how WHO would carry out the renewal of the health-for-all strategy, and as such would be an
especially important document. It was encouraging that the Programme would, according to the Director-
General’s report, allow for evaluation and was explicitly linked to the budget-setting process. The Programme
should be sharply focused and contain clear and quantifiable actions to be achieved during the period concerned.
He requested confirmation of his understanding that preparation of a general programme of work was a
requirement under Article 28 (g) of the Constitution. He supported the Australian view that the breadth and
scope proposed for the Tenth General Programme in paragraph 15 of the report were unduly elaborate. The
Programme was, in his view, a medium-term management tool which should dictate the short-term actions to
be undertaken as part of the programme budgeting process. As to the time frame, the Programme should not
be launched until the direction to be taken for the renewal of the health-for-all strategy had been clarified.

Professor ŠKRABALO (Croatia) welcomed the preparation of the Tenth General Programme of Work,
with which WHO would enter the new millennium. It would no doubt be compatible with and complement the
renewed health-for-all strategy, likewise under preparation. The special group to review the Constitution of
WHO would produce its recommendations by early 1998: they would then have to be reviewed by the Executive
Board and the Health Assembly. Those recommendations would deal with the new profile, functions and
mission of WHO and necessitate a decision as to whether the Constitution should be modified accordingly. In
any event they would have to be taken into consideration in finalizing and approving the Tenth General
Programme of Work.

Mr TSUDA (Japan) said WHO could prepare a realistic Tenth General Programme of Work only once
the orientations for the renewed health-for-all strategy had been determined. An outline of the renewed health-
for-all strategy should be submitted for consideration as soon as possible so that the work could really get under
way.

Professor PICO (Argentina) expressed general agreement with the orientations for the Tenth General
Programme of Work outlined in the Director-General’s report; they could of course be fine-tuned in future as
other, related documents intended to respond to the challenges of the next century were approved. It would
indeed be useful to elaborate strategies to enable the Organization, in consultation with Member States, to move
forward in the renewal of the health-for-all strategy. The proposed Tenth General Programme provided guidance
for the overall activities of the Organization; it complemented and was entirely compatible with other
documents before the Health Assembly. It would accordingly serve as a sound basis for progress in the
structural and programmatic transformation of WHO and could be enriched by the future work of the governing
bodies. He supported the draft resolution recommended in resolution EB99.R15.

Professor ORDÓÑEZ CARCELLES (Cuba) endorsed the development of the Tenth General Programme
of Work, which oriented countries towards the concepts of solidarity, equity and sustainability. His country had
applied those principles in implementing the health-for-all strategy since 1983. The Cuban health system was
based on constant analysis of the economic, political, social, demographic and environmental factors that
affected health and development. The strategic priorities in Cuba for the gradual development of health for all were:
giving priority to primary health care based on family doctors and nurses; the revitalization of hospital
care; greater dynamism in advanced technology programmes and research institutes; the development of a
programme of traditional medicine; and the promotion of priority programmes, including care for mothers and
children, noncommunicable diseases, communicable, including vaccine-preventable, diseases, and care for the
elderly. The results of that strategy had been a gradual improvement in the national health system, based on
universal access to free family care, the integration of services, training and research, quality improvement, a
strategy of management by objectives, and the development of primary health care through over 30 000 health
teams, which covered more than 97% of the population. Other important elements in the system were social and community participation, intersectoral action for sustainable health care, the maintenance of past achievements, the promotion of future progress and innovations, the allocation of 12% of the national budget to health and the strengthening of local government bodies, and particularly people's councils. Priority was also given to developing advanced technology and applying it through appropriate methodology to satisfy the needs of the population.

Since Cuban health policies reflected WHO's strategies, he hoped that they would be supported by United Nations agencies and nongovernmental organizations through technical and financial cooperation in the twenty-first century.

Ms VOGEL (United States of America) expressed doubt as to whether the proposed Tenth General Programme of Work was a good vehicle for planning. She endorsed the considerations and constructive ideas put forward by the delegates of Sweden and Australia. WHO needed to engage in a very dynamic and energetic planning effort. However, the process of moving from the Ninth to the proposed Tenth General Programme of Work in the year 2001 could be somewhat mechanical, slow and bureaucratic. It would perhaps be more useful to adopt two-year rolling plans of action, as exemplified by the two-year strategic budget.

Article 28(g) of the Constitution appeared to allow some leeway when it called for consideration and approval of a general programme of work covering a specific period. However, she feared that the proposed Tenth General Programme of Work would be out of date and redundant before it commenced. She also believed that reconsideration of the proposed Programme would result in cost savings. The strategic budget guided the Organization, while the renewed health-for-all strategy provided guidance to the global community and Member States. Perhaps those two together might constitute the Tenth General Programme of Work? She therefore suggested that a drafting group should be convened to consider appropriate amendments to the draft resolution recommended in resolution EB99.R15.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) expressed agreement with previous speakers, in particular the delegates of Canada, Sweden, Netherlands, Australia, and the United States of America. At a time of resource constraints and reforms throughout the United Nations system, it was imperative that the Tenth General Programme of Work should complement the renewed health-for-all strategy and be in accordance with the missions and functions of WHO, which might be modified by the current constitutional review.

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation), responding to the debate, noted that WHO was now two years behind the traditional timetable for the preparation of general programmes of work, partly as a result of awaiting the preparation of the health-for-all policy for the twenty-first century and the recommendations of the special group to review the Constitution of WHO. Those two matters would have a major influence on the General Programme, if such a programme were indeed to be prepared, since a number of speakers had suggested otherwise. As the United States delegate had said, Article 28(g) of the Constitution was vague as to the type of programme that should be submitted. Moreover, that provision might indeed be revised as part of the review of the Constitution.

Nevertheless, she noted that the General Programme would have two principal tasks: to translate the general lines of the health-for-all policy into the precise targets for WHO; and to update that policy in a rapidly changing world. The policy that was currently being developed would, it was hoped, be valid for at least the next 20 years. A third task, which general programmes of work had never satisfactorily fulfilled, was to provide an opportunity for reflection on the effects of WHO's activities over a five- or six-year period - a longer-term evaluation separate from annual and biennial monitoring of the programme budget. The current trend was to abolish medium-term management tools such as WHO's medium-term programmes, with the result that the only tool of that kind remaining was the general programme of work. She believed that some type of medium-term management tool was needed, although the Secretariat was very open to any suggestion in that respect.

Regarding the content of the Tenth General Programme of Work, note had been taken of speakers' comments that it would have to be more specific and succinct and simplified in comparison with previous general programmes. It should also be geared to the specific role of WHO and be developed in such a way that it could be translated directly into programme budgets. If the majority view was that there should no longer be a general programme of work, the Secretariat was ready to rearrange its programming tools accordingly.
However, if the decision was to prepare a Tenth General Programme of Work, she assured the Committee that it would be different from its predecessors.

Dr THYLEFORS (Secretary) suggested that the Committee might wish to convene a drafting group to propose amendments to the draft resolution contained in resolution EB99.R15.

It was so agreed.

(For continuation, see summary record of the ninth meeting, section 2).


Prevention of violence (Resolution WHA49.25; Document A50/INF.DOC./4)

Professor ABERKANE (representative of the Executive Board) recalled that in May 1996 the Forty-ninth World Health Assembly had adopted resolution WHA49.25, which, inter alia, requested the Director-General to initiate public health activities to combat violence, to submit a report to the ninety-ninth session of the Executive Board describing the progress made, and to present a plan of action for progress towards a scientific public health approach to the prevention of violence.

In order to meet those requests the Director-General had established a task force on violence and health which in June 1996, had prepared a draft action plan for consideration at the global consultation on violence and health, held in December 1996. The plan had also been reviewed at a meeting of collaborating centres on injury prevention and control. It had been endorsed by the Executive Board and was submitted to the Health Assembly in document A50/INF.DOC./4.

The plan set the time frame and priority objectives for a period of three years. The first priority was to describe the full public health scope of the problem in its different forms and circumstances. The specific action that had been taken since the review of the action plan by the Board was described in part I of document A50/6, which also contained a draft resolution for consideration by the Health Assembly. All the activities had been funded by voluntary contributions.

Mrs HERZOG (Israel), speaking as delegate and also on behalf of the International Council of Women, welcomed the proposed WHO integrated plan of action on violence and health. Turning to the draft resolution contained in document A50/6, she proposed the insertion between the penultimate and final preambular paragraphs of the following:

Concerned at:

(1) the increase in all forms of violence, particularly domestic violence that is directed mainly at women and children;
(2) child trafficking and sexual abuse;
(3) bullying in schools and in institutions, and various forms of organized violence;
Realizing the complexity of the issue, and that violence does not only affect health but in many cases is the outcome of practices detrimental to health such as alcohol and drug abuse, as well as of various socioeconomic factors;

She further proposed an additional operative paragraph reading:

3. REQUESTS the Director-General to continue to develop the plan of action and to submit to the Fifty-first World Health Assembly:

(1) a report of the past year's activities, a budget, a timetable for implementation and a list of priority actions to be undertaken by WHO with its appropriate collaborating centres;
(2) guidelines for preventive activities to be undertaken by Member States.

Mrs COLIN (Canada) expressed full support for the scientific public health approach to violence adopted in the plan of action. Although it took different forms, such as bullying, homicide, rape and suicide, and reached
different levels of intensity, violence occurred in all countries and societies, to such an extent that it was
appropriate to refer to a pandemic, but a pandemic that was little understood and sometimes not even recognized.
It was therefore necessary to take action and do more than merely care for the victims, though that was of course
essential. There was an urgent need to increase preventive measures against intentional injury and to promote
security, for which better knowledge of the problem was required. Coordinated community-oriented
intersectoral activities must also be promoted, supported by committed policies to combat violence, particularly
violence in families, and above all against women and children. She therefore supported the draft resolution and
the amendments proposed by the delegate of Israel. The submission of a progress report in 1998 and the
development of a more precise action plan were essential if knowledge was to be extended and effective
measures adopted.

Dr MOREAU (France) suggested that the mandate outlined, which would mean WHO’s taking the lead
in mobilizing and coordinating action to prevent and control violence, was unrealistic. The proposed approach
gave inadequate recognition to the hidden economic and social dimensions of the phenomenon. It would be
preferable if the project were limited to the areas of competence of WHO, together with the establishment of
partnerships with other organizations in the United Nations system and its collaborating centres. Nevertheless,
he welcomed the intent to take action against a real and expanding scourge.

Dr Б RO OKMAN-AMI SSAH (Ghana) commended the Director-General on initiating public health
activities to combat violence and endorsed the draft resolution. She was encouraged to learn of the proposed
meeting of experts to review the definitions and typology of violence, and hoped that sexual violence would be
seriously considered. However, she was disappointed that the integrated plan of action did not go beyond the
crucial first step of establishing adequate information systems to include strategies and interventions for
preventing and managing violence in areas such as legislation, emergency services and ambulance services.
With injuries assuming epidemic proportions, there was already enough information for action to begin.

Dr SULEIMAN (Malaysia) expressed strong support for a WHO integrated plan of action on violence and
health, covering all aspects of violence, and with women and children as the major target group. Health
promotion, including mental health aspects, and advocacy against violence were important, as violence was
frequently related to the mental health status of its perpetrators. All countries should be encouraged to
strengthen their legislation and law enforcement to reduce the incidence of violence. In Malaysia, an Act on
domestic violence, which included the provision of shelter for victims, had been passed in 1996. The Act
required close cooperation and coordination between various agencies in government and the private sector, and
it was hoped it would lead to more systematic collection and analysis of data on violence. The proposed Child
Protection Act was also relevant.

Dr BELMAR (Chile) welcomed the new focus on violence. Chile’s experience of dealing with it in the
context of human rights violations had enabled it to elaborate programmes which extended to other forms of
violence that permeated society and were on the increase. He agreed with previous speakers that the recognition
of violence must be followed by its prevention. Efforts should focus on those social groups in which the
problem was most acute: women and children, the poor and ethnic minorities. He offered to make available
to the Organization the fruits of Chile’s experience over the preceding decades.

Ms STEGEMAN (Netherlands) stressed the importance she attached to the prevention of violence. She
suggested that special risk groups, such as girls working in domestic service, should be given more emphasis
in the plan of action. Efforts should focus on those social groups in which the problem was most acute: women and children, the poor and ethnic minorities. He offered to make available to the Organization the fruits of Chile’s experience over the preceding decades.

Dr MALYŠEV (Russian Federation) voiced concern at the growing worldwide threat to public health from
violence. He supported the efforts being made by WHO, particularly the plan of action for progress towards a
scientific public health approach to violence prevention. He endorsed the draft resolution and favoured greater
international cooperation in the area.
Ms OLLILA (Finland) said that violence reflected social disintegration and inequity. Its determinants were many and its appearance differed from one society and culture to another. The importance of stability and social security in enabling people to enjoy full human rights and lead satisfactory lives should not be overlooked. She welcomed WHO's intention to build a coherent public health approach to violence. However, the promotion of healthy lifestyles, including psychosocial aspects, should receive greater prominence as a vital element of violence prevention. In fact, violence prevention should be a focus throughout WHO's programmes. A survey conducted in 1988 of victimization and deliberate violence in Finland had shown that, when sexual harassment and sexual violence were taken into account, victimization rates were as high for women as for men, if not higher. Finland looked forward to collaborating with WHO in the area.

Dr EL SHAFEI (Egypt) welcomed the identification of violence as a public health problem. Concerted efforts must be made by governments, and by local and international organizations, both governmental and nongovernmental, particularly those with a human rights mandate, to combat violence. WHO had a role to play in publicizing the problems involved in order to help overcome widespread reluctance to discuss them. She was in favour of adding a paragraph on violence within the family to the draft resolution.

Professor GRANGAUD (Algeria) was gratified to learn that the prevention of violence had become a priority for health professionals in the international community. His country was currently experiencing the worst kinds of violence, and finding a way of enabling the victims and perpetrators of that violence to live in a more just society was a matter of real and immediate concern to Algerian health workers. He agreed with the delegate of Canada on the need for an intersectoral approach and expressed support for the draft resolution. An international symposium was scheduled to be held in Algiers in September 1997 on the subject of contemporary forms of violence and the culture of peace, and he hoped its work would prove useful to WHO's deliberations.

Dr DLAMINI (Swaziland) welcomed the inclusion of the topic of violence on the agenda and supported the draft resolution with the amendments proposed by the delegate of Israel. She also agreed on the need for a multidisciplinary team approach. Violence, often masked by cultural factors, had attained epidemic proportions. In her own country, levels of violence were very worrying, some of it being directed against health workers, leading to the closure of health facilities. The aspects covered by the plan of action should include the psychology of the perpetrators of violence, their legal treatment, surveillance, the immediate rescue of victims, especially in Third World countries which did not have the necessary structures, and the definition of violence within different cultural groups.

Dr SANOUIRA (Burkina Faso) welcomed the proposed plan of action. She agreed with previous speakers that the problem was a huge one with many different causes and requiring a multisectoral approach. She supported the proposed activities to assess the magnitude of the problem and stressed the need for research into the underlying causes, the importance of which had not been made explicit in the plan of action.

Mr COELHO DE SOUZA (Brazil) said that in his country violence was considered a public health matter. External causes of death, especially those related to violence, were the fifth most important factor of mortality in Brazil. He therefore fully supported the Director-General’s report and the leadership and guidance of WHO in assessing the problem. The plan of action should give prominence to the prevention of violence against children, adolescents and women.

Dr MOORE (United States of America) associated herself with the comments of previous speakers in recognizing the importance of violence as a public health problem and emphasizing the need for a science-based, multisectoral approach to its prevention. She welcomed the prompt action taken by the Director-General in establishing a task force on violence and health and preparing a plan of action. That action showed that WHO was indeed working creatively on problems extending into the twenty-first century. It offered an important opportunity for the Organization to demonstrate leadership across a number of social sectors.

Professor D’ALMEIDA-MASSOUGBODJI (Benin), welcoming the draft resolution, said she was gratified at the attention being given to the prevention of violence. In a number of African countries, including her own, a law dating from 1920 prohibited family planning and abortion, thus preventing women from enjoying their
sexual and reproductive rights. She urged WHO to support efforts for better family planning as a means of preventing the violence perpetrated against women either by themselves or by third parties through abortion. Benin was in the process of introducing legislation to repeal the act, and so the draft resolution was very timely.

Dr AKBARI (Islamic Republic of Iran) believed that controlling violence was an important public health priority. In general he was in favour of the action proposed in document A50/INF.DOC./4. However, he underlined the important role of the television and the cinema, often western in origin, as a determinant of violence. He suggested that a sentence should be added under the objectives of the proposed plan of action drawing attention to the significance of public media production and educational material.

Ms KINGMA (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that the Council (ICN), which was a federation of national nurses’ associations from 111 countries, welcomed the draft resolution on the prevention of violence. As previous speakers had mentioned, violence in society was increasing and there was growing recognition of the health and social challenge. Of equal concern, as the delegate of Swaziland had noted, was the rising number of violent incidents in the health care environment, representing an occupational health risk for personnel. The proposed plan of action was worthy of support and ICN would assist in any way possible the development of a sound database and a classification system relating to violence and its consequences. She asked whether selection criteria had been developed for expert committee members and programme consultants to guarantee a multidisciplinary approach to the issue of violence, thereby covering the social, treatment and caring dimensions, and whether performance indicators had been developed to determine the effectiveness of proposed interventions. If the reply was negative, within what time frame would the two sets of criteria be elaborated and in what way might ICN participate?

Dr TÜRMEN (Family and Reproductive Health) noted delegates’ comments and guidance. She was fully aware that violence was a multidimensional problem that could be properly tackled only with an integrated multisectoral approach. A sound, scientific public health approach had been adopted to describe the problem, define its magnitude, assess its public health consequences, quantify the burden of violence in terms of its impact on mortality and morbidity, identify and evaluate interventions aimed at preventing violence, and document best practices. That information would be made widely available to policy-makers. Several delegates had expressed strong support for making domestic violence and violence against women, adolescents and children a priority. The funds needed to carry out the activities of the plan of action would come mainly from extrabudgetary sources, and that resource base needed to be strengthened if the promises made in the plan were to be met.

Dr THYLEFORS (Secretary) said that, in response to a request from the delegate of the Netherlands, the amendments proposed by Israel to the draft resolution would be circulated in writing.

(For approval of draft resolution, see summary record of the eighth meeting, page 107.)

The meeting rose at 12:30.
SEVENTH MEETING
Friday, 9 May, at 14.35

Chairman: Dr R. CAMPOS (Belize)

IMPLEMENTATION OF RESOLUTIONS AND DECISIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda (Document A50/6 and Corr.1) (continued)

Reorientation of medical education and medical practice (Resolution WHA48.8)

Professor ABERKANE (representative of the Executive Board), said that the report in part II of document A50/6 was submitted in response to paragraph 2(6) of resolution WHA48.8; it incorporated comments made by members of the Executive Board in January 1997. The Committee should note that the scope of the report did not include doctors, nurses, midwives, dentists or pharmacists. In accordance with the wishes of the Forty-eighth World Health Assembly, it dealt with two broad categories of health providers: those who carried out a range of primary health care functions at first-contact level, including community health workers, health officers and medical assistants; and health workers performing specialized tasks at various levels, such as laboratory technicians, nutritionists and physiotherapists. The report commented on their scope of practice, education, training, employment and deployment and drew attention to measures to improve productivity and results. With proper planning and management, those health workers could make a very real contribution to health care. Their classification, however, and the terms used to describe their functions varied widely, and the Committee was invited to comment on those matters and on whether WHO should seek to standardize the terminology in the interest of international comparability.

Dr SULEIMAN (Malaysia) said that the report prompted three remarks. The education of health workers was a life-long process and provision should be made for learning activities based on experience and practice. Secondly, increased female participation meant that planning was needed in training programmes and in the work environment in order to promote equality between the sexes as set out in the Fourth Beijing Platform for Action endorsed by governments at the United Nations World Conference on Women in 1995. Finally modern communication technology could enhance the productivity and effectiveness of health care providers but would alter the role of the different categories, creating a need for multiskilled health workers, and that should be accounted for in medical curricula.

Dr BROOKMAN-AMISSAH (Ghana), commending the report, said that health professionals had for too long been ill equipped for the problems and conditions of daily practice, particularly in developing countries, where medical education was still shaped by standards drawn up for developed countries. Health professionals trained at considerable expense by developing countries often failed to put their expertise to use at home, finding work in wealthier countries. Developing countries received little or no compensation for that loss. Further, postgraduate training, generally dispensed in developed countries, did not prepare health professionals to meet the more basic needs of developing countries. She called for assistance to be provided to developing countries in setting up their own medical and postgraduate training programmes suited to the environment in which their professionals would work.

Dr DLAMINI (Swaziland) regretted that the report made no reference to traditional healers and herbalists, who in some countries were the first contact of up to 80% of patients. Their training, regulation and supervision needed to be attended to and work to be continued on standardizing the terminology applied to them. Another problem was the increasing promotion of homoeopathy in the African Region, where it was unfamiliar.
Guidance was needed on the status of homoeopaths in the traditional Western medical system and on the necessary classification, standardization and control. The problem was compounded by the titles used - often the same as in Western medicine - and by the existence of quacks.

Professor SHAFI QURAISHY (Pakistan) feared that the curriculum for medical education in many countries, including Pakistan, was outdated, subject-based, teacher-centred and hospital-oriented. Community-oriented education had been suggested to shift the emphasis to communities and the problems encountered there. Accordingly, Pakistan had tried to ensure that health personnel were educated to provide preventive, promotive and rehabilitative services to individuals and communities and to meet the challenges of the twenty-first century. The training of the men and women would not be restricted to the tertiary hospital level, but also provided in government dispensaries, clinics and other primary health care facilities in the vicinity of the training college. Health personnel would thus be exposed to the health care delivery systems commonly used by the people. A national coordinator would oversee implementation of the scheme throughout the country.

Dr TEMU (Papua New Guinea) said that, given the resource constraints facing countries like his, emphasis should be laid on training in combined skills and on curriculum development. He asked for assistance in that connection, for example in linking midwifery and paediatric training with the education of physicians and public health workers. Since many developing countries were unable to sustain their own training institutions, stress should be laid on regional collaborative training centres specifically designed to meet the needs of developing countries.

Mrs AL-RIFAI (United Arab Emirates) said it was important to ensure that health care was provided by properly qualified personnel trained to satisfactory standards. To that end, a clear classification of health care activities and of those who performed them was needed. New categories might have to be defined, but that should be done only with the greatest care.

Dr BELMAR (Chile) said that health services were often limited by lack of human resources, which tended to be concentrated in the major urban areas. Training programmes should be shaped not only by factors affecting the health services that were covered in the report and by health-related factors such as the environment, lifestyles and "social diseases" like violence, but also by the need for communication skills among health personnel and professionals. For example, those working with particular ethnic groups required special communication skills as well as knowledge of social anthropology and of the group's lifestyle and culture; usually, indeed, it was preferable that they themselves should belong to the ethnic group concerned. Cultural diversity was an important aspect of overall economic and social development and should be employed to the advantage of health and environmental protection. Formal training needed to be adapted accordingly. Referring to the restrictions societies placed on female participation in certain professions, he stressed the importance of incorporating "gender sensitivity" as a basic component of human-resource management.

Professor LEOWSKI (Poland), referring to the shifting of resources from treatment to prevention, which was more cost-effective, pointed out that the shift from intensive late care to less intensive early care and away from routine specialized care, as practised particularly in developed countries, was more problematic. Debates and decisions relating to health policy had tended to concentrate on the organization and financing of health services rather than on the health effects of such shifts. The tremendous power vested in all those involved in public health made constant evaluation of the effects of medical intervention essential at the individual and community levels, but the necessary evaluation methods were taught only at schools of public health, not in medical schools. That placed the responsibility for essential public health services solely with official public health agents. The makers of public policy, for whom public health was only one among many considerations, needed to rethink their methods and strategies if they were to make a significant impact on all areas of policy, including health. That entailed a reaffirmation of public, not just individual, responsibility for health, associated with reasoned action for the protection of health. Public responsibility involved not only governments, health ministries and public health officials, but all the partners in society at large. Reasoned action had to rest upon epidemiological findings and the results of quantitative and qualitative research and had to pursue objectives determined by the outcome of the practical application of the past judgements of policy-makers.
It was obvious that the reorientation of medical education and medical practice was bound to be a continuing process for many years to come as the effects of the social and epidemiological transition that the world was undergoing unfolded.

Dr HAVARD (Commonwealth Medical Association), speaking at the invitation of the CHAIRMAN, recalled that both the International Conference on Population and Development and the United Nations Fourth World Conference on Women had strongly recommended that adolescents' health needs should be met through improved health information and services. However, there was very little evidence that those responsible for the basic and continuing education of health professionals had reacted positively to the situation. Training in paediatrics was usually concerned only with the period up till 5 years of age, and adolescent health was not taught as a special subject even though the body was undergoing its most profound changes during that period of growth. It was known from surveys and from his Association's experience in developing countries that health professionals were not providing adolescents with an acceptable service to meet their health needs; indeed, adolescents had said that they did not trust health professionals and consulted them only as a last resort. Established health professionals in developing countries could spare little time from their practices to attend structured courses, so he welcomed the opportunity to draw attention to training modules in adolescent health that were being developed for them by the Commonwealth Medical Association in collaboration with WHO and UNICEF. They had undergone pilot trials in Uganda, and would shortly do so in Namibia and Zambia. The aim was to ensure that, wherever appropriate, participation in at least one of the modules, each of which lasted only three hours, should be a condition of annual renewal of the licence to practice. The document before the Committee did not deal with medical practitioners, nurses or midwives, but in the view of his Association training modules on adolescent health should be developed for other health workers as well.

Dr GOON (Division of Organization and Management of Health Systems) said that WHO's work in human resources development had revealed that it was not enough merely to deal with training: as implied by Ghana, there was a clear need to look into working and employment conditions. WHO had a programme on traditional medicine, but he would endeavour to obtain the relevant information on the larger area of alternative medicine and pass it on to the Swaziland delegation.

The CHAIRMAN suggested that the Committee might wish to take note of the progress report by the Director-General on reorientation of medical education and medical practice.

It was so agreed.

Guidelines on the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce (Resolutions WHA22.50 and EB99.R21; Document A50/INF.DOC./3)

Dr AL-SAIF (representative of the Executive Board) said that part III of document A50/6 provided background information on the development of the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce and on the guidelines for its implementation. The guidelines had been submitted to the Executive Board at its ninety-ninth session in the form of Annex 10 to the thirty-fourth report of the WHO Expert Committee on Specifications for Pharmaceutical Preparations,1 together with a draft resolution to endorse them. During the discussion the Expert Committee's report had been welcomed and the importance of the guidelines emphasized. One member of the Board, while strongly supporting the spirit of the Scheme, had referred to recently enacted national legislation for exports and had suggested the addition of a paragraph to the draft resolution in order to emphasize the importance of formally identifying and submitting any necessary national reservations with regard to participation in the Scheme to the Director-General. It had also been stated that in many developing countries that were not self-sufficient in the manufacture of pharmaceuticals the high proportion of their budgets spent on purchasing foreign currency to meet the cost of imports was a considerable burden, and the least they could expect was that such imports should conform to

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minimal standards. Often imported products did not even correspond to their own labelling. While legal mechanisms were already available at the national level, the adoption of international standards for pharmaceutical manufacture and marketing, established by WHO, had been supported in the hope that all Member States would in due course respect those standards. The Board had unanimously adopted resolution EB99.R21, in which it recommended for adoption by the Health Assembly a draft resolution incorporating the additional paragraph he had mentioned.

Dr MAYNARD (Trinidad and Tobago), endorsing the draft resolution, said the WHO Certification Scheme was of importance to small countries such as hers which had limited drug-testing facilities. With mergers in the pharmaceutical industry, factories were being moved from country to country, and it had become quite common for different phases of production to be carried out in different countries. The experience of her country had been that the certificates received did not always conform to the required standards, especially with respect to labelling. Systems needed to be put in place and enforced that would provide importing countries with all the information they needed.

Dr LARIVIÈRE (Canada) said the WHO Certification Scheme was an extremely important tool to ensure the international circulation of pharmaceutical products that were effective and safe. The export certificate was intended to provide a formal attestation of a product's marketing status in the exporting country and of the manufacturer's compliance with good practices. Canada had no difficulty providing information in that regard, but believed that information was now being requested that went beyond aspects relating to product quality, safety and efficacy or good manufacturing practices. For example, with specific reference to sections 4.7 and 4.8 of the guidelines (reproduced in document A50/INF.DOC./3), since Canada did not have a price control system its regulatory authority could not provide information on drug prices which could be interpreted as an official endorsement. In spite of those practical difficulties, Canada strongly supported WHO's work in the field and urged Member States to make full use of the Scheme. Canada welcomed resolution EB99.R21, notably the inclusion of paragraph 2(2).

Dr DINARVAND (Islamic Republic of Iran) supported WHO's initiatives but said that much more needed to be done. One of the main elements in his country's national drugs policy had been to ensure their availability and accessibility, and consequently support had been given to local production. Currently more than 90% of the pharmaceuticals used in the country were produced by local manufacturers, but most of the raw materials were imported, and he proposed a new paragraph to ensure the quality of those raw materials, reading:

3. REQUESTS the Director-General to provide guidelines on the certification of the pharmaceutical active ingredients moving in international commerce, and to submit the guidelines to the Fifty-first World Health Assembly for endorsement.

Dr NIGHTINGALE (United States of America) said that the guidelines could not be applied in his country in the form proposed by the WHO Expert Committee on Specifications for Pharmaceutical Preparations owing to legal, regulatory, resource and other difficulties which were primarily but not only the consequence of recently enacted legislation on drug exports in the United States regulated by the Food and Drug Administration. Among the matters affected by the new legislation were user-fee requirements and time requirements. Furthermore, the United States lacked or could not easily obtain information that would be required under the Scheme, including the format specified by it. Nevertheless, it supported resolution EB99.R21 and the Certification Scheme, and would participate in it within the limitations described. The United States reservations would be filed with the Director-General in the manner prescribed.

Dr AGGARWAL (India) said his country supported any move to establish general standards and guidelines on the quality of pharmaceutical products moving in international commerce, and was already issuing certificates providing an assurance that good manufacturing practices were being followed by Indian companies and offering product certification if required. Good practices had been a statutory requirement in India since 1988. India was establishing a national drug authority but there was no national pharmaceutical inspectorate, and that work would have to be undertaken by the Drug Controller General of India and State Drug Controllers who were the licensing authorities.
Dr SULEIMAN (Malaysia) said that, with the pharmaceutical industry flourishing in many parts of the world and generic products entering the markets as soon as patents expired, technical harmonization of data on the quality, safety and efficacy of pharmaceutical products was urgently needed. Quality assurance depended largely on a well formatted system of licensing, reliable analysis of the finished product, and certification that the product was manufactured in accordance with current good practices. The guidelines could be used as a tool to ensure the quality of pharmaceutical products marketed internationally and as a standard prerequisite for the registration of imported pharmaceutical products in all countries. Malaysia fully supported the implementation of the guidelines, which would make it easier for the registration process in the importing country to be carried out smoothly because the necessary information concerning the imported product would be more readily accessible. The free sale certificate and certificate of good manufacturing practices issued by the authorities listed in the Scheme should be recognized for the purpose of registration by all importing countries if the formats complied with those set out in the Scheme: all Member States were encouraged to standardize the formats used. Countries intending to export pharmaceutical products should also issue WHO-type certificates to facilitate entry into the importing countries as the quality of those products would not be questionable. The importing country would have access to information on the quality and regulatory status of the product in the exporting country, and that would be a safeguard to ensure that substandard products not registered for use in the country of origin were not being exported. Compliance with the WHO Certification Scheme would serve to facilitate trade between Member States. He urged Member States to implement the Scheme, and supported the draft resolution recommended in resolution EB99.R21.

Dr TEMU (Papua New Guinea) also supported the draft resolution. He urged other Member States, upon which his country relied so much for its drugs, to comply with the guidelines, and WHO to continue monitoring the Certification Scheme. Papua New Guinea was still a victim of low-quality products and of fabricated certificates, and in the absence of quality-testing laboratories it would continue to rely on the Scheme for the quality of its pharmaceutical products.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland), welcoming the further development of the Certification Scheme and especially resolution EB99.R21, said that clarity was needed so that Member States could obtain unambiguous information about pharmaceutical products moving in international commerce. In order to avoid any confusion being caused if countries receiving requests for certificates issued them in a different form from that proposed, paragraph 2(1) of the draft resolution recommended by the Executive Board should be amended by adding the words “and to issue the certificates in the form proposed” at the end.

Dr DLAMINI (Swaziland) appreciated WHO’s work on the extremely important topic under review. Swaziland spent large sums on the purchase of imported drugs and she therefore welcomed the draft resolution under consideration. A further matter for concern was that donated drugs sometimes had very short validity or had even exceeded their expiry dates, making it difficult to assess their effectiveness. Control of over-the-counter sale by general practitioners of some medicines was needed, and unscrupulous sale of drugs which were not acceptable in their countries of origin also occurred. She felt that the WHO quality control programme should extend to all drugs entering her country and hoped that the Organization would help to that end. Swaziland would update its pharmacy regulations accordingly. Finally, she expressed concern regarding the quality of some vaccines, particularly against measles, since children had contracted the disease even after vaccines had been stored carefully; she therefore advocated assessment of the effectiveness of vaccines.

Ms FILIPSSON (Sweden) supported the adoption of the draft resolution, which she considered very important. Although her country would not be in a position to comply with all points contained in the new guidelines by 1 January 1998, she hoped that it would comply fully as soon as possible.

Professor SHAFI QURAISHY (Pakistan) commended WHO’s efforts in improving and maintaining the quality of pharmaceutical products. Pakistan had been committed since 1976 to ensuring that its drug manufacture, licensing, registration and certification were conducted in accordance with the Organization’s recommendations. That had resulted in substantial improvement in the standards of the pharmaceutical industry and the quality of drugs in his country. Further improvement had been ensured by market surveillance and
independent quality control monitoring measures. Pakistan supported the draft resolution and would participate fully in the Certification Scheme.

Professor PICO (Argentina) stressed the importance of applying throughout the world the guidelines on the WHO Certification Scheme and the responsibility borne at national level for so doing. To that end, his country had established, with WHO assistance, a National Food, Medicines and Medical Technology Administration and maintained formal relations with similar bodies in other countries which had longer experience in the matter. WHO should take the lead in ensuring that clear quality control standards were laid down to protect people's health. He supported the draft resolution with the United Kingdom amendment.

Professor ACHOUR (Tunisia) said that his country had participated in the preparatory work for the WHO Certification Scheme, which gave important guarantees to importing countries; its provisions had been included in Tunisian regulations concerning drug registration for marketing and Tunisia also ensured that certification was given when drugs were exported. He congratulated WHO on its endeavour, supported the draft resolution on the guidelines, and urged WHO to ensure that certification truly reflected manufacturing conditions in exporting countries.

Dr KALITE (Central African Republic) said that since 1993 essential drugs had been distributed to health centres in his country as part of the Bamako primary health care initiative and that other drugs were also sold in private pharmacies. There was no national quality control system for imported drugs and he therefore gave the strongest possible support to the draft resolution.

Ms STEGEMAN (Netherlands) welcomed the revised guidelines for implementation of the WHO Certification Scheme. Like many other delegates, she considered the Scheme to be an important instrument. The new guidelines were clear and left no room for differing interpretations, and she therefore urged that, once they had been adopted, only the WHO Certification Scheme should be used. She endorsed the draft resolution, with the amendment proposed by the United Kingdom.

Dr MWANZIA (Kenya) endorsed the Director-General's report contained in document A50/6 and supported the draft resolution before the Committee. Kenya had set up a national quality control laboratory for pharmaceuticals and had trained personnel, with assistance from Germany, for which he expressed his gratitude. WHO support was needed for information exchange among regulatory authorities. Kenya welcomed the arrangements made by the regulatory authorities of South Africa with Kenya's Pharmacy and Poisons Board to ensure that the problem of illegal importation of substandard drugs into those countries would be dealt with.

Mr ROKOVADA (Fiji) commended WHO for the development of the guidelines. In the absence of drug registration systems and drug quality testing facilities, the WHO Certification Scheme was a useful control tool for assessing the quality and efficacy of drugs imported into countries. The new guidelines appeared to address some of the practical problems encountered with the former guidelines, such as the question of WHO assistance with national inspections. The drawback of the Scheme was that it was voluntary and that the importing authority relied on the goodwill of the exporting authority to provide true and accurate information; there were reports in some countries of falsified certificates being provided. In the absence of other quality control mechanisms, however, the WHO Scheme could be relied upon to provide some information regarding the quality status of the products provided and he therefore supported use of the guidelines.

Mr TSUDA (Japan) supported the draft resolution and urged Member States to implement the Scheme firmly as it was so important. The guidelines had a long history but had not necessarily been used a great deal.

Dr ZEINE (Mauritania) said that his country was an importer of drugs and had not so far developed a national system of quality control. The international Certification Scheme would offer protection from certain illegal practices and give confidence to those dispensing treatment using imported drugs. He supported the draft resolution.
Dr AL-JABER (Qatar) said that his country imported drugs from all over the world. Qatar had studied the problem in the Gulf region and adoption of the draft resolution would greatly assist in controlling and verifying the quality of imported drugs. He supported the draft resolution and the United Kingdom amendment.

Dr SUKWA (Zambia) endorsed the guidelines and also the suggestion that the certificate used should be exclusively in the form proposed.

Dr AL-MADI (Saudi Arabia), supporting the draft resolution, said that no drug could be imported into his country without being checked under a strict control system that had been in operation for seven years.

Dr ALBRECHT (Switzerland) said that his country had a long tradition of issuing certificates for pharmaceutical products moving in international commerce. For over 15 years, the certificates issued by Switzerland had been in keeping with the WHO Scheme. He therefore strongly supported the draft resolution.

Miss WEHRLI (Regulatory Support), replying to comments, referred to Canada’s reservations about price: the intention was that the price would not be part of the information certified by the authority but could be attached to the certificate on the responsibility of the manufacturer. Regarding the amendment proposed to the draft resolution by the Islamic Republic of Iran, whereby certification would be extended to active pharmaceutical ingredients, appropriate guidelines were in preparation but would not be ready by 1998. She understood that the proposer of the amendment was agreeable to having the matter submitted to the Fifty-third World Health Assembly. The United Kingdom amendment requiring certificates to be issued in the form of the WHO proposals was welcome.

It was quite understood that some countries, like Sweden, might be unable to comply fully with the conditions by 1 January 1998 but would do so as soon as possible thereafter. She added that the Certification Scheme also applied to biological preparations.

The CHAIRMAN invited the Committee to consider the draft resolution recommended in resolution EB99.R21 with the amendments proposed by the delegates of the Islamic Republic of Iran and the United Kingdom.

Dr NIGHTINGALE (United States of America) expressed reservations concerning the United Kingdom amendment and suggested wording along the lines of “and to issue the certificates in the form proposed, in so far as possible”, to reflect the fact that it might prove impossible for certain countries which had their own legally imposed systems to apply the WHO guidelines without modification. Regarding the amendment proposed by the Islamic Republic of Iran, he suggested that, in order to take into account the changes that might occur during the lengthy period of development, it might be reworded to include a request to circulate the proposed guidelines on ingredients to all Member States before submission to the World Health Assembly through the Executive Board.

Dr LARIVIÈRE (Canada) suggested that the substance of the amendment proposed by the Islamic Republic of Iran might, if there was no objection, be considered for inclusion in the agenda of the next meeting of the International Conference of Drug Regulatory Authorities, for which WHO acted as Secretariat, rather than being included in the draft resolution. That would enable the regulatory authorities to consider the technical and legal aspects relating to active ingredients, after which the matter could be submitted to the Fifty-third World Health Assembly.

Dr DINARVAND (Islamic Republic of Iran) said that WHO was already engaged in providing the relevant guidelines, so there would be sufficient time in the next three years to circulate them to Member States for their comments.

Dr THYLEFORS (Secretary) suggested that the Committee might make a recommendation to the Director-General to provide appropriate guidelines, along the lines suggested by the Islamic Republic of Iran, rather than including the amendment in the body of the resolution.
Dr DINARVAND (Islamic Republic of Iran) replied that he had no objection to that suggestion.

The CHAIRMAN suggested that, if there were no objection, the Committee might approve the draft resolution in resolution EB99.R21, as amended by the delegate of the United Kingdom, and make a recommendation that the Director-General should provide Guidelines on the Certification of the Pharmaceutical Active Ingredients moving in International Commerce for submission to the Fifty-third World Health Assembly.

On that understanding, the draft resolution, as amended, was approved.

The CHAIRMAN drew the Committee's attention to a draft resolution on "cross-border advertising, promotion and sale of medical products through the Internet", proposed by the delegations of Argentina, Austria, Bahrain, Belarus, Belgium, Canada, Croatia, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Indonesia, Ireland, Italy, Japan, Malaysia, Netherlands, New Zealand, Norway, Oman, Qatar, Republic of Korea, Russian Federation, Saudi Arabia, Switzerland, Tunisia, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America and Zimbabwe, which read as follows:

The Fiftieth World Health Assembly,

Aware of the increasing use of electronic communication means by the general public for shopping and gathering information;

Aware of the fact that the efficacy, safety and quality of medical products require careful assessment, and that in many Member States such products require authorization prior to marketing, and are available only on medical prescription;

Aware that the proper and safe use of medical products may require review of the medical history, medical examination, diagnosis of the condition and subsequent counselling and follow-up by the health care professional;

Recognizing that regulations and regulatory control vary among countries regarding prescription/non-prescription (over-the-counter) status of medical products, resulting in national differences in their availability;

Aware that advertising, promotion and legal sale of medical products in one country may be violative in other countries;

Recognizing that in some situations provision of medical products by an authorized health professional on the basis of an electronically communicated request may contribute to more rational and better health care, and to the easier availability of necessary medical products and information about them;

Recognizing that such mail order service may in some countries include prescription-only products, and that in such situations national law may specify additional requirements to authorize the order;

Noting the continued need for vigilance in the maintenance of legal and ethical standards in the advertising, promotion and sale of medical products;

Concerned, however, that uncontrolled advertising, promotion and sales of medical products by electronic communication may present a hazard for public health as well as a risk for the individual patient, particularly with regard to misleading or fraudulent product information and lack of individual counselling;

Particularly concerned that advertising, promotion and sales through the Internet may lead to uncontrolled across-the-border trade of medical products that may be unevaluated, unapproved, unsafe or ineffective, or used inappropriately,

1. URGES all Member States to collaborate with WHO in order to facilitate collection of information on the Internet regarding the points listed above;

2. REQUESTS the Director-General:
   (1) to collect information on the various aspects and consequences of advertising, promotion, and sale of medical products through the Internet;

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1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.3.
(2) to collaborate with the drug regulatory authorities and national and international enforcement agencies, consumer groups, professional associations, the pharmaceutical industry and other relevant parties, to collect all necessary information on the subject;
(3) to convene a WHO ad hoc working group consisting of representatives of the parties mentioned above, and, in addition, experts in ethics, legal matters, marketing and communication, and other experts as required, to consider and review the above and related issues in the advertising, promotion and sale of medical products through the Internet, and to formulate recommendations for action to the Director-General;
(4) to report on progress to the Executive Board at its 101st session in January 1998, and to the Fifty-first World Health Assembly in May 1998;
(5) to mobilize extrabudgetary resources for this activity.

The subject of the draft resolution had a direct bearing on the question of the guidelines on the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce, currently under discussion. It had been referred to at the Committee’s third meeting in a statement by the delegate of Belgium on agenda item 17.1 in relation to programme 3.3 (Essential drugs) and was now submitted to the Committee for approval.

Dr HANSEN-KOENIG (Luxembourg) welcomed the draft resolution, which concerned a matter that might have highly negative consequences for public health. Luxembourg wished to be included among the sponsors. She proposed the inclusion of a reference to “fraudulent imitations” in relation to “medical products” in the last preambular paragraph.

Dr THIERS (Belgium) said that Belgium had proposed the draft resolution because it considered that WHO could not await the outcome of the discussions at other levels of the United Nations on more general international measures concerning the impact of the Internet in society, and on solutions to counteract some of the negative effects of that technology, which nevertheless had the potential of bringing people together and contributing to development. WHO should assume its responsibilities in that field as part of its mandate to protect public health at world level. The problem, which hitherto had affected a small number of privileged consumers in industrialized countries which had access to the Internet, was now spreading to the less developed countries and might assume disquieting proportions at international level, cancelling out WHO’s efforts over many decades to ensure the high quality and rational use of medicines and drugs. The Belgian Minister of Health had made certain commitments concerning the financing of the meeting of the ad hoc working group if the resolution was adopted. He thanked the many countries which had cosponsored the proposal.

Dr NIGHTINGALE (United States of America) considered that the Internet provided useful information about many consumer products and that their purchase over the Internet could benefit consumers, for instance, offering lower costs and easier availability. However, the Internet could be abused for fraudulent purposes, a matter that was particularly significant when health products were being advertised, promoted and sold internationally. He supported the collection of relevant information, WHO’s collaboration with industry associations and other relevant parties, and the convening of an ad hoc working group to examine questions regarding advertising, promotion and sale of medical products on the Internet and to make recommendations to the Director-General. His delegation would be pleased to participate in the working group, especially as a workshop had been held recently in his country on the question of promotion of medical products on the Internet, and as numerous instances had been noted of fraudulent and inappropriate sales of unapproved products on the Internet from and within his country. While supporting the substance of the draft resolution, he expressed concern that the matter had not been submitted to the Executive Board for consideration in January 1997. However, in view of the urgency of the problem, he would raise no objection to the resolution, which was process-oriented rather than substantive and would prepare the way for action by the Health Assembly when the Executive Board had reviewed the matter and made recommendations. He supported the amendment proposed by Luxembourg.
Dr OWONA ESSOMBA (Cameroon) said that his delegation, which was well aware of the positive and negative uses of the Internet, strongly supported the draft resolution with the amendment proposed by Luxembourg and wished to be included among the sponsors.

Professor WHITWORTH (Australia) shared the concern expressed by previous speakers. Questions to be considered included the nature of the Internet and the difficulty of regulating advertisement or even establishing the intent of the entry on the Internet, and also the distinction between advertising or promotion and actual sale of prescription medicines to the public, which was illegal in some countries yet not in others, making it difficult to regulate the problem internationally. While sales were usually more tightly controlled, the personal importation of medicines was permitted in many countries for individual treatment as opposed to marketing. Whereas the ad hoc working group might help to define the scope of the problem, it was difficult to imagine an international approach which could control such practices.

Mr TSUDA (Japan) and Dr MOREAU (France) supported the draft resolution with the amendment proposed by Luxembourg.

Dr ZEINE (Mauritania) also supported the draft resolution and shared the views expressed by previous speakers.

Dr MTSHALI (South Africa), supporting the draft resolution, proposed that the title should be expanded to include a reference to electronic and other mail-ordering systems.

Mr BERLIN (European Commission) said that the Commission had been increasingly concerned at the growing use of the Internet and realized the difficulties which might be encountered. It welcomed in particular the proposal in the draft resolution for collection of information, which would be of great value to it in assessing appropriateness for action.

The draft resolution, as amended, was approved.

Quality of biological products moving in international commerce (Resolution EB99.R22)

Dr AL-SAIF (representative of the Executive Board) noted that an ad hoc working group had been convened in October 1996 to consider the responsibilities of WHO's Biologicals unit and the WHO Expert Committee on Biological Standardization in ensuring the quality of biological products, such as vaccines, moving in international commerce. Those responsibilities included the establishment and distribution of international biological reference materials which ensured the comparability of activity of biological products throughout the world, and the publication of guidelines and requirements for production and quality control of specific products.

The recommendations of the ad hoc working group had been submitted to the Executive Board in January 1997. The Board had considered them important, not only scientifically and technically, but also from an institutional point of view, since they were intended to strengthen national control authorities, particularly in developing countries, and to reinforce WHO's efforts to guarantee the safety and efficacy of existing and future biological products. The recommendations also took into account the possible implications of recent changes in international trade agreements. In resolution EB99.R22, the Executive Board recommended a draft resolution for adoption by the Health Assembly. The Director-General’s report was contained in part IV of document A50/6.

Dr OTOO (Ghana), expressing strong support for the draft resolution, said that the matter was of particular concern to his country because of a recent unfortunate occurrence. Ghana’s poliomyelitis eradication programme had almost been derailed because of a vicious rumour circulated to the press to the effect that the poliomyelitis and other vaccines sent to Africa for the Expanded Programme on Immunization were

1 Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA50.4.
contaminated with HIV. It was a ridiculous allegation but to a gullible and poorly informed public it had the potential to cause incalculable damage to the immunization programme. It was important that vaccines and other biological products used for public health programmes should be subjected to more stringent review, and when unfounded allegations were made perhaps WHO should publicly refute them.

Dr NIGHTINGALE (United States of America) expressed his support for the work of the ad hoc working group and the well-structured draft resolution recommended by the Executive Board. He hoped it would be approved by the Committee and adopted by the Health Assembly without amendment and that its provisions would be swiftly implemented.

Dr SULEIMAN (Malaysia) said that there had been a great increase in the use of biological products over the past decade. Their increasing availability, individual characteristics and relative expense made it essential to develop a systematic method of evaluation which could be used in various health care systems. Quality control of biological products was a major problem. The WHO guidelines and requirements for production and quality control had been useful to many Member States, and he hoped the Organization would continue to act as a reference point for quality, safety and efficacy, with particular emphasis on increasing the capabilities of national control authorities. The service provided by WHO, through its Biologicals unit and the International Laboratories for Biological Standards, in preparing and distributing biological reference materials had been invaluable and should continue to receive adequate funding. The system of WHO alerts and newsletters had helped to disseminate information rapidly, and the advent of electronic mail should ensure that information both from WHO and from national control authorities could be shared even more rapidly in future. He supported the draft resolution.

Dr DINARVAND (Islamic Republic of Iran) said that WHO's leadership was needed to ensure the safety of biological products because of the rapid pace of scientific and technological advance in that field. He accordingly supported the draft resolution.

Ms STEGEMAN (Netherlands), speaking on behalf of the European Union, proposed an amendment to the draft resolution to take into account not only national control authorities, but also international mechanisms. In paragraph 1(2) the words "and international" should be inserted before the words "control authorities".

Professor ORDOÑEZ (Cuba) noted three different opinion groups among countries. The industrialized countries were pressing for the worldwide harmonization of quality control standards at their level of accomplishment and were perhaps worried by the more reasonable standards of WHO, which might be met by less developed countries. The poorest developing countries, which were importers without the capacity to produce any biological products, called upon WHO to establish quality standards to protect them from low-quality products not registered in the exporting countries. Finally, countries such as his own, with some production capacity, favoured the WHO standards so that they could continue manufacturing. Three conclusions followed from those points. Firstly, the question of quality was inseparable from that of development, since quality could not be guaranteed solely by regulation; it was also essential to reduce the inequalities in economic, scientific and technical capacity in different countries. Secondly, WHO's quality guidelines should be limited to essential elements of safety and efficacy, without going into details, which varied from one product to another. Thirdly, WHO should not set itself up as a supranational regulatory authority, but instead should provide assistance and support to national regulatory authorities, which were the ones ultimately responsible for ensuring the quality of biological products. He supported the draft resolution.

Dr MAHJOUR (Morocco) said that quality control of biological products on the international market was essential, particularly since national control authorities in many countries were not sufficiently developed to undertake that task. He therefore supported the draft resolution.

Dr AL-JABER (Qatar) agreed that the setting of international standards for biological products was essential. However, he hoped that the need to comply with such standards would not drive the price of biological products beyond the reach of countries that needed them. Qatar therefore supported the adoption of adequate, but practical, international standards and welcomed the draft resolution.
Dr ÇAKMAK (Turkey) expressed his support for the draft resolution. His country's national regulatory authority had fully implemented the existing WHO guidelines on biological products in its national legislation. External technical assistance would be essential for the strengthening of national regulatory authorities, and he therefore particularly welcomed the reference to increased assistance for Member States in paragraph 2(2) of the draft resolution.

Professor PICO (Argentina) supported the draft resolution in its original form. He could not accept the amendment proposed by the European Union.

Dr NIGHTINGALE (United States of America) said that the amendment changed both the meaning and the intention of the draft resolution and that, accordingly, he too could not accept it.

Ms STEGEMAN (Netherlands), speaking on behalf of the European Union, said that she was not authorized to withdraw or revise her amendment without consulting the other Member States of the European Union.

Dr THYLEFORS (Secretary) suggested that the delegations concerned should meet informally in order to reach a consensus on the wording. The Committee could then resume its consideration of the draft resolution at a later date.

It was so agreed.

(For continuation, see summary record of the eighth meeting, page 108.)

The meeting rose at 16:45.
1. IMPLEMENTATION OF RESOLUTIONS AND DECISIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda (Documents A50/6 and Corr.1) (continued)

Reproductive health (Resolution WHA48.10)

Professor ABERKANE (representative of the Executive Board) said that the Board had reviewed the Director-General's report on implementation of resolutions EB95.R10 and WHA48.10, which requested him to coordinate research and action on reproductive health. A reorganized programme of family and reproductive health including divisions for technical support and research had been approved by the Health Assembly in 1996. The Board had been informed that the aim of the programme was to strengthen the ability of countries to ensure the promotion and protection of sexual hygiene and reproductive health for all and access to health services of good quality and the necessary care. The technical-support, standard-setting, research and advocacy sectors of the programme were based on outcome. Three global priorities were emphasized: (i) family planning, (ii) maternal and neonatal health and (iii) prevention and control of reproductive tract infections, including those sexually transmitted. The programme favoured a progressive approach and use of existing structures, taking all possible opportunities to improve coverage, access to and quality of care. Research needs in the fields of sexual hygiene and reproductive health were being defined and research priorities set for the coming years. The regional offices helped Member States to develop strategies and reproductive health programmes based on sustainable activities using existing primary health care services. WHO was collaborating with other organizations in preparing core indicators of reproductive health for use in global monitoring. The Board considered that reproductive health was a crucial area of health in general that was closely linked to sustainable development; members welcomed the outcome-based approach used by the area of family and reproductive health. WHO had been congratulated for having taken due cognizance, in developing its programme of work, of the sensitive nature of reproductive health and of the many factors linked to traditional and cultural beliefs and social attitudes. A comprehensive report on reproductive health, which had been requested by the Forty-ninth World Health Assembly, was considered by the Board to give an accurate reflection of activities in the area.

Dr INFANTADO (Philippines), referring to resolution WHA48.10, said that the principles and the plan of action espoused by WHO had been incorporated into the framework of the women's health and safe motherhood programme in her country. The life-cycle approach was used, with strategies directed to the specific needs of the target population, which had been defined in studies that had shown how resources might best be allocated. Strengthening of the reproductive health and family planning project, which was part of the UNFPA programme, focused on social reform areas for which support was lacking. In a project supported by the World Bank and the Asian Development Bank, the priorities for implementation were programme components to cover areas of family planning, maternal and child health and nutrition that had not been addressed otherwise. The programme was, however, short of resources. It was to be hoped that the budgetary and administrative reforms being undertaken within the United Nations system, including WHO, would result in optimum allocation and use of development funds for reproductive health.
Dr ALVIK (Norway), recalling her country's active participation in securing the adoption of resolution WHA48.10, welcomed the progress that had been made by the reorganized reproductive health programme. Section V of the report of the Director-General (document A50/6) mentioned that in cooperation with UNICEF a review had been undertaken of the health status of young people in developing countries and new estimates of maternal mortality had been made. Collaborative efforts with other agencies were under way to develop additional indicators and better information on reproductive health. Those were positive examples of the constructive cooperation that Member States had encouraged WHO to develop with other competent agencies. She welcomed the focus in the report on equality between the sexes and on men's participation and responsibility, the widespread introduction of the "mother-baby package", consisting of a minimum set of measures to ensure safe pregnancy and childbirth, other measures to reduce maternal mortality, the development of training materials to upgrade midwifery skills, and the emphasis on guidelines for adolescent reproductive health education. WHO would have an increasingly important role in assisting Member States to move towards a more closely integrated approach to reproductive health. Reproductive health was a core activity of WHO in empowering people; it was imperative that resources for the programme should be secured. She requested that a report should be prepared for the Fifty-first World Health Assembly on progress in the field.

Dr KONG Lingzhi (China), noting that prevention of violence was discussed in section I of document A50/6, said that sexual violence was an important problem faced by women in many countries. It could not be solved by WHO alone, as it was not merely a health problem. Paragraph 9 of section V of the report mentioned the strategies that had been developed by the Regional Offices for Africa, the Americas, Europe and the Eastern Mediterranean. There were more women in Asia than in any other region, but no concrete strategies had been suggested for the Western Pacific Region. The priority topics in that region were (i) the reproductive health of adolescents and the prevention of sexually transmitted diseases including AIDS, (ii) the effects of family planning and (iii) evaluation of long-term strategies and family planning measures.

Dr VAN ETтен (Netherlands) welcomed the report, which provided a general review of activities undertaken with UNFPA and UNICEF. He also appreciated the integrated approach taken towards reproductive health and the fact that the programme was based on recommendations of the United Nations International Conference on Population and Development, held in Cairo, and the Fourth World Conference on Women, held in Beijing. He would, however, have liked greater emphasis on problems of nutrition, including micronutrient deficiencies, especially with regard to the mother-baby package. He requested further information on the research activities of the family and reproductive health programme.

Dr OOMI (Japan) said he would welcome information on how WHO supported and cooperated with those nongovernmental organizations that played a significant role in implementation of reproductive health programmes at community level, and how it provided training and support to researchers in the areas of maternal and child health and family planning.

Dr AKIN (Turkey), welcoming the report and the holistic, comprehensive approach taken by the Organization to reproductive health, a crucial part of general health, said that one aspect of reproductive health care which warranted greater attention from WHO was provision of information and services targeted at adolescents. Many behaviour patterns laid down in that formative period could have major consequences for reproductive health later in life. The needs of adolescents should be realistically and impartially assessed and appropriate approaches adopted. Only thus could the root cause of most problems relating to that age group be effectively tackled. Member States should also be given greater guidance and assistance in promoting adolescent health. Another area in which WHO's continued support would be welcome was in improving the quality of reproductive health care services.

Dr DAULAIRE (United States of America) commended the report and welcomed its approach to reproductive health. In particular, he applauded the reliance on rigorous scientific review and analysis as the basis inter alia for advocacy, standard-setting, technical cooperation, research, and information. He agreed that reproductive health was an essential part of general health and should therefore form an integral part of basic health services everywhere. Furthermore, the United States took the view that reproductive health lay at the very heart of the development process and therefore that programmes to promote it should be considered the central
element of health services aimed at improving the lives of families mired in poverty throughout the developing world. In particular, such programmes should provide adolescents, and especially adolescent girls, with the opportunity for healthy adult lives that their mothers had been denied. Consequently, reproductive health would remain a priority area in the United States' international cooperation efforts in the health field. Lastly he asked whether he rightly understood from the report that activities other than technical support to Member States were considered of lesser importance.

Dr MONISOV (Russian Federation) endorsed the Organization’s general approach to reproductive health as set out in section V of the Director-General’s report. Russian research and operational centres were ready to play a more active role in scientific research, standard-setting and technical cooperation. Greater attention should be paid to fertility enhancement and to child health care, especially with regard to children of school age and adolescents, including establishment of gynaecological services for children. Assistance from the Organization in those areas was especially needed at country level.

Dr LEGNAIN (Libyan Arab Jamahiriya) said that since reproductive health was closely related to human development, WHO should increase its assistance to Member States in maternal, child and adolescent health. Programmes should not be developed on a worldwide basis, but should be tailored to suit the particular characteristics and different priorities of each region.

Dr MAPETLA (Lesotho) said that in his report the Director-General dealt with all the critical issues relating to the successful implementation of the reproductive health programme. Lesotho still had a long way to go in that area and therefore greatly appreciated WHO’s continuing technical and financial support, on which progress made so far had largely depended.

Dr PARK (Republic of Korea) said that since the 1994 United Nations International Conference on Population and Development many countries had incorporated reproductive health into their national policies. In that connection he expressed his appreciation to the Director-General and WHO staff for their efforts.

In the Republic of Korea a family planning programme had been successfully implemented since 1962, resulting in a dramatic drop in the population growth rate and a decrease in the total fertility rate. However, one problem associated with the family planning programme was the preference for male offspring, leading to an imbalance in the sex distribution of newborn infants. Since June 1996 the Korean Government had been implementing a new population policy focused on enhancing maternal and child health, reducing adolescent sex-relation problems, and correcting the sex imbalance. Free mass screening of the newborn had been introduced to detect inherited metabolic deficiencies. WHO should give greater attention to the prevention of such deficiencies and step up its technological and financial support for related activities, particularly in the developing countries.

Professor ORDÓÑEZ CARCELLES (Cuba) said that in his country social and political change had resulted in a higher level of education, equality of the sexes and specific programmes to improve reproductive health. Reproductive health encompassed family planning and sexual health and was accorded priority in the Cuban health system. Society had a duty to respond to the growing needs of adolescents in relation to reproductive health and family planning by providing information that would enable them to make responsible decisions, to understand sexuality and to protect themselves against unwanted pregnancies, as well as against sexually transmitted diseases with the risk of infertility that they entailed. Education played a vital role in such matters. Furthermore, when policies to promote economic growth and sustainable development were under consideration by the international community, due account should be taken of national priorities and specific cultural and religious differences as part of respect for basic human rights.

Professor GRANGAUD (Algeria), referring to paragraph 6 of section V of the report, said that some progress had been made in recent years with respect to reproductive health in Algeria, inasmuch as 76% of births in the country now took place under medical supervision, family planning was available to 58% of women of childbearing age, and the population growth rate had fallen to 1.9%. Nonetheless, Algeria still had unacceptable maternal and perinatal mortality rates. Some programmes were still too vertically-oriented and activities were not sufficiently well integrated at the field level. For that reason, Algeria fully subscribed to the approach
recommended in paragraph 9, which laid emphasis on integrating activities into the basic health care programme and on training.

Professor SHAFI QURAISHY (Pakistan) expressed appreciation of the report and the Organization's integrated approach to reproductive health. Thanks were due to WHO for the technical assistance provided to his country in the area of reproductive health, where great strides had been made following the launching of several new initiatives. They included the training of 43,000 female health workers with particular responsibility for reproductive health. Through their efforts, the mother-baby package had been greatly strengthened, resulting in visible improvements in various reproductive health indicators such as maternal and neonatal mortality, anaemia of pregnancy and low birth weight. Other related achievements included efforts made in the planning and implementation of primary health care approaches, for which the previous Prime Minister had been awarded the Health-for-all Medal by the Regional Committee for the Eastern Mediterranean, and special new programmes for female literacy and women's development. Pakistan would welcome greater technical and financial support from WHO for reproductive health in the developing countries over the coming years.

Ms MILLEN (Finland) said her country welcomed WHO's new involvement in the coordination and integration of the activities most essential to reproductive health and supported the greater emphasis on social science perspectives within the programme. The family and reproductive health programme should seek to establish close cooperation with programmes concerned with health systems development. HIV/AIDS and sexually transmitted disease prevention and care should be integrated within reproductive health functions, which could help to strengthen the overall position of primary health care. The ethical use of reproductive health technology and, conversely, the application of sex determination technologies which resulted in abortion of female foetuses were a complex issue that must be tackled. Sustained attention should be paid to ensuring access to optional, good-quality services in reproductive health. The decision to convert the UNICEF/WHO Committee on Health Policy into a WHO/UNICEF/UNFPA Coordinating Committee facilitated a comprehensive approach to reproductive health. Finland expected that, in addition to coordination of actions among the agencies, the Coordinating Committee would focus on health policy dialogue on questions of reproductive health.

Mrs AL-RIFAI (United Arab Emirates) said her country attached great importance to listening to the needs of mothers and children, the twin pillars of its heritage and nationhood. The competent authorities paid a great deal of attention to coordination with other members of the Gulf Cooperation Council in meeting the needs of the people. A number of activities related to the overall programme of reproductive health had been initiated, with positive results. Early diagnosis of cancer and of inherited disease was important in that connection. Efforts were being made to strengthen the reproductive health services offered by convening a conference on "The health of women in the United Arab Emirates". Her country particularly welcomed the Director-General's report on reproductive health and was grateful for WHO's efforts on behalf of mothers and children in the Eastern Mediterranean Region. Activities in the field of adolescent education had been especially useful, as young people needed to be taught to respect the cultures into which they had been born.

Dr HEMATRAM YADAV (Malaysia) also wished to place on record his satisfaction with section V of the Director-General's report and his country's gratitude for WHO's assistance in the domain of reproductive health. Collaboration between the international agencies and with nongovernmental organizations could, however, be improved.

Dr AKBARI (Islamic Republic of Iran) agreed that section V of the report had been very well prepared. The reproductive health programme took a holistic view and integrated activities for people of all ages, including, very importantly, adolescents. More attention should, however, be paid to male participation in and support for female reproductive health, and the mental and social aspects of reproductive health issues should be taken more fully into account.

Dr ARGADIREDJJA (Indonesia) joined in commending section V of the report and welcomed the progress made in reproductive health, which was a crucial part of general health. Member States should be urged to implement reproductive health programmes, which called for good intersectoral coordination and would benefit from enhanced community participation.
Mrs MUNLO (Malawi) also welcomed the Director-General's report on reproductive health. Malawi had endeavoured to comply with WHO's recommendation that reproductive health should be made accessible to all by restructuring its maternal and child health service to include all the proposed components of reproductive health care. The bulk of the support for such activities had come from WHO. One of the goals of the safe motherhood initiative in Malawi was to increase general public awareness of maternal mortality and to show what individuals, families and communities could do to promote safe motherhood practices. To that end, a network of community-based safe motherhood advisers had been set up to supplement the traditional methods of imparting information to communities. The advisers were ordinary village women, some of them illiterate, who were selected by community leaders and received two weeks' training centred on the magnitude of the problem of maternal mortality, on its common causes and their prevention through proper and early utilization of health services for antenatal care and delivery, on the prevention of high-risk pregnancies, and on the importance for the promotion of women's social status of educating girls. The advisers were also instructed in how to impart their teaching through songs, role-playing and group discussions.

The first group of advisers had completed training in May 1996 and had already conducted more than six sensitization meetings, each with different population groups from their villages including men, women of childbearing age, schoolchildren, village health committees and women's church or business groups. As a result of the meetings, many women had registered for antenatal care or reported for delivery early in labour, and the number of clients for family planning services had risen. Malawi sought WHO's continued support to sustain and expand those activities.

Professor SOE TUN (Myanmar) expressed high appreciation of WHO's activities in reproductive health; the Director-General was to be congratulated on an excellent report. Reproductive health was being promoted at all stages of the life cycle in Myanmar through initiatives on safe motherhood, family planning, prevention and treatment of complications in abortion, sexually transmitted diseases (STDs) and adolescent health, and through implementation of the regional reproductive health strategy developed for the South-East Asia Region in 1995. Myanmar had transformed its conventional maternal and child health care into comprehensive reproductive health care, including family planning, in line with global changes after the holding of the International Conference on Population and Development in 1994. Though the maternal mortality rate had been reduced, it still remained a problem, and holistic care had to be promoted by integrating safe motherhood, family planning and STD programmes. Birth spacing programmes implemented since 1991 now covered one-third of the country, and would reach half the nation within a year or two. Myanmar would do its best to promote, protect and restore reproductive health by long-term social as well as medical interventions, especially in regard to women, using the "lifespan approach". In those endeavours, it would welcome continued support from WHO.

Ms HAUPTER (International Alliance of Women), speaking at the invitation of the CHAIRMAN, said that women's right to make informed decisions on reproductive health had long been included in the action programme of the Alliance. In the early 1990s, a questionnaire on family health and family planning, answered by 50 of its 70 member organizations, had revealed that though information on infant mortality was readily available, the same did not apply to maternal mortality or pregnancy-related maternal morbidity. Thanks to WHO's Division of Family and Reproductive Health and its collaboration with international and nongovernmental organizations, more data on those problems were becoming available. Clearly, family planning could prevent 25% of maternal mortality and save millions of lives among women and children in developing countries; on the other hand, recent data from WHO and UNICEF indicated that maternal mortality had been grossly underestimated and that reproductive health rights were far from a reality for most girls and women. A number of human rights were directly or indirectly violated or frustrated if family planning was prohibited. They included the right to make reproductive decisions, the right to equality of the sexes, the rights of women to health and to make free and responsible use of their bodies, the right to human dignity, the rights of children and the right to development and to live in a safe environment. Universal availability of family planning was therefore a necessity: enjoyment of the right to reproductive health helped to improve the living conditions of the whole family.

Based on the conviction that men must assume their responsibilities and be made to understand that good quality family planning services were in their best interest, as well as that of women, successful initiatives from local nongovernmental organizations and development agencies in West Africa had been integrated into official health and development structures. The International Alliance endorsed that approach and appealed to
governments and societies to help women to enjoy their reproductive health rights in terms both of childbearing and of avoiding untimely pregnancies. To that end, the relevant instruments approved and ratified by the international community should be translated into reality for women worldwide.

Ms HAUPTER (International Confederation of Midwives), taking the floor again at the invitation of the CHAIRMAN, welcomed the report on WHO's activity in the field of reproductive health. It covered a crucial period of life, the outcome of which could affect the entire lifespan. Equity required that individuals, particularly young people and women of childbearing age, should have access to affordable, high-quality, comprehensive services wherever they lived. An encouraging number of countries were taking steps to make such services available, and were strengthening the capacity of health workers to respond with sensitivity to the needs of the population. Experienced midwives were especially well-placed to make an effective contribution, and recent activities of the Confederation had been targeted to enhance their ability to provide a full range of reproductive health services, with special reference to violence, female genital mutilation, HIV/AIDS, unsafe abortion and the needs of the newborn.

Safe pregnancy and childbirth were central to any effective reproductive health programme. Nonetheless, as the tenth anniversary of the launch of the Safe Motherhood Initiative approached, the signs were that an extra effort was called for to tackle the problem of high maternal and neonatal mortality and morbidity in the many countries where levels of avoidable death and suffering were inadmissible.

The Confederation recognized the efforts which had gone into the programme. Together with other international agencies and many nongovernmental organizations, WHO had considerable experience in strategy development, programme design and implementation for safe motherhood, as well as the competence to assist countries in taking swift and professional action to achieve sustainable results. The Confederation called upon countries which had not yet developed or implemented safe motherhood action plans to consider doing so without delay; although such plans were no substitute for a comprehensive reproductive health programme, they were indispensable in providing a sure point of entry for a fully comprehensive service and would go far in ensuring that pregnancy and childbirth were no longer feared as life-threatening.

Dr TÜRME (Family and Reproductive Health) said that delegates' comments had been carefully noted. Countries in all regions were obviously attempting to implement an integrated, comprehensive reproductive health approach in their national programmes. WHO was endeavouring to facilitate that approach by collecting and disseminating data on reproductive ill-health, supporting national efforts for data generation and interpretation, producing technical guidelines and supporting national research. Establishing a comprehensive reproductive health approach would necessitate a greater effort in setting priorities, achieving cost-effectiveness and making the best use of available resources to respond to people's needs. As many delegations had noted, reproductive health required the kind of multisectoral approach adopted by WHO.

In regard to sexual violence, mentioned by the delegate of China, WHO's reproductive health programme would seek to use its comparative advantage when working with other agencies and to support health care providers in detecting and managing the consequences of violence as they related to sexuality and to reproduction. It would also help to build community support for those subjected to violence. Activities in the Western Pacific Region were detailed in the comprehensive report.

In answer to the delegate of the Netherlands, she said that nutrition had recently been included in the reproductive health programme and a report on those related subjects would be issued in 1998. Regarding research, the largest global programme within the United Nations system was the WHO-administered Special Programme of Research, Development and Research Training in Human Reproduction. For the past 25 years the Special Programme had been granting research training fellowships; 46 had been granted in 1995, 52% of trainees were women, and the total expenditure had amounted to US$ 700,000. The Director of the Programme could be consulted if further information was required.

The delegate of Japan had asked about collaboration with nongovernmental organizations. WHO worked closely with such organizations at international level, as well as with women's groups and professional bodies.

Several delegations had noted the importance of adolescent reproductive health. The adolescent health programme was considered a priority area within reproductive health. It aimed at assisting health systems to respond to adolescent reproductive health needs.
She assured the delegate of the United States of America that standard-setting formed a core part of WHO’s reproductive health programme. Norms and standards were set in all the main areas and served as the basis for the guidelines and the practical tools developed to support country programmes.

With regard to the comments by the delegate of Finland, she said that the programme worked with all WHO divisions and in particular those involved in strengthening health systems, financing, integrated training, curriculum development and health sector reform. As to the ethical aspects of sex selection, the programme would be presenting a proposal for conducting research on the misuses of medical technologies including prenatal sex selection.

The delegates of Algeria, Indonesia, the Islamic Republic of Iran and Pakistan had stressed the importance of community involvement and participation in reproductive health. A major part of the work of the programme in the next biennium would involve the sharing of experiences and the lessons learned in community involvement in order to strengthen that component of programmes at national level. As the delegate of Norway had requested, a progress report on reproductive health would be submitted to the Fifty-first World Health Assembly.

The CHAIRMAN said that in the absence of further comments, he would take it the Committee wished to take note of the contents of section V of the Director-General’s report, concerning reproductive health.

It was so decided.

**Tobacco or health (Resolution WHA43.16)**

Dr ABERKANE (representative of the Executive Board) drew attention to resolution WHA49.17, which urged Member States, organizations of the United Nations system and other international organizations progressively to implement comprehensive tobacco control strategies. The resolution also requested the Director-General to initiate the development of a framework convention which would encourage Member States to adopt tobacco control policies and to deal with the aspects of tobacco control which transcended national boundaries. A background paper entitled “An international strategy for tobacco control” had been issued as a technical document (WHO/PSA/96.6).

Preparations for the international framework convention on tobacco control had begun. The process would involve close consultation with Member States and with experts on public health, international law and convention administration. It was planned to submit the draft convention to the Health Assembly in the year 2000. Extrabudgetary funding would have to be found for the drafting of the convention; contributions already received from some Member States had allowed a start to be made.

World No-Tobacco Day continued to be observed annually in WHO Member States, often serving as a significant occasion for health promotion and education on “tobacco or health” issues. Specific material issued to mark the day included recommended tobacco control strategies based on the theme chosen for a particular year. The theme for 1997 was “United for a tobacco-free world”. Owing to budgetary constraints, advisory material for 1997 was available only in electronic form on the Internet. However, it was to be hoped that comprehensive information would be accessible to all without restriction.

Dr EL-SHAFEI (Egypt) thanked the Director-General for the excellent report on tobacco control at international level. However, as someone who had been affected by tobacco and health problems, she believed that the matter had not been dealt with seriously enough. The use of tobacco was increasing among women, children and adolescents. Some countries encouraged the production and consumption of and trade in tobacco, which remained highly profitable. Health infrastructures were not able to deal effectively with the problem. There was also the harmful influence of television and tobacco advertising. While it was true that airlines increasingly banned in-flight smoking, that did not affect the majority of the world’s population. All countries should be encouraged to introduce legal measures prohibiting the growing of tobacco and providing compensation for the growers. It was to be hoped that WHO would introduce even more efficient programmes and would encourage education programmes in schools and for women.

Ms MILEN (Finland) said that WHO should continue to play a central role in combating the smoking of tobacco. The latest picture of the situation was given in *Tobacco or health: first global status report.* If current
smoking patterns persisted, the annual death toll from the pandemic would rise from the present level of 3 million deaths to 10 million, the burden shifting first to countries with economies in transition and then towards developing countries. After extensive debate the Forty-ninth World Health Assembly had adopted resolution WHA49.17, requesting the Director-General to initiate the development of a framework convention. She commended the progress made in preparing the convention, which should be ready for discussion by the World Health Assembly in the year 2000. Finland had actively supported WHO’s work on “tobacco or health” and would continue to do so.

Dr LARIVIÈRE (Canada) paid tribute to the extremely important work done by WHO, especially in central and eastern Europe, in support of national tobacco control strategies and programmes, and commended its action to implement resolutions WHA43.16 and WHA49.17. Canada was pleased to make voluntary contributions to WHO for that priority work. It was, however, beginning to question the absorptive capacity of the Organization. The human and financial resources WHO allocated to tobacco control remained sadly insufficient, considering that tobacco was about to cause the worst pandemic in human history and that there was so much that could be done to prevent that.

Nevertheless, he welcomed the steps taken to develop an international framework convention for tobacco control and looked forward to the WHO meeting of national experts, who would begin drafting the convention, in Halifax, Nova Scotia, in June.

Dr HEMATRAM YADAV (Malaysia), after thanking the Director-General for his report, described some of the progress made in his country in combating the use of tobacco. In accordance with resolution WHA43.16, which urged all Member States to implement comprehensive multisectoral tobacco control strategies, Malaysia had enacted the Control of Tobacco Products Regulations 1993, which prohibited smoking in hospitals, clinics, lifts, public transport, cinemas and air-conditioned restaurants. The Regulations had come into effect on 1 May 1997 and had been extended to include shopping complexes, schools, institutions of learning, public service counters, banks, sports complexes, transport terminals, public halls, airports and government offices. It also prohibited young persons under the age of 18 from smoking, chewing tobacco or being in possession of cigarettes or tobacco products. In addition, the whole country would continue to be covered by health promotion action, including a mass media campaign and special programmes to help people stop smoking.

Dr SZATMÁRI (Hungary) gave full support to WHO’s activities to assist national and international tobacco control programmes. WHO assistance had been valuable in preparing Hungary’s effective, although not aggressive programmes. One measure was an act to protect non-smokers that would be discussed in the Hungarian Parliament in the weeks to come. However, such efforts were being endangered by tobacco multinationals. Legal measures must therefore be taken at the national and international levels to curb the advertising of tobacco. Smoking was an addiction and smokers required appropriate help; giving such help was one of the responsibilities of those who participated in tobacco control programmes.

Mr LIU Xinming (China) expressed appreciation of the efforts of WHO over the past two years to control tobacco use and welcomed the progress made. The framework convention for tobacco control would encourage Member States to adopt appropriate programmes and measures to control tobacco and help solve the problems of international tobacco control.

Many industrialized countries still exported large quantities of tobacco products to developing countries, thereby causing difficulties and imbalances in tobacco control. All governments should pay more attention to that problem and make joint efforts to control tobacco and the hazards of tobacco consumption. Unfortunately, his country was a major tobacco consumer, with sales increasing over recent years. His Government attached great importance to the problem; regulations had been issued prohibiting smoking in public transport and waiting areas and had come into effect on 1 May 1997.

In conclusion, he reminded the Committee that the Tenth World Conference on Tobacco or Health was due to be held in Beijing in August 1997 and was receiving very positive support from his Government. He looked forward to further strengthening of cooperation with WHO and the promotion of tobacco control in his country through a variety of measures.
Mr CHAUHAN (India) said that tobacco consumption was the largest public health problem that was completely preventable and avoidable. Of the estimated 3 million tobacco-related deaths throughout the world every year, approximately 0.8 million occurred in India.

The Indian Ministry of Health considered it necessary to develop a more comprehensive anti-tobacco programme. That effort included The Cigarettes (Regulation of Production, Supply and Distribution) Act, 1975, which required a statutory warning to be printed on all packets of cigarettes offered for sale. The Parliamentary Committee on Subordinate Legislation had also examined a draft bill and recommended a number of measures, including a ban on advertising and the prohibition of smoking in public places. An Expert Committee on Tobacco Economics, which included representatives of the tobacco industry, had been set up in 1996 and had undertaken a study of revenue, foreign exchange earnings, employment and consumer expenditure, as compared with expensive tertiary-level health care facilities for the treatment of tobacco-related diseases, losses due to fire hazards, ecological damage due to deforestation and the disposal of tobacco-related waste. At a more local level, a bill had been adopted in 1996 prohibiting smoking in places of public work, in public-service vehicles, and by persons under the age of 18 in the National Capital Territory. Moreover, the Government of India had directed all ministries and departments to prohibit tobacco consumption in public places.

Dr MONISSOV (Russian Federation) said that the consumption of tobacco had increased considerably in his country, causing an increase in mortality from tobacco-related causes. A preliminary legal measure to prevent the use of tobacco had been adopted, involving the use of the mass information media. He expressed great appreciation for the substantial assistance provided to his country by WHO. Nevertheless, a comprehensive tobacco-control policy was needed. For that reason his country had agreed to host a large-scale tobacco-control conference in Moscow in May 1997. His Government was doing everything possible to ensure that the work of the conference was fruitful.

Mrs HERZOG (Israel) regretted that so many years of effort by WHO, Member States and others had produced such meagre results and that so many people still used tobacco. New approaches were needed. She suggested that WHO should stage a mock trial, in which the judges would be emeritus members of supreme courts from all over the world and the accused would be the industry and trade that made and promoted the sale of a product they knew 40% of users would die from. The next Health Assembly would provide an appropriate opportunity for staging that trial, which would attract media attention and create an atmosphere that would facilitate the implementation of the international framework convention for tobacco control.

Dr ÇAKMAK (Turkey) said that a new law approved in November 1996 by the Turkish Parliament to strengthen the national tobacco-control programme afforded greater protection from involuntary exposure to environmental tobacco smoke, prohibited smoking in all health, educational and sporting institutions, and strictly limited it in other public places. From November 1997, it would be forbidden for tobacco companies to advertise and promote their products. Regular television and radio programmes to increase public information on the hazards of smoking were compulsory features of the work of the mass media.

The plan of action for the “Tobacco or health” programme, which consisted mainly of strategies covering legislative measures and promotion, public information and advocacy, should be expanded to target the smoking population in a broader manner, which should include the organization of group sessions to help people stop smoking and overcome the physical problems of addiction. In other words, treatment and rehabilitation services for tobacco-dependent persons should be available on demand. The provision of such services was limited in his country, and WHO’s assistance possibly through the dissemination of experiences and guiding principles, was needed.

Dr MESBAH (Algeria) said that, despite the many health problems and current difficulties which countries faced, the fight against tobacco remained extremely important. In Algeria one in two men smoked, as did 10% of women, and children began smoking as early as the age of 10. Tobacco-control efforts had not yet been formalized in the shape of a multisectoral or transnational programme, but were essentially based on the information-related activities advocated in the Director-General’s report. Such information and education activities were extremely common in schools and in public spheres in general, where a very important role was played by the media.
Professor WHITWORTH (Australia) said that the proposed framework convention should serve to encourage Member States to implement existing Health Assembly resolutions. Australia was currently considering contributing to the preparation of the convention in response to WHO's request for assistance, and similar support from other Member States would be welcome. The convention, combined with concerted action against the tobacco industry, should lead to victories of the kind recently seen in the United States of America. Australia was also interested in exploring options for developing the framework convention. The Director-General's report suggested consultation to that end between Member States and experts on public health, international law and convention administration; her country was well placed to participate in such work, given its experience in restricting tobacco advertising, particularly in sport. However, funding questions in connection with the formulation of the framework convention needed to be clarified.

She also expressed support for WHO's work in its "Tobacco or health" programme. It was important that the work should continue, and Australia would continue to provide extrabudgetary contributions as well as conducting other specific activities under the Programme on Substance Abuse.

Dr PARK (Republic of Korea) said that in his country, 6 out of every 10 males over the age of 15 smoked, as did 5 of every 100 women. In order to reduce the heavy burden of smoking-related disease, his Government had adopted a tough national "tobacco or health" policy since 1995. It was now forbidden to sell tobacco products to anyone under the age of 20. Regulations on the public advertising of tobacco products had been strengthened. Further, smoking was prohibited in all public places, apart from restricted smoking areas. A national health promotion fund, estimated at about US$ 15 million per year and financed by donations from tobacco companies and health insurance societies, had been set up; the money would be invested in health promotion activities such as the "tobacco or health" initiative. From July 1997 it would be forbidden to install tobacco-vending machines.

The Director-General's report was most welcome, but it was regrettable that some activities had not been fully implemented owing to financial restrictions. He would request the Director-General to seek further extrabudgetary resources and to allocate a larger regular budget to "tobacco or health" initiatives. The preparation of the international framework convention for tobacco control should also be accelerated. The Republic of Korea was ready to cooperate with WHO and other Member States in that area.

Dr OMORI (Japan) welcomed the progress made on the international framework convention for tobacco control and requested the Director-General to initiate close consultation with Member States and experts at the earliest possible opportunity within the limited resources available. WHO should concentrate on prevention of the initiation of smoking among young people. To that end, it should support the promotion of health warning labels on cigarette packets and vending machines, as well as the promotion of education activities conducted by peer educators.

Dr BOXER (United States of America) said that the campaign to prevent or reduce smoking, particularly among children and young people, had never been more urgently needed, in view of the increase in the overall prevalence of tobacco use. A major United States tobacco manufacturer had recently admitted that nicotine was addictive, that smoking caused lung cancer and that advertising was targeted at children and young people. If a child or adolescent could be deterred from smoking, there was a greater chance that he or she would never smoke as an adult. That was one of the major objectives of the United States. Within the past two weeks, a United States federal judge had upheld the authority of the Food and Drug Administration to regulate nicotine as a drug and a medical device. It was the intention of the United States to do everything possible to protect the health of children and young people. Other countries represented at the Health Assembly should endeavour to do the same. The matter was so important, indeed, that the President of the United States himself had been actively involved in advocating the protection of children in relation to tobacco use. At the same time, all governments and the United Nations must set an example by protecting non-smokers from the smoke of those who did use tobacco. The time had come to enforce bans on smoking in all United Nations and specialized agency buildings and in government offices. Since an example had been set in the United States at national level, many States, cities and towns had followed suit with their own smoking bans in public buildings and spaces.
Dr FARSHAD (Islamic Republic of Iran) said that three national committees of governmental and nongovernmental organizations had been established in his country to conduct programmes for the control of smoking and tobacco. Domestic airlines now offered smoke-free services and further activity had led an increasing number of intercity bus companies to do the same. The Government was working towards the implementation of regulations to ensure smoke-free environments in public places. He expressed full support for the practice of observing a World No-Tobacco Day and suggested that the theme of a smoke-free society should be chosen for one of the World Health Days before the year 2000.

Mrs AL-RIFAI (United Arab Emirates) said that the introduction of anti-tobacco and anti-smoking programmes was extremely important. The United Arab Emirates was very much interested in implementing appropriate legislation based on coordination with all national economic and social sectors. Coordination activities were also conducted with other countries and the Gulf Cooperation Council. A number of resolutions on reducing tar levels and tobacco consumption had been tabled. Steps had been taken to limit smoking in all public places and ministries. Given the interest expressed, WHO’s support for national programmes to combat smoking was greatly appreciated and further collaboration was eagerly awaited. Efforts must be focused on the groups that appeared to be smoking more, namely young people and adolescents; special programmes for them would be desirable.

Dr WAHEED (Maldives) said he strongly supported WHO’s work on tobacco control. It was becoming increasingly evident that tobacco was the most important reversible cause of ill-health. In his country legislative, regulatory and advocacy measures had been taken, including a ban on advertising tobacco products and on smoking in all public buildings. With government encouragement, some of the island communities had declared their islands tobacco-free. However, those efforts would be in vain if tobacco companies were allowed to dump their products on Third World markets, and he called on Member States to take counter-measures.

Professor SHAFI QURAISHY (Pakistan) said that his country’s new Government had, with effect from February 1997, banned smoking in public offices, on domestic flights and in airport lounges, on public transport, in railway compartments, waiting-rooms and restaurants, in government hospitals, and in government educational institutions. While statutory warnings on packets and advertisements had long been in force, there were now regular spots on the radio and television each day cautioning against the dangers of tobacco and smoking. Measures were being prepared to apply those rules to the chewing of tobacco, a common habit in Pakistan. He called on tobacco-growing countries to seek ways of gradually stopping its cultivation.

Professor NURUL ANWAR (Bangladesh) expressed his support for WHO’s tobacco control activities. In keeping with resolution WHA43.16, a ban had been imposed in his country on the advertising of tobacco and promotion of smoking in government mass media. Smoking was also prohibited in certain public places such as hospitals, government offices and public transport. Anti-smoking campaigns were being conducted by the Government, nongovernmental organizations and social organizations at all levels. A crop diversification programme had reduced the cultivation of tobacco in many areas where it had traditionally been the main cash crop. Intensive information, education and communication work was being carried out with the collaboration of the health, education and social welfare sectors to encourage smokers to give up the habit. He looked forward to continued support and technical cooperation from WHO in the anti-tobacco programme.

Dr SANI (Nigeria) commended the Director-General on WHO’s tobacco control activities. In line with WHO resolutions, smoking had been banned in all public places in Nigeria for a number of years, advertising was restricted, and ways of limiting the cultivation and importation of tobacco were under consideration. He joined previous speakers in calling on WHO to initiate, at the international level, further efforts to limit smoking, and expressed his full support for the action called for in resolution WHA49.17.

Dr MTSHALI (South Africa) strongly endorsed WHO’s leadership role on various international initiatives to control tobacco use and supported the proposed framework convention. However, she was concerned to find smoking permitted in some areas of WHO buildings and, like the delegate of the United States of America, urged WHO to set an example by banning smoking in all parts of its buildings, at headquarters and in the regions.
Dr MOREAU (France) commended the Director-General’s report. A large number of measures, some of them regulatory, had been taken in his country to combat the scourge of tobacco. As a mark of its resolve, France would support WHO’s activities in tobacco control.

Dr KIYONGA (Uganda) was in favour of measures to reduce loss of life through smoking, but stressed that their success would depend on collaboration with other multilateral agencies. Endorsing the views of the delegate of Nigeria, he observed that, since tobacco production contributed significantly in some economies to government revenues and the incomes of poor communities, alternative sources of income would have to be found if production was to be reduced effectively. In view of the power of some multinational companies involved in tobacco production, it was not sufficient to place restrictions on smokers or reduce the exposure of non-smokers; far-reaching measures were needed that would eventually lead to the complete cessation of tobacco production.

Dr ZEINE (Mauritania) commended WHO’s “tobacco or health” activities. Smoking in the Third World, particularly among women and young people, was still increasing. Tobacco control programmes, including those of WHO, had not succeeded in changing attitudes. Nor had the media borne their share of responsibility. The developing countries in particular were exerting every effort to control smoking, but the constraints were many. He therefore called upon WHO to redouble its efforts.

Professor SISSOURAS (Greece) commended the progress made in implementing resolutions WHA43.16 and WHA49.17. In his country, a series of intensive measures to combat smoking had been put in place over the past 25 years within the framework of many international programmes. Young people in particular had been targeted, and he had been greatly encouraged by the success of the health-promoting schools project carried out with collaboration from WHO, the European Commission and the Council of Europe. WHO’s programme should focus on health promotion policies. They had proved very effective in tobacco control, particularly in conjunction with other programmes dealing, for example, with cancer or cardiovascular diseases. Account should be taken of the cultural and economic implications, which differed from one country to another. New information technologies might also be used. Furthermore, it was important to consider how best to capitalize on the acceptance by the tobacco industries that smoking was harmful, as reported by the delegate of the United States of America. Lastly, the importance of international collaboration should be stressed still further. Many international organizations had embarked on important tobacco control programmes, and they should be taken into account.

Dr BERLIN (European Commission) said the European Community had already taken a number of legislative measures, covering its 15 Member States, on warning labelling, limitation of tar and nicotine contents in cigarettes, advertising on television, and recommendations on smoking in public places. Further legislation to restrict advertising at Community level was under discussion. The European Commission also placed emphasis on prevention and education aspects through its cancer and health promotion programmes. The health-promoting schools project mentioned by the delegate of Greece was an example of close and productive multilateral cooperation. The Commission also supported scientific research towards improving the efficacy of prevention measures. On the basis of its competence and activities, not only in health, but in agricultural and industrial policies and trade, it was willing to cooperate with WHO on the preparation of a draft convention. The Commission also maintained close contact with the United Nations Focal Point on Tobacco.

Mr PETTERSSON (Sweden) announced that the Swedish Parliament had recently decided that the sale of tobacco to people under 18 was to be restricted. He endorsed the comments of previous speakers in support of WHO’s tobacco control activities but believed that more energetic preventive measures were required. Special attention must be paid to the increase in smoking among young women, the harmful effects of which were easy to predict. His delegation was prepared to share its experience in that respect.

Mr URANGA (United Nations Focal Point on Tobacco or Health) responding to the concern expressed by several delegations about the lack of success in reducing global tobacco use, explained that since the focal point had been established, it had maintained contact with all governmental levels concerned and with intergovernmental organizations inside and outside the United Nations system. He was pessimistic about global
trends in tobacco control, although substantial progress had been made in some places, like the United States of America, where tobacco companies were struggling to defend their interest against a groundswell of public unrest.

The issue transcended health problems. Substitutes had to be found for the tobacco crop, because in many developing countries in Latin America and Africa tobacco-growing was on the increase, although it was decreasing or being contained in the developed countries. WHO forecasts indicated that the developing world would suffer more from tobacco-related problems in the future. Multisectoral action by all United Nations agencies was needed to combat the scourge, but unfortunately the modesty of the resources of WHO, FAO, UNESCO and UNICEF, and of the intergovernmental organizations outside the United Nations system which were also striving to contain tobacco use, hampered their activities on that score. He would be collaborating closely with WHO in the development of an international convention on tobacco control but recognized that negotiations would be difficult. Multisectoral cooperation on tobacco control was being dealt with by the United Nations Economic and Social Council, to which he would be presenting the Secretary-General’s report in June 1997.

Dr ABDUL WAHAB (Bahrain) said that the member countries of the Gulf Cooperation Council were implementing WHO’s principles and objectives in respect of tobacco control and prevention, and had set up a ministerial body to examine that question. Despite the enormous efforts made, smoking continued to increase among young women and adolescents, probably because advertisements in the media often showed popular personalities holding a cigarette. The educational system had a responsibility to warn of the dangers of tobacco and should include the subject in its curricula. Cancer prevention institutions should likewise be involved. Delegates themselves should find out how to stop the habit and offer young people more appealing ways to spend their leisure time.

Dr NAPALKO V (Assistant Director-General) emphasized the educational aspects of WHO activities. The campaign against tobacco would never succeed unless most people in the Member States came to regard smoking as indecent, uncivilized behaviour.

Dr COLLISHAW (Tobacco or health) said that WHO was gratified to note how many nations were taking positive steps to curb the spread of tobacco and were giving technical and financial support to the “Tobacco or health” programme. That support was vital if all countries were to be helped to implement comprehensive tobacco control measures. All the suggestions for boosting the effectiveness of WHO activities would be taken into consideration.

The delegations of South Africa and of the United States of America had raised the question of continued smoking in United Nations workplaces. Smoking had been prohibited at WHO since 1988, and in 1993 resolution WHA46.8 had called for a ban in all United Nations buildings. There had been renewed collaboration with the Secretary-General’s Office and he hoped that more progress would be made on the issue in the future. Nevertheless, each agency was an independent entity and could be influenced only by moral persuasion and argument.

Turkey was to be congratulated on the headway it had made. In response to a request for assistance, a mission was being planned for the autumn of 1997 to strengthen tobacco control and to help with the implementation of legislative measures in that country.

The CHAIRMAN took it that the Committee wished to note the report of the Director-General on “tobacco or health” in section VI of document A50/6.

It was so decided.

Prevention of violence (Resolution WHA49.25; Documents A50/6 and A50/INF.DOC./4) (continued from the sixth meeting)

Dr THYLEFORS (Secretary) recalled that at the sixth meeting the delegate of Israel had proposed amendments to the draft resolution contained in document A50/6. A revised text incorporating those
amendments had been circulated. The amended draft resolution was sponsored by the delegates of Algeria, Cameroon, Canada, Chile, Egypt, Finland, Swaziland, Sweden, Turkey and the United States of America.

The draft resolution, as amended, was approved.¹

**Quality of biological products moving in international commerce** (Resolution EB99.R22) (continued from the seventh meeting)

Dr THYLEFORS (Secretary) announced that, following informal discussions, it had been proposed that the words “competent national” in paragraph 1(2) of the draft resolution recommended in resolution EB99.R22 should be replaced by “recognized competent”.

The draft resolution recommended in resolution EB99.R22, as amended, was approved.²

**World Tuberculosis Day** (Resolutions WHA46.36 and EB99.R27)

Professor ABERKANE (representative of the Executive Board) recalled that in 1982 the International Union against Tuberculosis and Lung Disease had proposed the designation of 24 March as World Tuberculosis Day to commemorate Dr Robert Koch’s announcement one hundred years earlier of his discovery of the tuberculosis bacillus, thereby giving hope of eliminating a disease with an enormous death toll in Europe and the Americas. Although the means for controlling tuberculosis were available, it remained a scourge in many parts of the world. World Tuberculosis Day offered an opportunity for raising global awareness of the disease and encouraging the involvement of new participants in the fight against it. However, little had been done to highlight the event until 1996, when WHO had joined in activities together with governments, nongovernmental organizations and the mass media in 50 countries. Over a thousand groups were involved in 1997. The draft resolution recommended by the Executive Board in resolution EB99.R27 requested the Director-General to coordinate its annual observance.

Dr HENDERSON (Assistant Director-General) pointed out that WHO had participated in the highly successful World Tuberculosis Day 1996 without the specific endorsement of the Health Assembly. The draft resolution before the Committee would provide such endorsement for future days.

Dr KONG Lingzhi (China) fully supported the draft resolution, since World Tuberculosis Day could be instrumental in enhancing knowledge, eliciting government interest, and mobilizing resources for treatment and prevention, in particular to strengthen surveillance and promote implementation of the “directly observed treatment, short course” (DOTS) strategy.

Dr MWANZIA (Kenya), Dr GAYLE (United States of America), Mr PARK (Republic of Korea), Dr MAPETLA (Lesotho), Dr SHONGWE (Swaziland), Professor PICO (Argentina), Dr GBARY AKPA (Côte d’Ivoire), and Dr KALITE (Central African Republic) all voiced support for the resolution recommended in resolution EB99.R27, some calling attention to the prevalence or resurgence of tuberculosis in their respective countries.

Dr INFANTADO (Philippines), supporting the draft resolution, said that World Tuberculosis Day would boost the National Tuberculosis Day held in her country on 15 August each year.

Dr MESBAH (Algeria) said that World Tuberculosis Day 1997 had given his country the opportunity to relaunch and assess its own antituberculosis programme.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.19.
² Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.20.
Mr DENHAM (Ireland) said that the fight against tuberculosis should be carried on throughout the year, as well as on designated days. It was important that such days be community-based and not imposed from outside. Had any analysis or evaluation been done in order to ascertain whether continuing with World Tuberculosis Day would be beneficial in relation to the cost?

Dr BROOKMAN-AMISSAH (Ghana), while endorsing the draft resolution, agreed with Ireland that tuberculosis must remain on the agenda throughout the year. WHO was increasingly designating special days, without sometimes considering the burden imposed on countries. It would be helpful to coordinate such events.

Dr MONISSOV (Russian Federation) endorsed the recommended resolution. World Tuberculosis Day 1996 had raised public awareness in his country and stimulated his Government to draw up a national programme for tuberculosis control.

Mr CHAUHAN (India) said that on 24 March 1997, World Tuberculosis Day, India had launched a massive five-year project with assistance from the World Bank, since tuberculosis was the leading cause of death in his country. India fully supported the draft resolution before the Committee.

Professor SHAFI QURAISHY (Pakistan) endorsed the draft resolution. Pakistan was attempting to analyse whether the celebration of such days actually helped in the control of the disease, which was a massive killer in the country.

Dr MOREAU (France), while supporting the draft resolution, said that the number of such days was increasing and it would perhaps be advisable to keep an eye on the situation.

Dr OTTO (Palau) supported the draft resolution. However, mindful of the burden of organizing all the designated public health days in the year, Palau had taken a local decision to set aside one week every quarter in order to commemorate all the health days occurring in that quarter. Palau would participate in World Tuberculosis Day on that basis.

Professor D’ALMEIDA-MASSOUGBODJI (Benin), endorsing the draft resolution, observed that World Tuberculosis Day 1997 had been marked in her country by the allocation of funds to improve the food of hospital patients on that day. There had been a resurgence of tuberculosis in Benin, linked to HIV/AIDS. Countries should redouble their efforts to ensure better epidemiological surveillance.

Dr HENDERSON (Assistant Director-General) assured the Committee that every day was tuberculosis day at WHO, as it no doubt was in their countries. World Tuberculosis Day had been celebrated since 1982; however, WHO had given its full support as a coordinating health agency only since 1996. That was the reason why the Committee was being asked formally to approve the resolution. WHO indeed had concerns about the evaluation of such days and their proliferation, both in the health sphere and in the United Nations in general. An appropriate balance was being sought.

The draft resolution was approved.1

(For continuation, see summary record of the ninth meeting, section 4.)

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1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA50.21.
2. **FIRST REPORT OF COMMITTEE A** (Document A50/36)

Dr ZOBRISt (Switzerland), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

The meeting rose at 13:00.

¹ See page 237.
1. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1998-1999: Item 17 of the Agenda (continued from the sixth meeting, section 1)

FINANCIAL REVIEW: Item 17.2 of the Agenda (Resolution EB99.R2; Documents PB/98-99 and A50/4)

Financing of the WHO worldwide management information system through the use of casual income (Resolution EB99.R2)

Mr AITKEN (Assistant Director-General) drew attention to the draft resolution recommended by the Executive Board in resolution EB99.R2, which concerned the use of about US$ 6.1 million of casual income available at the end of 1996 to help finance the new worldwide management information system, in addition to funding from the regular budget and other sources. Development of the system, which would integrate all the processes of the Organization into a single effective management information system, was already well under way. The system was regarded by senior managers as an essential requirement for WHO in the next century.

The draft resolution recommended in resolution EB99.R2 was approved.¹

Proposed appropriation resolution for the financial period 1998-1999

The CHAIRMAN directed the Committee’s attention to the following draft resolution:

The Fiftieth World Health Assembly

RESOLVES to appropriate for the financial period 1998-1999 an amount of US$ 926 118 000 as follows:

A. Appropriation section Purpose of appropriation Amount US$
1. Governing bodies 19 414 300
2. Health policy and management 257 151 500
3. Health services development 170 806 700
4. Promotion and protection of health 134 177 700
5. Integrated control of disease 135 657 800
6. Administrative services 128 910 000

Effective working budget 846 118 000
7. Transfer to Tax Equalization Fund 80 000 000

Total 926 118 000

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.24.
B. Amounts not exceeding the appropriations voted under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 1998 - 31 December 1999 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 1998-1999 to sections 1 to 6.

C. Notwithstanding the provisions of Financial Regulation 4.5, the Director-General is authorized to make transfers between those appropriation sections that constitute the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made, this percentage being established in respect of section 2 exclusive of the provision made for the Director-General’s and Regional Directors’ Development Programme (US$ 7 592 000). The Director-General is also authorized to apply amounts not exceeding the provision for the Director-General’s and Regional Directors’ Development Programme to those sections of the effective working budget under which the programme expenditure will be incurred. All such transfers shall be reported in the financial report for the financial period 1998-1999. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.5.

D. The appropriations voted under paragraph A shall be financed by assessments on Members after deduction of the following:

\[
\begin{array}{l}
\text{(i) reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of . . .} & 2\,900\,000 \\
\text{(ii) casual income (other than interest earned)} & 2\,622\,980 \\
& 5\,522\,980
\end{array}
\]

thus resulting in assessments on Members of US$ 920 595 020. In establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by (a) the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their WHO emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization and (b) the amount of interest earned and available for appropriation (US$ 9 994 020) credited to them in accordance with the incentive scheme adopted by the Health Assembly in resolution WHA41.12.

E. The maximum net level of the exchange rate facility provided for under Article 4.6 of the Financial Regulations is established at US$ 31 000 000 for the biennium 1998-1999.

Three amendments to that draft resolution had been proposed by the delegations of Argentina, Australia, Belgium, Canada, Germany, Netherlands, New Zealand, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland. First, in subparagraph A, the amount in US dollars shown for the effective working budget, “846 118 000”, should be replaced by “842 654 000” with consequent subsidiary adjustments to the other figures. Secondly, a new paragraph should be added, reading:

REQUESTS the Director-General, in finalizing the adjustments, to reduce the effective working budget to US$ 842 654 000, to confine these adjustments to non-operational (i.e. administrative and related) activities at the global, regional and country levels. Operational activities should continue to receive the same level of resources as specified in the Director-General’s proposal.

Thirdly, a further new paragraph should be added, reading:

DECIDES further that the net amount of casual income for 1997 remaining after meeting the provisions of the incentive scheme and exchange rate facility be returned to Member States to apply to their assessments in 1999.
Mr AITKEN (Assistant Director-General), illustrating his comments with overhead projections, said that the appropriation of US$ 846 118 000 for the 1998-1999 biennium proposed in the draft resolution represented an increase of 0.4% compared with the previous biennium. It had been WHO’s practice to make certain deductions from the appropriations to assist Member States with their contributions, as provided for in the Financial Regulations. In the current year, the deductions totalled US$ 15 517 000, equivalent to 6.7% more than the casual income and other resources available at the end of the 1996-1997 biennium, and comprised: casual income returned to Member States in proportion to their contributions; casual income returned to Member States in accordance with the financial incentives scheme; and UNDP support cost payments. The proposed final total of contributions by Member States was therefore US$ 830 601 000 and represented, at approximately US$ 2.5 million, a 0.3% average increase in contributions. The actual percentage increase for individual Member States would vary according to their payment record, and the exact figures would not be known until the final calculations had been made.

The proposed appropriation was based on delivery of the same programme level as in 1996-1997 and allowed for marginal cost increases of 0.4%, which arose from the combination of two factors. The first was worldwide inflation, totalling 4% on average. Although the actual figure was very much higher, the Director-General had decided, after extensive discussion, that the Organization must absorb some costs. That factor was, however, offset by favourable exchange rate movements against the currencies in which the Organization operated and in favour of the US dollar, leading to a reduction of 3.6%. The net impact was the 0.4% increase.

The proposed amendments effectively called for the US$ 3.4 million, or 0.4%, increase to be absorbed, and for WHO to present the same expenditure figures as for the 1996-1997 biennium. In that case, the Organization would have to cope with those potential cost increases through a variety of measures and reductions.

The DIRECTOR-GENERAL said that the proposed appropriation resolution for 1998-1999 had found wide support among Member States. The changing health of countries and their peoples required a strong and effective WHO, which he was confident the programme he had proposed and the ongoing reforms, particularly in the fields of budget and personnel, would provide. Nevertheless, he recognized that for some other Member States, including those which had proposed the amendments, there was a wider policy imperative for the United Nations system as a whole not to increase the level of budgets. He also realized that WHO’s largest contributor hoped to achieve a still lower budget and had worked hard in the preceding days to try to obtain a consensus. The difference of less than 0.5% between his proposal and the figure suggested in the amendment should not cause a division. He had hoped that the idea of using the available casual income at the end of the current year to reduce contributions for 1999, as proposed in one of the amendments, would alone be sufficient to permit consensus. It would reduce the overall level of contributions, on current exchange rate estimates, by about a further 2.5%, putting them below the contributions for the current biennium. Furthermore, he confirmed that, in the following year, he would present his proposal in the light of the implications for WHO of any new scale of assessments adopted in 1997 by the United Nations General Assembly for the United Nations itself.

Noting that the current programme budget was the fifth - and last - to be presented by him, he expressed the hope that it would be adopted by consensus, as had each of the previous ones despite a great deal of debate and initial differences of view. If all delegations could rally to a consensus around the proposal set forth in the draft resolution with the proposed amendments, the best interests of the Organization, including its unity and solidarity, would perhaps have been served.

Ms GERSO (United States of America) said that she could support the proposed amendments which would maintain the budget level of the current biennium. She was pleased that the Director-General was now in agreement with an appropriation level of US$ 842 million. If the amendments, just endorsed by the Director-General, were accepted, the United States would not call for a vote in Committee A. However, its position was closely tied to the outcome of discussions in Committee B on the scale of assessments. If the United States’ objectives were met in Committee B, it would not call for a vote on the appropriation resolution in plenary session. If they were not met, the United States would call for a vote in plenary session and would vote against the proposal.

The United States delegation had explained at the outset of the debate in the first meeting of Committee A that the budget level for the 1998-1999 biennium should be at least 5% below that of the current biennium, i.e., approximately US$ 800 million. There were a number of ways that a lower budget could be achieved...
without damaging the core programmes of the Organization. The cost increase of 4% allowed for in the Director-General’s original text could be absorbed with little difficulty. Moreover, the substantial exchange rate gains provided an outstanding opportunity for WHO to develop a reasonable budget without affecting any high-priority programme.

A prudent, fiscally responsible budget proposal could have gained acceptance by consensus. In all the discussions, the United States delegation had underscored its commitment to the essential consensus process. It had been flexible in the discussions and had said it was prepared to join in the consensus on the budget at a level of US$ 842 million - a budget without a cut - if a resolution could be adopted that reflected the need to revise the WHO scale of assessments in line with any decision taken in the United Nations General Assembly later in the year and the need to apply those revised scales for the next biennium at WHO.

WHO’s financial difficulties were amply detailed in the documents before the meeting. At the end of 1996, 63 countries had not paid any assessments for a full year, and more than 40 had not paid anything for two years or more. Internal borrowing, which had reached an unprecedented level in 1996, continued. The United States delegation had expressed concern about the problem two years previously when the Health Assembly had adopted the 1996-1997 programme budget, and she regretted that that concern had proved to be well founded. She believed that the decline in government contributions to the extrabudgetary or voluntary programmes stemmed in part from the need to pay higher assessments.

There was no indication that the public sector budgets of Member States would have more resources in the coming biennium. Virtually all Member States of WHO were having difficulty in paying assessments at past levels. The public sector resources that provided the bulk of United Nations system funds, including those of WHO, were declining, and that trend could be tackled only by the adoption of realistic budget levels across the United Nations system.

Some international agencies were working hard to formulate significantly lower budget levels while raising, or at least maintaining, programme delivery. The International Labour Organization’s proposed budget was 3.75% below the current budget level. It was her belief that still further reductions were possible there, but a very constructive start had been made. The Secretary-General of the United Nations had announced cuts of US$ 120 million from the current level. The World Bank was undertaking a major reorganization aimed at saving money. She urged WHO to be among those responding to an extremely uncertain resource picture by recommending a budget level that could reasonably be expected to be fully funded by the contributions of Member States. It was essential that only realistic budget levels should be supported, and not those with little prospect of being funded.

The United States recognized that shortfalls in its payments had contributed significantly to the current cash-flow problem. The objective of her Government was to pay its assessment in full and on time, as many speakers at the current Health Assembly had urged, and to eliminate the outstanding arrears. However, with the budget level proposed, she doubted whether that would be possible in the absence of a commitment to change the scale of assessments beginning in 1998.

A United States vote against the appropriation proposal, forced by failure to resolve the scale of assessments issue, would signal not only additional United States arrears in the future but also the country’s possible inability to repay the arrears currently outstanding. The situation was not a comfortable one either for WHO or for the United States delegation. Other Member States might ask why the United States was taking such a difficult position. The answer was, it had no choice.

The past decade had witnessed a crisis of political confidence in many public sector institutions, including the United Nations and its affiliated agencies. Legislators in all countries, who must account to the public for the tax funds they spent, were demanding that publicly funded institutions should reduce costs and curb spending. For WHO to meet the challenges ahead, it was imperative that it should focus on priority programme areas and allocate increasingly limited resources wisely. WHO must be cost-effective. One opportunity had been missed in 1995 when the current programme budget had been adopted. Failure to take the opportunity offered by the 1998-1999 programme budget would result in WHO’s facing a deepening financial crisis, just as the Organization was moving to new leadership.

A vote against the appropriation resolution by the United States delegation would be a signal to WHO, its Member States and the new leadership in the coming year. The United States was not abandoning WHO or the United Nations system, but the sooner budgets that could be fully supported by the payments of all Member States were in place, and the sooner realistic scales of assessment were established, the sooner WHO’s real challenge, to improve the world’s health in the twenty-first century, could be tackled.
Mr KOEZUKA (Japan) said that he was ready to join in the consensus and support the proposed appropriation resolution, as amended. Those proposals served the best interests of the WHO community as a whole, a view which he believed to be widely shared by his fellow delegates. However, he warned that Japan could not agree to the introduction of retroactive elements into the 1998 scale of assessments, a matter to be discussed in Committee B under agenda item 24.2, since it would be difficult to accommodate such adjustments in national budgets. Payment of arrears was an obligation on all Member States; in the current circumstances, many countries were facing similar budgetary difficulties at home.

Dr KALUMBA (Zambia) sought clarification on the various positions taken in the debate, and on the implications of the proposed amendments.

Mr AITKEN (Assistant Director-General) said that it was his understanding that a consensus appeared to be emerging within Committee A in favour of the draft resolution as amended. However, two speakers had linked the matter to the outcome of the forthcoming debate in Committee B on the scale of assessments under agenda item 24.2, and a result unsatisfactory to the United States of America might impel it to vote against the appropriation resolution in plenary session.

If the proposed amendment regarding casual income was accepted, casual income would be returned to Member States in accordance with the Financial Regulations, the only difference from previous practice being that some additional payments could be made specifically in the second year of the biennium.

Dr KALUMBA (Zambia) asked whether in that case the Committee would be unable to approve the draft resolution until a decision had been reached in Committee B on the scale of assessments.

Mr AITKEN (Assistant Director-General) replied that it was possible for a position to be taken in Committee A and then reversed in plenary session, if delegations so wished.

Dr KALUMBA (Zambia), feeling that the differences expressed appeared to relate to the domestic difficulties of two delegations, rather than to any unwillingness to join in the consensus, suggested that a decision should be deferred to allow for informal consultations between Japan and the United States of America.

Mr BOYER (United States of America) said that no delegation had expressed opposition to the draft resolution, as amended, and he saw no reason to delay approval on account of the debate on the scale of assessments or differences of opinion between delegations on that score.

Mr KOEZUKA (Japan) fully endorsed that view.

Dr ROMUALDEZ (Philippines) voiced concern that the decision not to provide for cost increases in appropriations during the financial period 1998-1999 could lead to further reductions in health development activities at a crucial period for the health sector. Economic and financial considerations were threatening to overshadow the human value of health. In answer to contentions that the proposed amendment would have only an insignificant impact on important health activities, he argued that further cuts would mainly affect smaller, poorer countries, who could least afford it. Subject to that reservation and with the hope that steps could be taken during the implementation of the budget to alleviate the plight of smaller countries, he supported the draft resolution as amended.

Mr JUDIN (Russian Federation), referring to remarks made on the scale of assessments, pointed out that the Committee A agenda item under consideration covered programme and budget matters only. The scale of assessments would be considered by Committee B under agenda item 24.2, at which time his delegation would offer its comments.

Mr MOEINI (Islamic Republic of Iran) supported the draft resolution as amended, on the assumption that its approval would not prevent discussion taking place or a decision being reached in Committee B on the scale of assessments and use of casual income.
Dr MOREL (Brazil) said that, to offset falling levels of public sector financing, a new 0.2% tax had been levied on all financial transactions in Brazil and the additional US$ 600 million generated per month allocated solely to the Ministry of Health. He would therefore have supported the original draft resolution but, in deference to the Director-General’s request for consensus, accepted the proposal as amended. He was not, however, in favour of retroactive application of a revised scale of assessments, since a change in contribution levels during a biennium ran contrary to national policy.

The draft resolution, as amended, was approved.¹

Reallocation to priority health programmes of amounts resulting from measures to increase efficiency

Professor WHITWORTH (Australia) drew attention to a draft resolution proposed by the delegations of Andorra, Argentina, Australia, Austria, Belgium, Brazil, Cambodia, Canada, Cook Islands, Denmark, Fiji, Finland, France, Gambia, Germany, Ireland, Japan, Lesotho, Mexico, Namibia, Netherlands, New Zealand, Niue, Palau, Papua New Guinea, Republic of Korea, Samoa, Solomon Islands, South Africa, Sweden, Switzerland, Tonga, Turkey, Tuvalu, United Kingdom of Great Britain and Northern Ireland, Vanuatu, Zambia and Zimbabwe, which read as follows:

The Fiftieth World Health Assembly,
Recalling resolution EB99.R13 on programme budgeting and priority-setting;
Recognizing the need to ensure that a maximum amount of funds is allocated to specified priority health activities, as recommended by the Executive Board at its ninety-eighth session,

REQUESTS the Director-General:
(1) to develop and present to the 101st session of the Executive Board an efficiency plan for the Organization, based on a review of the six appropriation sections, which specifies administrative savings and more effective means of programme delivery;
(2) to specify clearly, in the development of the efficiency plan, steps to achieve an efficiency savings target of 3% from the administrative costs and overheads in the six appropriation sections over the 1998-1999 biennium and to reallocate these amounts to activities of priority health programmes;
(3) to report in detail to the 101st session of the Executive Board on progress made in the implementation of resolution EB99.R13.

Particular attention should be paid to achieving savings in appropriation sections 1 and 6. She urged all Member States to sponsor and/or support the draft resolution.

The draft resolution was approved.²

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.25.
² Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.26.
2.3 National health policies and programmes development and management (continued from the second meeting, page 25)

The CHAIRMAN drew attention to a draft resolution on strengthening health systems in developing countries, proposed by the delegation of Colombia on behalf of the Non-aligned Movement and reading as follows:

The Fiftieth World Health Assembly,
Mindful of the principles of, and obvious need for, technical cooperation among developing countries (TCDC) and of the interest shown by the Health Assembly by virtue of its resolutions WHA31.41, WHA31.51, WHA32.27, WHA35.24, WHA36.34, WHA37.15, WHA37.16, WHA38.23, WHA39.23, WHA40.17 and WHA40.30, in strengthening this type of cooperation with a view to improving the health situation in the developing countries;
Reaffirming resolutions WHA42.37, WHA43.9, and WHA46.17 with regard to the importance of technical cooperation among developing countries as a fundamental element of health development;
Recognizing the equality of all people and the need to promote sustained economic and social development as a means of eradicating poverty and reducing the increasing numbers of marginalized people;
Underlining the purposes and principles of the United Nations, as set out in the United Nations Charter, including the sovereign equality of States, and the purposes of developing friendly relations among nations based on respect for the principle of equal rights and self-determination of people;
Expressing particular concern for the health of people living under exceptional conditions, especially during natural disasters or armed conflict and under foreign occupation;
Noting with satisfaction the decisions taken by the non-aligned and other developing countries concerning the adoption of principles related to health development of their people and particularly those related to health sector reform as is currently under way in many countries;
Welcoming in this regard the recommendations made at the Technical Consultation Meeting on Health Sector Reform, held in Cartagena, Colombia on 19-21 February 1997;
Proclaiming that health sector reforms should facilitate the provision of health care to meet human needs, and that these must be governed by respect for human dignity, equity, solidarity and ethics;
Recognizing that health sector reforms, while intended to rectify failures of the health system, can be adversely affected by forces and constraints outside the purview of the health sector, such as high indebtedness, fiscal stringencies, structural adjustments and undue restrictions;
Recognizing the importance of TCDC as an effective vehicle for health development and realizing that cooperation among the non-aligned and other developing countries is not an option, but an imperative, and that only the nurturing of a spirit of collective self-reliance and adoption of joint strategies will allow effective implementation of people-centred socioeconomic development,

1. WELCOMES the continuing political commitment of the non-aligned and other developing countries to facilitating the enjoyment of good health by all their people without hindrance, and to providing access to proper health care for all;
2. REMINDS Member States that everyone has the right to the enjoyment of the highest attainable standard of social well-being and physical and mental health;
3. CALLS UPON Member States:
   (1) to promote the improvement of the health conditions of their people by strengthening the health sector within the context of comprehensive and sustained economic and social development;
   (2) to identify appropriate policies and programmes for the promotion of health for all in accordance with the specific needs of each country;
(3) to strengthen the advocacy and negotiating capabilities of the health sector in order to ensure greater resources for health development;
(4) to strengthen the leadership role of ministries of health in reducing inequity, performing regulatory functions, monitoring health financing mechanisms, reallocating financial and human resources and coordinating internal and external cooperation for health in order to prevent fragmentation and dysfunction of health programmes;
(5) to foster the reorientation of human resources in the light of the needs of each health care system;
(6) to support activities oriented towards harmonizing the multiple actors - public and private - to make them consistent with national health policies;
(7) to accord the highest priority to health development;
(8) to foster the identification of critical factors impeding health development and the systematization, documentation and dissemination of experiences with health sector reforms within an international network of cooperation;
(9) promote and support TCDC actions, activities and programmes for reforms in the health sector among Member countries and their institutions;

4. CALLS UPON the developed countries:
(1) to facilitate the transfer of materials, equipment, technology and resources to developing countries for health development programmes that correspond to the priority needs of those countries, and further to support the application of the principles of TCDC;
(2) to provide WHO with the necessary financial resources to implement agreed priority programmes which support effectively the efforts of developing countries in accelerating the attainment of health for all through primary health care;

5. REQUESTS the international and multilateral institutions and agencies:
(1) to provide, within their mandate, greater support and resources to facilitate health sector reforms in developing countries that is designed to achieve equity in access to health care for their populations;
(2) to identify obstacles to health for all and to support and uphold the self-reliance of these countries in charting their own path to health and human development;
(3) to implement the relevant conclusions of the summits and conferences of organizations of the United Nations system that address health problems and make recommendations in this field;

6. REQUESTS the Director-General:
(1) to provide full support to all countries, especially the non-aligned and other developing countries, to pursue their own health sector reform efforts, and to improve the quality of health for all their people, with the firm understanding that such efforts should respond to the specific needs of each country, and to seek extrabudgetary resources in addition to the regular budget resources already assigned for such efforts;
(2) to provide an analytical capability to distil the different experiences of health sector reform based on firm evidence;
(3) to promote and support countries, especially in the context of TCDC, in the area of health sector reform by establishing a network of relevant institutions to identify critical factors impeding health development and the systematization, documentation, and dissemination of health sector reform approaches and to enable countries to exchange experiences on a continuing basis;
(4) to ensure that activities supporting health sector reform are closely linked to those aimed at renewing the health-for-all strategy;
(5) to promote measures for joint action, in agreement with the United Nations and other relevant international agencies, in order to accelerate health development in the developing, and especially the least developed countries;
(6) to report on the progress achieved to the Fifty-first World Health Assembly.
The draft resolution was approved.¹

2. PREPARATION OF THE TENTH GENERAL PROGRAMME OF WORK: Item 18 of the Agenda (Resolution EB99.R15; Document A50/5) (continued from the sixth meeting, section 2)

The CHAIRMAN recalled that, during its discussion of item 18 at the sixth meeting, the Committee had considered the draft resolution recommended by the Executive Board in resolution EB99.R15. The delegate of the Netherlands had proposed that paragraph 2(3) be amended by inserting the word “quality” after “accessibility”, and a drafting group had been convened to consider further amendments in the light of the discussion. The drafting group, comprising the delegations of Australia, Finland, Sweden, United Kingdom of Great Britain and Northern Ireland, and United States of America, had proposed that paragraphs 1 and 3 should be amended to read:

1. PROPOSES that the renewed health-for-all strategy, taking into account regional differences and respecting cultural values should:
   (1) inspire and guide health programme priorities nationally, regionally and globally;
   (2) become [a] [the] guiding framework for the translation of WHO's constitutional mandate into the development of the Tenth General Programme of Work, strategic budgeting and evaluation;
   ...

3. REQUESTS the Director-General:
   (1) to use the renewed health-for-all strategy to enhance WHO's leadership in global health matters;
   (2) to continue the preparation of the Tenth General Programme of Work, which should clearly and concisely set out strategic priorities and targets for WHO and should be subject to periodic evaluation. The Tenth General Programme of Work should be derived from and be closely linked to the new policy for health for all for the twenty-first century;
   (3) to link the preparation of subsequent general programmes of work to the evaluation of the health-for-all policy, taking account of social, economic and health developments;
   (4) to ensure that priorities and targets of the Tenth and subsequent General Programmes of Work are reflected in development, implementation, monitoring and evaluation of programme budgets;
   (5) to optimize the management and use of WHO's human resources to enhance efficiency.

Dr THYLEFORS (Secretary) announced that in addition to the delegations mentioned by the Chairman, those of Austria, France, Netherlands, South Africa, Swaziland and Switzerland also wished to sponsor the draft resolution, as amended. He explained that the wording proposed for paragraph 1(2) provided two options: “a guiding framework” or “the guiding framework”. The Secretariat had suggested a third option: “the main guiding framework”.

Mr DENHAM (Ireland) said that his delegation had informed the Secretariat previously that it also wished to sponsor the draft resolution as amended. He explained that the wording proposed for paragraph 1(2), he rejected the use of the indefinite article and opposed the insertion of “main”, since both would undermine the status of the renewed health-for-all strategy, once adopted, as the key guideline to be followed when preparing the Tenth General Programme of Work, strategic budgeting and evaluation in accordance with WHO’s constitutional mandate. He was not aware of the existence of any other guidelines.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) and Ms FILIPSSON (Sweden) shared the reservations of the Irish delegation but, in the interest of achieving consensus, supported the Secretariat’s suggestion.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.27.
Dr KALUMBA (Zambia), pointing out that work on the renewed health-for-all strategy was still going on, proposed the wording “the interim guiding framework”.

Professor WHITWORTH (Australia) conceded that Zambia had made a valid point, but said that she could accept the Secretariat’s suggestion.

Dr THYLEFORS (Secretary) apologized for having omitted Ireland as a sponsor and added Denmark to the list. Given the number of different proposals for paragraph 1(2), he suggested that the delegates concerned might meet informally and report back to the Committee.

It was so agreed.

Dr MOORE (United States of America) noted that the drafting group had intended that the Tenth General Programme of Work should be relatively short and that its implementation should begin before the year 2002, as near as possible in time with the implementation of the renewed health-for-all strategy, once that had been adopted.

Dr THYLEFORS (Secretary), reporting on the informal consultations regarding the proposed amendments to paragraph 1, said that two changes were suggested. First, the words “when adopted” should be inserted after “health-for-all strategy”. Secondly, the wording of subparagraph 1(2) should begin: “become the principal guiding framework”.

Dr KALUMBA (Zambia) suggested that the words “when adopted” should also be added after “health-for-all strategy” in paragraph 3(1).

Professor ZAHRAN (Egypt) supported the proposed amendments, including that of the delegate of Zambia. His delegation also wished to sponsor the draft resolution.

The draft resolution, as amended, was approved.¹

3. SECOND REPORT OF COMMITTEE A (Document A50/37)

Dr ZOBRIST (Switzerland), Rapporteur, read out the draft second report of Committee A.

The report was adopted.²

4. IMPLEMENTATION OF RESOLUTIONS AND DECISIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda (Documents A50/6 and A50/6 Corr.1) (continued from the eighth meeting)

HIV/AIDS and sexually transmitted diseases (Resolution WHA49.27)

Dr ABERKANE (representative of the Executive Board) reported that the Board had expressed concern about a number of aspects of the policy and the strategic orientations and plan of action of WHO with regard to HIV/AIDS and sexually transmitted diseases outlined in section VIII of the Director-General’s report (documents A50/6 and A50/6 Corr.1). Since HIV/AIDS was a global disease of great concern, WHO should

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.28.
² See page 237.
give it sufficient attention so that the Organization and the health sector in general could continue to play a leading role. The spread of the HIV/AIDS epidemic was alarming, particularly in Africa, where factors such as the global economic recession were resulting in a further deterioration of the situation among people most at a disadvantage. However, budgetary allocations to ministries of health, especially in least developed countries, had decreased and insufficient funds had been raised by the UNAIDS Cosponsors’ Coordinated Appeal for Supplemental Funded Activities. The Board had also stressed the need for strengthening coordination within WHO and between UNAIDS and the sponsoring organizations and expressed concern at the methods of selecting members of the UNAIDS Programme Coordinating Board.

The Board had expressed its satisfaction at WHO’s emphasis on the control of other sexually transmitted diseases, safe blood transfusion, reproductive health, school health, control of substance abuse, tuberculosis control, and strengthening of health systems, fields in which the Organization was well placed to act. It had also commended the progress achieved by UNAIDS, with the participation of WHO.

The recently developed triple therapy for HIV/AIDS had been reported to be remarkably effective, although the very important problem of its cost had not been resolved. WHO was collaborating with UNAIDS to make the treatment more widely available and thus ensure equitable access, especially in developing countries.

Dr STAMPS (Zimbabwe) commented that paragraph 5 of the Director-General’s report should have taken into account hepatitis B, another sexually transmitted disease. The term “cost-effective” was inappropriate in regard to strategies concerned with safety of blood and blood products; in place of the wording in document A50/6 Corr.1 he would have preferred: “WHO will promote strategies that minimize the risks of transmission of infectious agents through blood and blood products by promoting safer blood donation, testing all blood and minimizing unnecessary transfusions”. The word “covering” in relation to programmes on misuse of substances might be misconstrued as “promoting” and he would have preferred the wording: “WHO will encourage programmes to prevent HIV and hepatitis B transmission through the misuse of substances, including injecting drugs, and related sexual transmission of HIV and hepatitis”. Finally, referring to “options for infant feeding” implied a departure from the Code that had been adopted in that regard; furthermore, the words “options for” were tautologous and could have been deleted.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) welcomed the major part played by WHO in UNAIDS, particularly at country level. Significant progress had been made with regard to the treatment of HIV infection and AIDS; however, prevention would remain the keystone until effective treatments and cures were available. He endorsed the remarks of the delegate of Zimbabwe concerning paragraph 5 of the Director-General’s report. Paragraph 14 mentioned activities to mobilize resources by the UNAIDS Cosponsors’ Coordinated Appeal for Supplemental Funded Activities. He asked how many of the 11 programmes mentioned had been funded and in which programme areas they were. Translation of the guidelines for syndromic management of sexually transmitted diseases into a number of languages, mentioned in paragraph 7, had been useful. Were there plans for translations into other languages? The cooperation of the World Bank in providing credit for activities relating to sexually transmitted diseases, HIV/AIDS and tuberculosis was welcome, and he wondered whether that would include credit for the provision of safe blood and blood products. He noted with concern the absence in the report of any mention of HIV transmission rates in people below the age of 25 years, and particularly young women. As 60% of new HIV infections occurred in people between the ages of 15 and 24, a report on action being taken with respect to that age group would be useful. Those suffering from AIDS required care, so he asked what importance was given to nurses within the UNAIDS programme.

Mr TSUDA (Japan) said he firmly believed that WHO should continue to lead in areas of public health relating to HIV/AIDS. It should, however, concentrate its activities in areas such as blood safety, tuberculosis, prevention of HIV infection within programmes on reproductive health, and development of a vaccine against HIV, which did not overlap with those dealt with by UNAIDS and other United Nations bodies. Japan was committed to supporting such WHO programmes, in close collaboration with UNAIDS.

Dr MWANZIA (Kenya) noted that one of the roles of WHO as a cosponsor of UNAIDS was stated in paragraph 4 of the Director-General’s report to be “to integrate HIV/AIDS activities into relevant WHO programmes”. That was important in view of dwindling resources. In Kenya, sexually transmitted diseases and
tuberculosis had been integrated into the theme group on AIDS. A successful meeting held earlier in the year to launch the initiative and to discuss the sharing of resources had been attended by representatives from WHO (from the Global Tuberculosis Programme and the Office for HIV/AIDS and Sexually Transmitted Diseases), UNAIDS, ministries of health and nongovernmental organizations. The remarkable efforts in the area of information, education and communication to prevent the spread of HIV infection had resulted in a stabilizing of the epidemic in areas where it had developed earlier. He hoped that, despite the cost, the new treatment for HIV/AIDS would become more widely available.

Dr KALUMBA (Zambia) recalled that the mandate for UNAIDS had been agreed upon at a meeting in his country; however, there remained some confusion in certain countries concerning the respective roles of UNAIDS, WHO and the other sponsors. The sponsors had not relinquished enough responsibility to allow the UNAIDS programme to become fully operational at country level. A consensus had been reached in Lusaka that the sponsors would contribute part of their budgets to support UNAIDS and that UNAIDS would continue the mobilization begun by the WHO Global Programme on AIDS. There appeared to be growing complacency in the West, due to a perceived reduction in the threat of AIDS, which had resulted in a reduction in allocations to country programmes. If it was not the job of United Nations agencies to raise funds, how were countries to bear the burden of controlling HIV/AIDS when bilateral supporters were imposing stiff conditions in terms of implementation of structural adjustment programmes? UNAIDS must be given the means to build up both its operational and its coordinating capacity at country level. WHO had begun to define its role more clearly, and he hoped that the other sponsors would follow suit. However, he was concerned that WHO was dispensing with the services of people whose experience was crucial to the success of its programme on HIV/AIDS. Complacency in the West put the African continent at risk of extinction. HIV/AIDS was not just Africa’s problem: any communicable disease in one country was a threat to other countries. The political will and the global consensus to fight HIV/AIDS initiated by the WHO Global Programme on AIDS should be maintained.

Dr KCHARABSHEH (Jordan), expressing gratitude for WHO’s role in the field of HIV/AIDS and sexually transmitted diseases, especially following the creation of UNAIDS, said he hoped that a focal point would be established in each country. HIV/AIDS was primarily a health problem and efforts to ensure its prevention had to be intensified in all countries. He requested WHO to provide guidelines on the triple therapy, which was being marketed very broadly in the developing countries by pharmaceutical companies. Couples planning to get married should be informed about and screened for HIV/AIDS; Jordan was already taking action in that regard.

Dr VAN ETEN (Netherlands) commended the report, WHO’s cooperation with the other UNAIDS sponsors, and the Organization’s active participation in the preparation of the UNAIDS Cosponsors’ Coordinated Appeal for Supplemental Funded Activities for the current biennium. It was encouraging that greater attention was being paid to the integration of activities relating to HIV/AIDS and sexually transmitted diseases into the overall framework of WHO, but cooperation at country and regional levels could be improved.

Dr BELMAR (Chile), welcoming the initiatives and work of WHO on HIV/AIDS, said that the multidisciplinary nature of the participatory process described in paragraph 6 of the report required the involvement of all organizations concerned with HIV/AIDS, and not only those from the health sector. There should be a change from a biomedical approach to a social one. The research activities mentioned in paragraph 11 should likewise include interdisciplinary studies incorporating the social sciences in order to better understand the social impact of the problem, and the Organization should have the capacity to disseminate the findings and guidelines produced by those studies in various languages.

Dr ÇAKMAK (Turkey) fully supported WHO’s strategic plan. His Government would be doing its best to implement Turkey’s national plan, which was fully in line with the strategic one, and it would be doing so in cooperation with national, regional and global bodies gathered under the UNAIDS umbrella.

Dr FERDINAND (Barbados) expressed concern about representation on the UNAIDS Programme Coordinating Board: the Caribbean subregion currently held a place on it, and there was a need to continue that representation because of the epidemiological patterns and the uniqueness of the subregion. She remained
anxious about the allocation of funds for the programme, since many country programmes were not gaining access to them as easily as they should, and mechanisms must be put in place to rectify that state of affairs.

Dr FREIJ (Sweden) said that UNAIDS could not be expected to solve the problem of HIV/AIDS without committed action and support by Member States and sponsoring organizations, but most important of all was what the Member States did in their own countries. The United Nations system could only support them in the implementation of their national plans. Global work on HIV/AIDS was now in its second phase: trying to expand into a multisectoral effort and to create the means to sustain it. The crux was how the Health Assembly could help to ensure coherent action and reinforce the high priority that must be accorded to HIV/AIDS. So far 130 theme groups had been established, with WHO chairing the majority of them, but it was discouraging to learn that many were not working as well as they might. The sponsors had not allocated sufficient administrative resources from their regular budgets and were not backing up national plans by joint programming. WHO in its capacity of cosponsor and with its extensive experience of work in the field of HIV/AIDS should do more to improve that situation. The integration of HIV/AIDS components within WHO programmes in areas such as blood safety, tuberculosis control, essential drugs and pharmaceuticals, reproductive health and health systems development were commendable, but more should be done in the areas of patient care and nursing. Other specific WHO-based projects were included in the UNAIDS Cosponsors' Coordinated Appeal for Supplemental Funded Activities. He asked whether appropriate administrative resources had been allocated to support WHO Representatives, whether there were consistent guidelines from headquarters and regional offices to help them in their work, and whether WHO's resources and expertise in the areas of blood safety, sexually transmitted diseases, health promotion in schools, etc. were sufficient to provide a sound basis for further development of HIV/AIDS-related interventions and to justify funding of WHO activities as requested in the UNAIDS Coordinated Appeal. A global response to HIV/AIDS must mean global solidarity between Member States and within the United Nations system. Member States should do whatever they could in their own countries, and the better-off ones should also continue to offer financial support, bilaterally, via UNAIDS, and through the mechanisms proposed in the UNAIDS Coordinated Appeal. Solidarity must also be shown in the ways in which WHO's extremely valuable competence was offered in support of the joint and cosponsored action of UNAIDS.

Dr PARRAS (Spain) commended WHO's contribution to UNAIDS during 1996, especially in diagnosis and treatment of sexually transmitted diseases to reduce the risk of concomitant transmission of HIV, and in blood safety. The participation of WHO Representatives in UNAIDS national theme groups during the past year had also been outstanding. WHO leadership in the majority of those groups was of fundamental importance. While not opposed to WHO broadening its work, he saw a danger in excessive diversification; it was essential to coordinate activities within UNAIDS in order to avoid duplication and inefficient use of resources.

Professor SISSOURAS (Greece), commending the strategic plan, said that thanks to the measures Greece had taken over the past seven or eight years it was currently one of the European countries with the lowest incidence of HIV/AIDS, and that despite being a tourist country whose population almost doubled during the holiday period. He would have liked to see a reference in paragraph 5 or 7 of the report to national policies and campaigns against the epidemic together with evaluation reports from each country, not confined to data on incidence. Countries would benefit from a comparative analysis of policies, which took account of different cultural, behavioural and lifestyle patterns, in designing and implementing an effective battery of preventive measures.

Mr MABOTE (Lesotho), commending the Director-General's report, said that, while it had recently been reported that the new triple therapy was producing very encouraging results, many countries, such as his own, were painfully aware that it was beyond their means and were wondering what to say to their people. How was WHO going to assist such countries so that the new treatment was accessible to those needing it most? He also sought clear guidance from WHO regarding infant feeding; much had been done in countries such as his own to encourage breast-feeding, but there was currently a good deal of confusion as to what advice to give people. Finally, it was important not to lose sight of the need to care for HIV/AIDS victims at all levels and to support those who provided that care.
Dr SAARINEN (Finland), commending WHO for having adjusted to its new situation as one of six cosponsors of UNAIDS, said health care systems development was an extremely well chosen objective. The prevention and control of both HIV/AIDS and other sexually transmitted diseases (STDs) would not be efficient without a functioning primary health care system, nor would there be effective surveillance if health services were disrupted. Prevention of STDs was an essential objective, and the integration of HIV/AIDS and STD prevention and care with reproductive health functions was to be commended. She supported the WHO strategic plan.

Dr MEAD (Australia) said that an integrated and cohesive response on the part of the whole United Nations system was necessary in order to mitigate the effects and limit the spread of HIV/AIDS. She congratulated WHO’s staff on its flexibility and dedication during the transition from the Global Programme on AIDS to UNAIDS, and hoped that efficient coordination between the sponsors of the programme would be sustained at the country level. It was essential to maintain WHO’s technical assistance to national public health authorities, particularly in such crucial areas as blood safety and HIV surveillance, which were fundamental to the system-wide response to the pandemic. Her country had recently launched two initiatives: the third national strategy on HIV/AIDS, which also covered other sexually transmitted diseases and hepatitis; and the first national strategy on the sexual health of indigenous peoples, which emphasized the need for access to primary health care.

Dr MOORE (United States of America) commended WHO on its leadership during the establishment of UNAIDS and its activities relating to HIV and other sexually transmitted diseases. She was encouraged by the priorities set by WHO, including the emphasis on the treatment and control of sexually transmitted diseases and the role played by substance abuse, particularly among injecting drug users. However, it was important not to forget the role of other substances of abuse, including alcohol, which affected people’s judgement and led them to take risks in their sexual behaviour. Another area which deserved attention was that of nosocomial transmission of HIV, particularly in settings where exposure to body fluids and blood was frequent and HIV prevalence was high. She asked the Secretariat to provide more details of the interaction between WHO and UNAIDS, given the risk of duplication of activities between the two.

Ms CALLANGAN (Philippines) said that her Government’s political commitment to the fight against HIV/AIDS was illustrated by the multisectoral Philippines National AIDS Council, which advised the President on prevention and control policies. The year 1997 had been declared National AIDS Awareness Year, and an international conference on HIV/AIDS in the Asia and Pacific region was to be held in October. Philippines health workers were being trained in the syndromic approach to the management of sexually transmitted diseases, and surveillance had been expanded to areas and communities most at risk from HIV/AIDS and other sexually transmitted diseases. Unfortunately, however, data were available only from Government-run facilities, which meant that it was not yet possible to gain a full picture of morbidity and mortality due to HIV/AIDS. Her country was grateful for the support of WHO and the Japanese Government.

The resources available for preventive activities were limited. It was essential to inform, to educate, and to influence attitudes and behaviour not only among people who were sexually active themselves, but also among those who influenced the attitudes of the younger generation. She called upon WHO and UNAIDS to strengthen their collaboration, particularly in the development and implementation of strategies to mitigate the impact of high-risk sexual behaviour and encourage safer sexual behaviour among young people.

Professor AYUB (Pakistan) endorsed the comments of the United Kingdom delegate on prevention of HIV infection. Prevention was an essential part of the fight against HIV/AIDS, involving all sectors including education, the press, the electronic media and religious leaders. Prevention programmes should be based on values which did not permit promiscuous sexual relations or drug use. His country had translated many of the key documents produced by WHO into its local languages.

At the Forty-ninth World Health Assembly, in 1996, his country had expressed concern about the transfer of the AIDS programme from WHO to UNAIDS. He now wished to reiterate that position. WHO should provide leadership in the control of HIV/AIDS and sexually transmitted diseases and should play its due part as a technical agency in programme planning, implementation and coordination. WHO’s leadership role should be restored, and UNAIDS should take on the role of an advisory agency.
Dr DLAMINI (Swaziland) expressed concern about the enormous cost of treating people with HIV/AIDS. People knew that new treatments were available, and their expectations grew constantly higher. What was WHO planning to do to make treatment more accessible in all countries?

Developing countries had been promised more support to strengthen their health care systems and help them to care for the large number of people with AIDS. In her own country, support for home-based care was particularly important, since many people with AIDS were discharged to their homes to be cared for by their families in order to relieve the overburdened health services. Swaziland was working to improve blood safety with the support of nongovernmental organizations, but more WHO support would be welcome. The current emphasis on confidentiality for people with AIDS, while upholding the rights of the patient, might not be in the best interests of relatives or health staff caring for that person. Leaving it to people with AIDS to decide whether or when to reveal their condition also distorted AIDS statistics and might lead to dangerous complacency. More coordination was needed between the many bodies involved in resolving the confidentiality issue. Her final point concerned the plight of children who had lost one or both parents to AIDS. Those children placed an extra burden on already overstretched communities, which did not have the resources and infrastructure needed to care for them. The problems of children infected or affected by HIV/AIDS and breast-feeding by HIV-positive mothers also deserved special attention.

Mr CHAUHAN (India) welcomed the action undertaken by WHO and UNAIDS and expressed appreciation for external support for India’s HIV/AIDS activities. Various agencies had reported that India was about to undergo an HIV/AIDS epidemic, with estimates of the likely number of people affected ranging from 5 to 10 million. The authorities were not complacent; they had already screened three million people, of whom 50 000 had been found to be HIV-positive and 3300 had already developed AIDS.

India had begun its AIDS control policy in 1987, and it had since been strengthened with the assistance of the World Bank. The programme now had the following elements: strengthening the management of AIDS activities at national and state level, surveillance and clinical management, blood safety, control of other sexually transmitted diseases, public awareness, and community support for people with AIDS. Activities were organized in a three-tier system, of which the top tier was a national AIDS committee, chaired by the Minister of Health, which provided the President with policy guidance.

The fight against HIV/AIDS took place on two main fronts: (a) information, education and communication, and (b) blood safety. The Supreme Court of India had recently been asked to consider a public interest case, and had ruled that all blood banks must be licensed and regularly inspected, that no payments should be made to blood donors, and that hospital waste must be properly disposed of. The Government had since modernized some 850 blood banks and 500 sexually transmitted disease clinics, set up 32 sentinel surveillance sites and established blood component separation units.

The meeting rose at 12:30.
1. IMPLEMENTATION OF RESOLUTIONS AND DECISIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda (Documents A50/6 and A50/6 Corr.1) (continued)

HIV/AIDS and sexually transmitted diseases (Resolution WHA49.27) (continued)

Dr MESBAH (Algeria) said that his country's programme against HIV/AIDS and sexually transmitted diseases, which was decentralized, was continuing in accordance with WHO's strategic guidelines, supported by the commitment of the national authorities and the participation of various sectors and associations and the media. The prevalence of such diseases had been shown to be low - a fact that could not be attributed to inadequate screening facilities as those had been strengthened in the past few years, notably by providing all blood transfusion centres with the necessary reagents for the detection of HIV/AIDS and hepatitis B and C, creating a national blood agency, and strengthening the capacity of the Institut Pasteur. It was nevertheless difficult, morally speaking, to accept that the high cost of recently developed therapies rendered them inaccessible to the populations most affected by such diseases. His country therefore supported all recommendations that were intended to promote accessibility.

Dr MOREAU (France) commended the Organization on the transition from the former Global Programme on AIDS to the current integrated structure, and supported WHO's leadership in all sectors affecting health - in particular in the field of transfusion safety. It would be desirable for WHO to make clear recommendations on certain major and complex questions such as breast-feeding and infant nutrition. Equality of access to care for all people affected by HIV/AIDS was also of much importance and should be ensured by a mechanism to be developed by UNAIDS in collaboration with WHO and the other sponsoring organizations.

Dr BIKANDOU (Congo) thanked WHO for its constant efforts to combat the HIV/AIDS pandemic. A Letter of Agreement covering the 1996-1997 biennium, signed by the Government of the Congo and UNAIDS, reflected the political commitment to supporting national AIDS prevention efforts. However, implementation of the 1996-1997 work plan, also approved by those parties, had been held up through delays in UNAIDS funding, which had hampered supervision and surveillance activities. National action has been sustained through training of health personnel, outpatient care for HIV/AIDS-infected persons and public information campaigns. In the face of dwindling resources, it was becoming increasingly important to achieve effective mobilization of funds at all levels and to coordinate action with that of the non-health sectors.

Professor PICO (Argentina) said that HIV/AIDS presented a health and social problem that went far beyond national and regional frontiers and had become a major world challenge; WHO should provide firm leadership. The technical and operational aspects of HIV/AIDS control should be guided and coordinated by WHO globally through the regional committees and national ministries of health. He acknowledged the valuable support provided by all the agencies and organizations involved in HIV/AIDS control, stressing the fundamental role to be played by health organizations. Preventive measures were of particular importance, especially as HIV/AIDS had a strong cultural component, calling for improvement in sexual behaviour and lifestyles. Health education should therefore be strengthened, using the media to carry clear messages, and social participation promoted through links between teachers, students and families. Although most of the population in his country
was now familiar with the problem, only 56% had changed their sexual behaviour. The national anti-HIV/AIDS programme and the national programme for the control of sexually transmitted diseases worked in complementary fashion, to provide training and to ensure the local distribution of drugs and reagents. Blood banks were also strictly controlled, to ensure the quality of the blood used in both public and private health services.

Dr ARGADIREDA (Indonesia) welcomed the progress made throughout the world in controlling HIV/AIDS. Although the number of reported cases in his country had been very low over the past decade, surveillance and control programmes were being sustained. Assistance from WHO and UNAIDS would be welcome in an epidemiological study to be conducted by ASEAN to elucidate the reasons for the substantial differences in the prevalence of HIV/AIDS between its member nations. Commending the efforts made by UNAIDS and WHO to make triple drug therapy available in developing countries at an affordable price, he requested information concerning its annual cost for one AIDS case.

Dr DANKOKO (Senegal) welcomed the report, which reflected WHO's commitment to support national institutions and bodies in combating HIV/AIDS. However, to reflect the concern expressed by Zimbabwe while emphasizing the importance of screening, the sentence in document A50/6 Corr.1 might better have been phrased to read: “WHO will promote cost-effective strategies that prevent transmission through blood and blood products of HIV and other infectious agents by promoting safer blood donation, testing all blood and minimizing unnecessary transfusions”. He also expressed the hope that WHO would assist the competent national institutions in promoting autologous transfusion. Expressing appreciation of WHO's sustained support through UNAIDS, he described his country’s anti-HIV/AIDS programme, in which information and public awareness measures played an important part. Recent symposia on the response of the religious communities to the AIDS problem had done much to improve health education and provide information for the public. The religious communities might also help to mobilize resources and to organize sustained care for HIV/AIDS patients. He stressed the importance of ensuring accessibility of drugs in the developing countries.

Dr SULAIMAN (Oman) commended WHO on its efforts to implement the programme to combat HIV/AIDS and sexually transmitted diseases in the Eastern Mediterranean Region. He endorsed the strategy in paragraph 5 of the report, but agreed with the delegate of Zimbabwe that the reference to cost-effectiveness was out of place. Observing that his region was represented by one country only on the UNAIDS Programme Coordinating Board, he said that wider representation would have a positive effect on the implementation of the programme. While supporting the move to increase public awareness in association with other sectors, he stressed that WHO’s vital role lay in protecting the health of the individual and especially that of adolescents, by such means as ensuring the safety of blood transfusion.

Ms HERZOG (Israel) said that confidentiality, previously mentioned by the delegate of Swaziland, should be distinguished from anonymity and that WHO's position on the matter should be made clear. In her country, there was confidentiality but not anonymity; it was therefore possible to identify HIV-positive persons and to provide treatment, guidance and follow-up. A problem did arise, however, because doctors were not permitted to divulge information about patients to their spouses, and that might represent a threat to public health and to the right of the individual to remain healthy. On the other hand, some considered that HIV/AIDS was a disease that should be approached in the same way as all other communicable diseases. UNAIDS might wish to convene a working group to study that specific, sensitive issue with its concomitant ethical aspects, and make recommendations to the next World Health Assembly.

Dr KALITE (Central African Republic) said that HIV/AIDS and sexually transmitted diseases constituted a major public health problem in many countries, with far-reaching economic, health and sociocultural consequences. He thanked WHO and UNAIDS for giving sustained support to the national programme for their control in his country, where emphasis was laid on a community approach to the problem, and sought the support of WHO in treating infected individuals, in providing safe blood transfusion and in preventing HIV/AIDS infection within the health care structures.
Dr KILIMA (United Republic of Tanzania), while welcoming the report and the increased coordination with WHO in his country, expressed concern over the statement in paragraph 2 that there were hopeful signs that the HIV/AIDS epidemic had stabilized in certain countries and that effective therapies had been produced. That might be true in some places, but it did not diminish the need to strengthen surveillance systems. Furthermore, effective therapies did not exist for the developing countries: they were the result of intensive research for which the poorer countries were often used. He therefore appealed for subsidies to enable the poorer countries too to benefit from the results. HIV/AIDS still called for a preventive approach in most countries, with intersectoral coordination to intensify action.

Mr ROBERFROID (United Nations Children’s Fund) said that UNICEF, as a cosponsor of UNAIDS, commended the report. Despite initial difficulties in harmonizing policies and procedures, UNAIDS was becoming a model of coordination within the United Nations system. UNICEF therefore pledged its support to the continuation of the programme, especially regarding education and social mobilization. Concerning the important problem of HIV transmission and breast-feeding, UNICEF continued to advocate national solutions that would best serve the needs of women and children, notably alternative options to breast-feeding in situations where they might increase a child’s chance of survival. He quoted from the UNAIDS 1996 interim statement on HIV and infant feeding, emphasizing the rights of women and children, the importance of preventing infection and the need for full information regarding all feeding options, and indicating that when children born to HIV-positive women could be assured of having uninterrupted access to nutritionally adequate breast-milk substitutes, they were at less risk of illness and death if they were not breast-fed. UNICEF was engaged with WHO and UNAIDS in the development of guidelines for policy-makers, health workers and those responsible for counselling mothers. In accordance with Article 24 of the Convention on the Rights of the Child, which established every child’s right to the highest attainable standard of health, UNICEF continued to advocate the protection, promotion and support of breast-feeding for the majority of infants. In the case of HIV infection of the mother, the use of alternatives must be weighed in order to determine what feeding choice would best serve the infant’s health. Regarding the mother’s right to keep information about her own HIV status confidential, UNICEF strongly held to the view that women should be empowered to make fully-informed decisions about infant feeding and be supported in carrying them out. The suggestive but partial evidence at present available did not provide sufficient grounds for recommending a limit to the duration of breast-feeding by HIV-positive women. UNICEF fully concurred as to the need for appropriate operational research in that area, including low-cost means of ensuring access to safe alternatives and minimizing the risks. Wherever alternative feeds were recommended, immediate improvement of water, sanitation, health care and child care conditions might be an essential concomitant. He stressed that any organization which provided an infant with a breast-milk substitute for home use had a responsibility to ensure that the supply was continued so long as the infant needed it - a principle laid down in the International Code of Marketing of Breast-Milk Substitutes. As anxiety regarding transmission of HIV through breast milk might lead to excess child deaths through diminution of breast-feeding, public communication should be careful to create a climate of reason rather than panic. The enormous health benefits that had accrued over the past decade of breast-feeding promotion should not be jeopardized by any reduction of support for women who breast-fed. It was important to analyse all the complications of alternative feeding, including supplies, delivery and cost, before coming to a carefully-balanced conclusion.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, expressed appreciation to WHO for its commitment to HIV/AIDS care and prevention and for The world health report 1997, which clearly identified HIV/AIDS as a major cause of suffering and death in the world, about 90% of its prevalence being in developing countries. Despite promising results, HIV/AIDS presented a major challenge in the 1990s. The International Council of Nurses (ICN) appreciated the response of WHO and UNAIDS to the AIDS pandemic. Participating in that concerted response, millions of nurses and other health care workers were in the forefront of AIDS prevention, counselling and care. Working in homes, communities, workplaces, prisons and health facilities, they came face to face with the painful realities of AIDS care. ICN worked hand in hand with its member associations in more than 112 countries and with WHO and UNAIDS and others to foster an environment that supported the social and ethical responsibility of providing care to all people, including those living with HIV/AIDS, in order to ease the burden of pain and suffering and create a more human environment. It was important that nurses should be involved at the policy-making level and at the level of implementation and delivery of good quality care. ICN therefore felt concern about the post of
Miss BRAUEN (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that the Confederation had adopted a policy statement on the subject of HIV/AIDS in May 1993 and had worked since then to ensure not only that midwives promoted practices which limited the spread of HIV infection, but that infected women had access to non-discriminatory midwifery care in pregnancy, childbirth and the puerperium. Recent research showed that midwives were a high-risk group for HIV infection, yet they were often unable to apply even basic precautions for lack of essential equipment and supplies. Before education or preventive measures could be effective, countries and their populations had to acknowledge the existence of the problem. Many health care workers possessed the knowledge necessary to implement preventive measures, though resources for so doing were slender and to change traditional attitudes within any culture required sensitivity if such measures were to be accepted by communities. Multidisciplinary, multisectoral approaches were therefore essential to the dissemination of appropriate messages. In addition, with regard to breast-feeding, the Confederation was anxious that, as the results of research on the risks of vertical transmission of HIV infection became more widely known, advice on infant feeding should change, although many women’s choice was limited by economic or other constraints.

For many reasons, including those she had outlined, the Confederation welcomed the Director-General’s report and urged all countries to collaborate in the global effort to tackle the problem in all its dimensions, to cooperate in research, and to facilitate the task of health care workers responsible for supporting the community in preventive and care measures.

Professor ABERKANE (representative of the Executive Board) said that the Board had been much concerned with the prevention of HIV/AIDS and with the gloomy prospects in the African Region. It considered that the question of access to recent therapy should be included in the wider problem of access to other sophisticated, long-term and very expensive care which it was extremely difficult to provide for in the health budgets of poor or developing countries, and had discussed that question in the framework of the ethical considerations and questions of equity examined by the Organization.

Dr VARET (Assistant Director-General) said that the statements of delegates had shown the resolve of countries to combat HIV/AIDS and bring the epidemic under control by unified action. It was a matter of grave concern that 22.6 million people were now affected and that the numbers had doubled between 1990 and 1996. Some success had been achieved in prevention but it was limited to a few developed countries that had begun to take action a decade previously.

Referring to the transition of activities from the Global Programme on AIDS (GPA) to UNAIDS and to the bonds between that new programme and WHO, she said the UNAIDS philosophy was quite different from that of GPA and was designed to incorporate lasting intersectoral AIDS control programmes into national structures. That entailed making the most of the particular skills and capabilities of each of the sponsoring organizations. During the transitional period, considerable efforts were being made by WHO. Working groups were set up involving partners at all levels in, for example, drafting the strategic plan in which representatives of countries, of regional offices, of headquarters programmes and of UNAIDS participated, or setting up epidemiological monitoring. There were eight working groups, of which two were of particular interest, their work having been mentioned frequently by delegations: one was concerned with the prevention and control of sexually transmitted diseases and HIV/AIDS, and the other with the strengthening of health systems and of primary health care in particular. The transitional period was also characterized by budgetary difficulties; WHO had had to mobilize resources at a time of financial constraints. The WHO funds allocated to AIDS control amounted to some US$ 14 million, partly from the regular budget, partly from extrabudgetary resources, and partly from UNAIDS. Three-quarters of that amount had been allotted to country activities. All the contributions from other WHO programmes - in the order of US$ 5.5 million - had to be added to that sum.
More details should be available in 1998, when an analytical accounting system would be operating. Obviously, those resources were not sufficient to implement the strategic plan for the period 1997-2001, on which a third annual meeting of country representatives would take place.

In reply to a question about support for WHO Representatives, she said that information and training sessions were held for them and a survey had been conducted to identify the problems arising during the difficult transition period at the country level. In answer to comments by the Netherlands and the United Kingdom, she said that the response to the UNAIDS Cosponsors' Coordinated Appeal for Supplemental Funded Activities, which had probably been prepared too hastily, had been disappointing for 1996-1997. An attempt was being made to launch a second coordinated appeal earlier in the year and it was hoped that results would be better. Five programmes - on the control of sexually transmitted diseases, substance abuse, mental health and health education, strengthening of health systems, and reproductive health - had benefited from the first appeal. A number of tools developed at WHO headquarters had been updated and used by UNAIDS. The guide to prevention, for example, already existed in three languages and would soon be available in three more; the syndromic approach to the management of sexually transmitted diseases mentioned by the Philippines was, of course, also supported. Furthermore, in collaboration with the regional offices, technical teams had been trained to set up control programmes for sexually transmitted diseases in the African and South-East Asia Regions. A continuing priority for WHO was to assist in strengthening case-finding and notification systems in countries, in collaboration with UNAIDS, as well as to estimate incidence and prevalence rates on the basis of special surveys and sentinel systems. Sound epidemiological information was essential for assessing trends and evaluating the results of action taken. Diagnosis and the provision of medical and psychosocial support - including treatment for patients with sexually transmitted diseases, AIDS and tuberculosis within existing health systems - were essential, and interregional workshops had been held for the purpose by the Regional Office for Africa. A collaborating centre had been established in Bangkok for training and research on psychosocial and clinical treatment of patients. The experience gained there could be transferred to countries wishing to benefit from it. In other countries, a holistic care approach had been implemented.

A further priority was safe transfusion practice. Donors were still relied on and cheaper, reliable techniques for blood-safety testing were required that would also show up diseases such as hepatitis B and C. Once again, the resources available were inadequate and assistance in that field and for training laboratory technicians would be appreciated. Strengthening of health systems was also of paramount importance; needs were being identified and coordination with other associated programmes and units envisaged to enable appropriate action to be taken. Endeavours were also being made to prevent accidental infection of health staff and to examine possible prophylactic measures for them.

Women were increasingly becoming infected with HIV, and young women who had contracted the infection were a further priority group for treatment. Attempts were being made to step up health personnel training to provide a specific approach to women's problems, both for syndromic diagnosis of sexually transmitted diseases and for standards of care for infected pregnant women.

In regard to the new triple therapy mentioned by several delegates, an informal consultation had been held several days previously in liaison with UNAIDS, but it was too early to take a formal position since long-term clinical testing of triple therapy had not yet been done. In addition to its great cost, the treatment schedule was very rigorous and therefore difficult to maintain, but care must be taken not to interrupt it so that resistance did not develop. Furthermore, disagreeable side-effects were frequent. Therefore, commitment to long-term fundamental prevention programmes and research on vaccines should continue. By the autumn it would be possible to publish guidelines on the triple therapy on the basis of data collected at the informal consultation and from other activities. The therapy would be applied progressively in accordance with the actual situation in each country; it would often rely on strengthening of health care systems.

On the question of confidentiality, WHO considered the right to privacy to be a fundamental human right and, as such, essential for prevention and for effective treatment. Avoidance of stigmatization and exclusion was of primary importance and it was clear that treatment could be followed only where the infected persons enjoyed psychological and social support. Confidentiality, however, did not mean secrecy. It was well known that information campaigns on AIDS led to acceptance and the avoidance of exclusion and were therefore essential to success in changing behaviour. Prevention efforts must continue, involving the allocation of adequate resources and mobilization of the partners involved, especially within communities, and not just through the mass media, since it was only through community support that behaviour would be changed and treatment taken full advantage of once it was available.
Dr TÜRMEN (Family and Reproductive Health) said that WHO had long emphasized the vital importance of protecting, promoting and supporting breast-feeding for the survival and health of infants throughout the world. The growing HIV/AIDS pandemic and the evidence that HIV could be transmitted through breast-feeding, however, had led WHO to review its policies on breast-feeding periodically. Various studies indicated that between one-quarter and one-third of infants born to HIV-infected women became infected with the virus themselves. An interim policy statement issued in September 1996, and subsequently developed as a joint statement with UNICEF and UNAIDS in April 1997, set out the considerations on the matter for countries developing policies and for health care workers advising individual women about infant feeding. The statement highlighted three main policy elements: the principle of informed choice for the mother; the high priority to be placed upon preventing HIV infection in women; and the need to promote infant-feeding practices that were likely to be most beneficial to the health of the mother and the infant.

The problem was complex, affording no simple or easy solutions. Although decisions about infant feeding would vary depending on the individual circumstances of the woman and her family, it was important at the global and national levels to continue to support breast-feeding. It was essential to safeguard the gains that had been made in protecting, promoting and supporting breast-feeding, thereby ensuring the survival of millions of infants. At the same time, the fact that HIV could be transmitted through breast-feeding could not be ignored. In conditions where safe and uninterrupted access to nutritionally adequate alternatives to breast-feeding were available, women who were known to be HIV-infected should be advised to consider the alternative methods. The principle of informed choice should be strengthened by improving access to optional counselling and testing and by providing women with support in putting into practice their decisions about infant feeding.

In conclusion, she emphasized the need for continued strict adherence to the International Code of Marketing of Breast-milk Substitutes. WHO was working with UNAIDS to develop more detailed practical guidelines for health care workers advising women about infant feeding.

Dr PIOT (Executive Director, UNAIDS) described the work accomplished and problems encountered by UNAIDS since early 1996. The four roles of UNAIDS consisted of: coordination within the United Nations system; the collection, dissemination and publicizing of best practices; the provision and facilitation of technical support; and advocacy. Although UNAIDS was not a fund, it did provide financial support to countries, mainly in the form of seed money for catalytic and innovative activities. It was also one of its functions to assist in building fund-raising capacity. In 1996 and 1997, it had committed over US$ 12 million for AIDS-related activities in low and middle income countries, 40% of which were in sub-Saharan Africa. Of the countries concerned, some 90% had already received funding, while signed letters of agreement were awaited from the others.

Over the past 16 months, since the foundation of UNAIDS in January 1996, real progress had been made towards a cosponsored programme at both country and global levels. In several countries joint and complementary advocacy, programming and resource mobilization activities were being undertaken by United Nations theme group members, often with the support of the UNAIDS Secretariat. At a more global level, interagency working groups had developed harmonized activities by sponsors and the Secretariat in areas such as HIV prevention in schools, “gender”, epidemiological surveillance and communications. Moreover, an interagency policy statement would soon be forthcoming on voluntary testing. He stressed the so-called “mainstreaming” effort made by WHO and the collaboration between UNAIDS and specific WHO programmes. Collaboration with WHO’s regional offices had also been strengthened significantly and was the key to UNAIDS work at the country level. The funding provided to WHO by UNAIDS over the course of the biennium amounted to some US$ 5 million, which was mainly allocated for activities and staff in regional offices.

Another achievement by UNAIDS had been the broadening of partnerships at the country, regional and global levels. In that context, collaboration with the private sector had been developed, particularly through the Global Business Council on HIV/AIDS. An agreement had been concluded with Rotary International concentrating on the promotion of HIV prevention among young people. Collaboration with ASEAN included the carrying out of a study and the development of a common intercountry approach. Finally, UNAIDS placed emphasis on the involvement of religious communities and was supporting several such initiatives.

With a view to providing effective assistance to countries to help them plan their response to the epidemic, UNAIDS had developed tools for national strategic planning. They were designed to evoke a broad multisectoral response, which experience in several countries had shown to be a powerful force for combating the disease.
On the question of access to care, drugs and prevention, UNAIDS had negotiated a public sector price for the female condom in order to make it much more accessible in low and middle income countries. It was also concentrating on developing a strategy to improve access to the appropriate therapeutic drugs and hoped that a special initiative would soon be announced in that regard. However, he counselled realism as to what could be achieved in practice in those areas.

In reply to other comments, he noted that UNAIDS had established a nursing post with a global mandate in Pretoria and that not all global activities were based in Geneva. World AIDS Day and the World AIDS Campaign shortly to be launched gave specific importance to young people and children, who were vulnerable to AIDS and many of whom were infected.

Not everything had worked out as had been hoped and there remained numerous challenges. For example, the picture was very mixed so far as resource mobilization at the country level was concerned. There was a lack of domestic and international support for the national response in many countries. A survey of eight African countries had shown that between 1992 and 1996 funding for AIDS-related activities had risen in seven of them, but had fallen by 60% in the eighth. An extensive survey of the question was being carried out and assistance to governments in the field of resource mobilization was one of the major tasks of the United Nations theme groups and the UNAIDS Secretariat. At a time when prevention needs were rising, it was important to combat any complacency induced by the development of more effective drugs and not to become trapped in what he described as a triangle of inaction. The three points of the triangle were: the continuing denial of the epidemic; a new complacency as more effective treatment was developed; and ignorance of the firm evidence that HIV prevention was effective and that the necessary knowledge, tools and strategies were available and were cost-effective.

Another challenge arose out of the cosponsored structure of UNAIDS. Much time had been spent setting up administrative arrangements, e.g. for the management of joint funds, but progress had been hampered by the bureaucracy involved.

In sum, although the first year of activities had been very difficult and UNAIDS had certainly not accomplished everything it had set out to do, considerable progress had been made. Moreover, the United Nations system was well placed to help countries address the formidable challenges that remained, both in terms of the national response to the epidemic and in terms of making UNAIDS a positive example of the reform that was required in order to strengthen the response to the epidemic at the level of the United Nations system. UNAIDS and its sponsors would continue to seek greater support for countries so that they could expand the national response to the epidemic. Its activities would concentrate on combating complacency through advocacy, strengthening capacity, providing technical assistance, assisting resource mobilization and developing new partnerships.

Dr THYLEFORS (Secretary), responding to a request for clarification from Dr STAMPS (Zimbabwe), said that it was not usual for a report by the Director-General to the Health Assembly to be amended by the Health Assembly. However, the comments made by delegates on the subjects covered by such reports were carefully noted by the Secretariat and appeared in the record of the meeting.

The CHAIRMAN took it that the Committee wished to note the Director-General’s report in part VIII of document A50/6.

It was so agreed.

2. CONTROL OF TROPICAL DISEASES: Item 20 of the agenda (Document A50/7)

Lymphatic filariasis (Resolution EB99.R17)

Professor ABERKANE (representative of the Executive Board) said that lymphatic filariasis affected 120 million people in 73 countries and continued to be a worsening problem, especially in Africa and the Indian subcontinent. Elephantiasis, lymphoedema and genital pathology afflicted 44 million men, women and children, while another 76 million suffered from parasites in their blood and hidden internal damage to their lymphatic
and renal systems. Earlier techniques and strategies for control had been inadequate. However, over the past
decade, dramatic advances in research had led to a new understanding of the severity and impact of the disease,
the development of new diagnostic and monitoring tools and, most importantly, the emergence of new treatment
means and a control strategy.

The new strategy focused on treating the human population through community-wide mass programmes,
which had already been planned in certain countries. An annual single dose of two drugs (ivermectin plus either
diethylcarbamazine (DEC) or albendazole) reduced blood microfilariae by 99% for a full year. Even single drug
use could result in 90% reduction and field studies indicated that transmission of the infection could be
interrupted. The pharmaceutical industry (Merck & Co. Inc.) was generously providing the necessary ivermectin
to countries collaborating with WHO in trials to demonstrate that filariasis could be eliminated by using that
drug alone or in combination with others once a year for two to five years. Taking into consideration those
remarkable technical advances and the success of recent control programmes, the Executive Board had adopted
resolution EB99.R17, in which it recommended for adoption by the Health Assembly a draft resolution calling
for the elimination of lymphatic filariasis as a public health problem.

Dr BUGRI (Ghana) reported that over recent years lymphatic filariasis had become one of the diseases
in his country that threatened public health. A new national integrated strategy, based on that outlined in
resolution EB99.R17, was currently being developed for the control of filariasis and other parasitic diseases,
including onchocerciasis, intestinal worms and schistosomiasis. He believed that the elimination of lymphatic
filariasis as a public health problem was an achievable goal and therefore endorsed the draft resolution.

However, treatment for filariasis in onchocerciasis-endemic areas required the use of ivermectin, which
was a rather expensive drug. He therefore appealed to WHO to take measures to make the drug affordable to
the countries affected, even after the termination of its trial period.

Mr EISS (United States of America) thought that acknowledgement should be given to Merck & Co. Inc.
for its donation of the drug which had made the important trials feasible.

Dr MAJORI (Italy) commended the important work done on lymphatic filariasis, particularly in view of
the results that had already been achieved by control programmes and the control strategy that had been
developed. He therefore gave strong support to the draft resolution proposed by the Executive Board and called
for its prompt adoption and implementation.

Mr CHAUHAN (India) said that, while lymphatic filariasis existed in many regions of the world, it was
a major public health problem in China, India and Indonesia, which together accounted for two-thirds of the
estimated total of 120 million affected persons. India had 38% and 20% respectively of the global totals of
bancroftian and brugian filariasis cases. The disease was found in 18 endemic states and union territories
inhabited by 412 million people, 20 million of whom had chronic filariasis and another 27 million were
microfilaria carriers. The Indian Government had launched a national filariasis control programme implemented
by the National Malaria Eradication Programme and with the research and development directed by the National
Institute of Communicable Diseases.

An international task force on disease eradication had identified filariasis as one of six potentially
eradicable diseases in view of the current availability of cost-effective control tools, such as annual mass DEC
chemotherapy and improved case management. His Government was considering organizing, on a phased basis,
a National Filariasis Day to introduce annual mass DEC chemotherapy, starting with 13 districts and covering
200 million people in five years. Tamil Nadu had already celebrated Filariasis Day on 5 August 1996 by
administering a single DEC dose in one district, achieving 90% coverage, and the community had accepted the
strategy.

Dr MOREL (Brazil) welcomed the Director-General’s report (document A50/7) and the recent
reorientation and achievements of the Division of Control of Tropical Diseases, in particular its new emphasis
on integrated control of tropical diseases within primary health care; capacity-building; development of
information systems and the evolution of public health mapping; the achievements and planned expansion of
the WHO pesticides evaluation scheme to encompass biopesticides and household pesticides, and the progress
towards the elimination of filariasis, which had become an attainable goal owing to new tools and control
strategies. While he endorsed the draft resolutions on tropical diseases contained in resolutions EB99.R17, EB99.R18, EB99.R19 and EB99.R20, he viewed with concern the recrudescence of dengue and dengue haemorrhagic fever (DHF); the potential return of yellow fever in the Americas; the difficulties of sustaining long-term programmes for control and eradication of insect vectors of tropical diseases, which called for coordinated political decisions; the continued seriousness of malaria in the Amazon region, despite some progress achieved particularly with PAHO support; the need to extend to the Andean and Central American countries the progress made in southern cone countries in controlling transmission of Chagas disease; and the fact that WHO collaborating and reference centres were a vastly underutilized resource that could play a major part in research and training. He therefore suggested intensified worldwide control of dengue and DHF, support for Andean and Central American initiatives for eliminating transmission of Chagas disease, and continued support to the collaborating centres in endemic countries.

Dr KILIMA (United Republic of Tanzania), endorsing the draft resolution on lymphatic filariasis, commended its timeliness and welcomed the Organization’s support for research that had identified cost-effective tools for control and elimination of the disease, which he was convinced would be achieved.

The United Republic of Tanzania’s elaborate primary health structure would be fully utilized for such control. Supported by WHO, it was initiating control based on an annual two-drug treatment. Resources were, however, needed for the initial stages and he wished the Organization to play a leading role in mobilizing resources for advocacy and community partnership, since control and elimination would be a responsibility of the communities themselves.

Dr STAMPS (Zimbabwe) also welcomed the headway made with filariasis control, and expressed interest in the use of DEC-fortified salt for 9-12-month periods. He asked whether any difficulties had arisen in attempts at its “population-based”, public health use.

Dr KIELY (Ireland) commended the excellent work reflected in the reports on item 20 of the agenda and hoped it would continue.

Dr HENDERSON (Assistant Director-General) said, in response to the statements by Ghana and the United States of America, that the Organization greatly appreciated the support of Merck & Co. Inc. for ivermectin demonstration projects and that WHO’s relationship with that firm was excellent. While he was optimistic that support would continue and expand, WHO could not make any undertaking on the firms’s behalf since that was a matter for its board of governors. Acknowledgement of the contribution of Merck & Co. Inc. would appear in the summary records of the Committee.

The delegate of Zimbabwe could rest assured that DEC had been highly successful in China; since all countries were different, however, the Secretariat would ensure that he received all relevant information.

The draft resolution recommended by the Executive Board in its resolution EB99.R17 was approved.¹

Malaria (Resolutions WHA49.11 and EB99.R18)

The CHAIRMAN invited the Committee to consider a revised text of the draft resolution recommended by the Executive Board in resolution EB99.R18. The amended version, proposed by Botswana, Cambodia, Canada, China, Ghana, Nepal, Norway and Sweden, read:

The Fiftieth World Health Assembly,
Recalling resolution WHA46.32, which endorsed the World Declaration on the Control of Malaria and asserted the gravity of malaria as an unacceptable and unnecessary burden upon human health and as a serious obstacle to social and economic fulfilment of persons and States;

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.29.
Recalling resolution WHA49.11, which noted the concern of the Health Assembly regarding malaria, recognized that further delay in intensifying the struggle against malaria could cost millions more lives, urged Member States to take action, Regional Committees to ensure that programmes are vigorously pursued, and the Director-General to explore ways and means of intensifying the programme,

1. **ENDORSES** the leadership role given to WHO by the United Nations Economic and Social Council in global malaria control in its resolution 1995/63;

2. **THANKS** the Director-General for his prompt action in establishing a task force to conduct an external review of the malaria problem and progress being made towards its control;

3. **NOTES** that the task force endorsed the global malaria control strategy and reaffirmed that the strategy is the best control approach available today;

4. **URGES** Member States to renew their political commitment to malaria control, to accord the highest priority to the control of malaria mortality in Africa south of the Sahara and in other highly endemic areas of the world, and to guarantee core funding and sufficient competent staff and other resources for national programmes;

5. **URGES** regional committees to fully support the global effort for malaria control by promoting increased political awareness and commitment, and ensuring adequate resource allocation;

6. **REQUESTS** the Director-General to continue intensifying efforts to increase resources for WHO’s action in malaria control including:
   (1) seeking a long-term financial commitment to consolidate the initial effort and results achieved, and
   (2) pursuing his actions to reinforce the training programme at country, regional and global levels.

Professor ABERKANE (representative of the Executive Board) said that the malaria situation was worsening throughout the world, especially in the needier countries, with an estimated 300 to 500 million clinical cases per year and 1.5-2.7 million deaths per year, of which 90% occurred in Africa south of the Sahara.

Antimalarial activities were conducted under the WHO Plan of Action for Malaria Control (1995-2000), which had been accepted by other United Nations agencies and endorsed by the United Nations Economic and Social Council in 1995, and which assigned priority to control programmes in Africa. The Forty-ninth World Health Assembly had highlighted the impediments to its implementation in its resolution WHA49.11 and requested the Director-General to increase the resources for WHO’s malaria control measures and reinforce malaria training programmes at all levels. The Director-General had set up a task force, which had met in October 1996, to recommend how WHO could best support Member States in the global control of malaria and had allocated US$ 10 million as additional support to accelerate control activities in 21 countries in the African Region and three African countries in the Eastern Mediterranean Region in 1997. In addition a joint programme by the World Bank and the WHO Regional Office for Africa for accelerated malaria control had been launched in February 1997. WHO was also collaborating with UNICEF in four African countries, with UNDP in Myanmar, with the World Bank in Bangladesh, the Lao People’s Democratic Republic, Madagascar and Viet Nam, and with the European Commission in Cambodia, the Lao People’s Democratic Republic and Viet Nam. Italy had cooperated in community malaria control activities in Eritrea and Ethiopia, and Germany in Mali and Uganda.

Dr LARIVIÈRE (Canada) explained that the purpose of the amended draft resolution introduced by the Chairman was to reaffirm the mandate given by the United Nations Economic and Social Council, stress the urgency of a vigorous response to malaria morbidity and mortality, especially in Africa, and emphasize that the global malaria control strategy was an effective tool if correctly implemented. The international community must realize that investments in that strategy would yield significant returns.
Professor MYA OO (Myanmar) said that malaria, a major public health problem in Myanmar, accounting for 8% of total outpatient attendance and 20% of hospital admissions, with a case fatality rate of 3.3%, was also hindering socioeconomic development. The country was launching a malaria control programme, promoting grass-roots health education and strengthening surveillance capabilities and diagnostic facilities in rural centres and township hospitals with the assistance of UNDP and external nongovernmental organizations.

The emergence of multdrug resistance in malaria parasites, behavioural changes in mosquitos and their development of resistance to insecticides, and cross-border population movements were the main causes of the malaria situation in South-East Asia. The situation called for solid political commitment, greater priority in resource allocation for malaria control, and effective control programme implementation. He therefore requested WHO and donor agencies to increase resources for malaria control at all levels.

Dr STAMPS (Zimbabwe) endorsed the section on malaria in the excellent report on control of tropical diseases. Sub-Saharan Africa had been particularly hard hit by a dramatic resurgence of malaria during the past two rainy seasons. Epidemic outbreaks had sextupled the number of diagnosed cases and significantly increased the number of deaths. The implementation of the global malaria control strategy had, however, reduced the number of deaths in 1997, so that the case fatality rate was only about three-quarters of what it had been in 1996 in Zimbabwe. He proposed the addition to the draft resolution of a new paragraph, reading:

4. NOTES that the Organization of African Unity is to consider a pan-African declaration on malaria at its thirty-third Heads of State and Government meeting in Harare on 2-4 June 1997.

Professor AKIN (Turkey) welcomed the report and the encouraging reaction to resolution WHA49.11. Malaria remained a major public health problem in many countries, with extremely serious consequences. Far from being under control, the problem was worsening for a number of social and environmental reasons. She therefore noted with appreciation the establishment by the Director-General of a task force on malaria prevention and control to conduct a worldwide review of the situation. Turkey welcomed the recommendations of the task force and was pleased that WHO’s overall plan for malaria prevention and control for 1998-1999 was in line with them. Multidisciplinary and multisectoral approaches were needed to prevent and control malaria, and every effort must be made to improve them. Countries needed financial support, of course, but they needed guidance and technical support from WHO even more.

For the past few years, Turkey had been implementing a malaria control programme through close cooperation between the appropriate ministries and with local authorities, especially concerning environmental factors. Support for such efforts was provided by WHO as well as by UNDP and the European Union. Surveillance activities had been improved and blood tests for screening and radical treatment had been carried out. In the past two years, the number of cases had not increased. Vector control activities and the training of care providers were priorities for the programme in the future. WHO’s research and training in malaria control were especially useful. Considering that the development of a vaccine against malaria would be a real breakthrough, she asked what progress was being made and when a vaccine would be available for general use. She endorsed the revised draft resolution before the Committee.

Mr LEGESSE (Ethiopia) expressed appreciation of the information on malaria control provided in the report and supported the draft resolution. Malaria was one of the major problems that his country faced. It ranked second, after acute upper respiratory tract infection, in the burden of disease as measured by discounted life years. Climatic changes, population movements and resistance to insecticides and drugs had caused malaria to spread to areas where it had not previously been a significant problem, and 70% of the Ethiopian population now resided in malaria endemic areas.

The successful democratization and decentralization process now being undertaken in his country had permitted significant efforts to be made to control malaria. That process had proved instrumental in bringing about intersectoral collaboration, community participation and decision-making at local levels; but major support, both technical and financial, was needed from the international community, including WHO. In view of the magnitude of the problem, WHO had begun to support a new malaria control initiative in Ethiopia. His country welcomed that support and hoped it would be intensified to mitigate the dreadful social and economic problems the disease caused. He thanked other United Nations agencies for their assistance in malaria control efforts and the Governments and peoples of the Netherlands, Sweden, Japan and the United States of America.
for their generous help in strengthening the health care delivery system of Ethiopia. He called on those governments, and others, for intensified support in the control of malaria and other major communicable diseases.

Mr TSUDA (Japan) said the fact that 40% of the world’s population lived in malaria epidemic areas, that the disease imposed the largest morbidity burden of all infectious diseases, and that it held first place among all causes of death made it clear that measures for malaria control had to be strengthened everywhere, including Asia and Latin America. Action to prevent infection and develop antimalarial drugs needed to be reinforced. Japan had therefore increased its cooperation with WHO in implementing its malaria control programme.

Dr MONISSOV (Russian Federation) said the amended draft resolution before the Committee went a long way towards outlining the efforts required to control malaria in the world. He would, however, submit two further amendments. The current paragraph 3 noted that the task force had endorsed the global malaria control strategy, but that strategy had in fact been approved by ministers of health at the conference on malaria in Amsterdam in 1992, and by the Health Assembly. The paragraph should therefore read: “NOTES that the Task Force reaffirmed that the Strategy is the best control approach available today and made specific proposals to improve the malaria control programme activities and programme structuring of the World Health Organization”.

Malaria was re-emerging in countries from which it had been eliminated, for example in Central Asia. In some parts of the Russian Federation, local transmission of the disease had resumed, and the number of imported cases was growing annually. Should an epidemic break out, the Russian Federation lacked the necessary resources to subdue it. He therefore proposed that in the current paragraph 4 the words “prevention and” should be inserted between “priority to the” and “control of”; that the word “and” between “Sahara” and “in other highly endemic areas” should be replaced by a comma; and that after “the world” the words “and also in countries where local transmission of malaria has begun again” should be inserted.

Dr BROOKMAN-AMISSAH (Ghana) stressed that malaria continued to exact a heavy toll in human lives in Africa and other endemic areas. It was the main killer of children under five years of age, and its economic impact in terms of loss of working days was incalculable. It killed more people a day than did AIDS in a year, but the resources spent to combat it were only a fraction of those devoted to the control of AIDS. WHO’s efforts to control malaria were welcome, but it should do a great deal more. Malaria should not be seen as an African problem alone, for it affected more than half the people in the world and, with increased travel, could now affect all countries. Priority action was required if any headway was to be made in what appeared to be a losing battle against the plasmodium, which seemed always to be one step ahead. The resources needed to control and treat malaria in African countries were enormous. Assistance was urgently needed to complement national efforts. WHO should therefore mobilize more resources to sustain the accelerated programme on malaria control embarked upon in Africa in 1997.

Dr LUETKENS (Germany) expressed appreciation of the progress made towards control and eradication of major tropical diseases. Regrettably, malaria remained a major scourge, but Germany hoped WHO would devote adequate efforts and resources to the problem. It felt privileged to have entered into a partnership with several endemic countries in a joint effort to contribute to the control of malaria.

Ms STEGEMAN (Netherlands) said that, in view of the vast burden of disease entailed by malaria, it should be given absolute priority in the tropical disease control programme, and that priority should be translated into financial terms. The establishment of a task force was welcome, but the report on its meeting in October 1996 was given insufficient attention in the Director-General’s report on control of tropical diseases (document A50/7). She endorsed the amended draft resolution but thought it could be strengthened by the insertion, in paragraph 6(2), between the words “reinforce” and “the training programme”, of the words “the implementation of the malaria control strategy with special emphasis on”.

Mr BERWAERTS (Belgium) thanked the Director-General for his continued support for the control of tropical diseases, particularly malaria, which remained an unacceptable burden, especially for African countries. Belgium had always supported activities aimed at combating malaria and had participated actively in task force
meetings held in Brazzaville. He thanked the Director-General for convening a special meeting on malaria control in Geneva and for allocating US$10 million for malaria control activities in Africa in 1997. Malaria control would be a long-running battle, however, and required the application of a long-term strategy. How would WHO, which must play the leadership role in the struggle, pursue and expand in future years the specific steps undertaken in 1997?

Mr MACDONALD (Australia) supported the global malaria control strategy endorsed by the task force on malaria prevention and control and urged the Division of Control of Tropical Diseases and the Special Programme for Research and Training in Tropical Diseases to continue to give high priority to malaria control. While recognizing the extent of the problem in Africa, he stressed the need to accord priority and allocate resources to the control of malaria in the Western Pacific Region, where it was still endemic in nine countries.

Dr GBARY AKRA (Côte d’Ivoire) noted the progress made since the adoption of resolution WHA49.11: extrabudgetary resources had been mobilized, the work of regional offices had been reinforced and training in malaria control had been extended. His country congratulated WHO and all its partners for those achievements and endorsed the draft resolution before the Committee. Yet the very visibility and efficacy of the malaria control programme compelled further, more intensive efforts: greater coordination and organization were needed. Accordingly, he proposed the insertion after subparagraph 6(1) of two subparagraphs reading:

(2) restructuring of the malaria unit at headquarters to include all elements of malaria prevention and control;
(3) appointment of an independent advisory body;

The former subparagraph (2) would become subparagraph (4).

The meeting rose at 17:30.
1. CONTROL OF TROPICAL DISEASES: Item 20 of the Agenda (Document A50/7) (continued)

Malaria (Resolutions WHA49.11 and EB99.R18) (continued)

Mrs MARIAMA (Niger), commending the integrated approach to the control of tropical diseases, strongly endorsed the draft resolution before the Committee.

Mr EISS (United States of America) said that while document A50/7 and the draft resolution rightly mentioned the lack of financial resources as a limiting factor in the control of tropical diseases, it must be remembered that the available treatment and prevention tools were also inadequate for many parasitic and infectious diseases, including malaria. Research and training were required to implement existing measures more effectively and to develop the techniques needed for comprehensive prevention and control. In that connection, he sought information on the working relations between the Division of Control of Tropical Diseases and the Special Programme for Research and Training in Tropical Diseases.

Many of WHO’s most significant achievements in tropical medicine had resulted from active cooperation with other organizations within and outside the United Nations system and with the private sector; the recent efforts to eradicate onchocerciasis in the Volta River basin and guinea-worm in endemic regions were cases in point. He commended WHO for fostering alliances between the public and private sectors to prevent, contain and treat parasitic and infectious diseases.

He concurred strongly with the special emphasis placed on malaria and supported an integrated approach to control and prevention, incorporating improved diagnosis of the sick child, rational drug use and monitored vector control measures. Regarding the need for research, he emphasized that there were no definitive treatment or control measures, mainly because of resistance of the parasites to available drugs and of the vectors to insecticides. The development and introduction of a vaccine would require a greater understanding of parasite biology and the mechanisms of immunity and transmission, including regional variations, and intensified efforts to develop new antimalarial drugs would depend on the dedicated participation of industry. Where promising new measures, such as the use of insecticide-impregnated bednets, emerged their development should be accompanied by a rigorous evaluation of their impact on immunity, morbidity and mortality. He hoped that the draft resolution would promote intensified research, both basic and applied, within the public and private sector to elaborate improved tools for control, prevention and therapy.

He noted the work of the National Institutes of Health in his country in bringing together malarialogists and medical research institutes from the Americas, Europe, Africa and elsewhere with WHO and the World Bank in an effort to determine the most promising research strategies and encourage a coordinated response to malaria.

Finally, he strongly encouraged the use of laboratory facilities to improve surveillance and case management.

Dr DLAMINI (Swaziland) said that her country, as one of 11 struck by an unexpected malaria epidemic in 1996-1997, thanked WHO, UNDP, UNICEF, the World Bank and the European Commission for funding efforts to control the outbreak.
Despite those efforts, heavy rains had increased population movements between countries and drug resistance had caused further malaria-related deaths and higher morbidity. Given the continued need to improve communication in preventive campaigns and to teach communities how to recognise malaria symptoms, particularly in young people, her Government appreciated renewed financial support for human-resource development. Joint programmes with neighbouring countries were being fortified.

She welcomed the Director-General's allocation of an additional US$ 10 million to accelerate the implementation of malaria control activities in Africa in 1997 and requested a further strengthening of programmes in view of the low levels (or absence) of immunity in countries faced with re-emergence and the fact that malaria was both preventable and treatable.

Voicing keen interest in vaccine development, she endorsed the draft resolution, as amended.

Mr CHAUHAN (India) said that malaria had been a serious public health problem in India for many decades. A national malaria eradication programme, launched in 1958, had reduced the number of cases from 75 million at the time of inception to 0.1 million in 1965. However, ensuing complacency and a decision to integrate the programme into the general health services had slowed down the effort and by 1976 the number of cases had increased to 6.47 million. A modified plan of action had succeeded in reducing that figure again to under 2 million, although it had risen to almost 3 million over the past two years. Similarly, deaths had dropped to between 50 and 400 over the 1976-1993 period before climbing back up to a record level for that period of 2731 in 1996.

Vector resistance had forced India to switch from conventional insecticides to synthetic pyrethroids, so that it was now faced with an approximately sixfold increase in required expenditure per annum. In addition, synthetic pyrethroids had to be used selectively in order not to induce resistance to them. A comprehensive project costing US$ 215 million had been prepared in conjunction with the World Bank and would be launched on 1 June 1997. It combined environmental control measures with the effective use of synthetic pyrethroids, biopesticides, larvivorous fish, and impregnated bednets, and would involve close coordination with other ministries, particularly on power, irrigation and agricultural projects, which could create conditions propitious to the spread of malaria. Attempts were also being made to ensure that health impact studies were carried out on all major projects.

In line with efforts by the Regional Office for South-East Asia to improve coordination through intercountry meetings, India was working with its neighbours to implement malaria control programmes simultaneously for maximum efficiency.

India was grateful for technical and financial assistance from various organizations, including WHO and the World Bank. It supported the draft resolution as amended, but would like to see a final version incorporating all amendments.

Dr MAJORI (Italy) reiterated the importance of sustained action against malaria and commended the Director-General's allocation of an additional US$10 million to malaria control in Africa. He endorsed the amended draft resolution, but would like measures to be taken to ensure a long-term financial commitment and would welcome any comments from the Secretariat in that connection.

Dr SANOU IRA (Burkina Faso) supported the amended draft resolution. Malaria was the main cause of sickness and death among the children of Burkina Faso and its threat was well recognized. A conference to determine research priorities had been organized in February 1996 with the support of WHO and the participation of policy-makers, partners in development and community representatives. Malaria control had been set as a priority to be achieved through the reinforcement of existing activities and the promotion of research. She thanked WHO for its financial and technical assistance to her country's malaria control programme.

Dr KONG Lingzhi (China) called for strengthening of antimalarial campaigns and increased financial support. The elaboration and implementation of malaria control programmes should be evaluated in order to make existing programmes more effective and to help countries without a programme to prepare one as quickly as possible. National commitment was important in that respect. WHO should ensure that all countries incorporated malaria control strategies into the activities of all ministries, not just that of health, since cross-sectoral cooperation had a significant bearing on programme implementation and funding. The Organization
should also reinforce its training and technical assistance programmes to reinforce the crucial work done by field teams.

Dr GHOSHEHGHIR (Islamic Republic of Iran) placed the seriousness of malaria on a par with that of tuberculosis, for which an annual action day had been created. Renewed strategies were needed to combat the disease and alleviate the burden it laid on an estimated 300 million victims as well as on social, financial, and economic resources throughout the world. He fully supported the draft resolution, but could have wished it to make four points more explicitly. First, a global task force or committee was needed to oversee the effective implementation of malaria control. Secondly, only an increased and sustained financial commitment would avoid the problems - including that of neglect - which currently hampered the control of other diseases. Thirdly, the task force or committee or the global malaria control programme should expand and encourage intersectoral collaboration both at country level and internationally. Finally, the endemic countries should be urged to collaborate more actively among themselves to control the trans-border spread of malaria which was a redoubtable feature of present-day population movements. Close attention to those points would do much to promote the containment of the disease and even its possible elimination at some future date.

Dr HASSAN (Benin), noting that one-third of all medical consultations in his country were for malaria, recalled that the World Health Assembly had adopted 74 resolutions on that disease between 1950 and 1996; postage stamps devoted to its eradication had even been issued in 1962. Malaria nevertheless remained a worldwide scourge, causing one death every two minutes in the 50 or so tropical countries. The control of malaria required proper management of rainwater and of ponds, rivers, backwaters and artificial lakes and reservoirs. It also required access to treatment with essential drugs stored under proper conditions. Everyone would like to see a vaccine developed, but that would require enormous resources. Environmental control had been the key to eliminating malaria from countries such as Seychelles, Cuba and Mauritius; similar control could be achieved in Africa if each country made the necessary effort. WHO should work with nongovernmental organizations and ministries of the environment, town-planning and finance in order to bring about environmental control, which was the only lasting way to control mosquitoes. In 1996, WHO had provided 21 countries with funds for a special malaria control programme; he hoped that that support would be sustained and even increased. He supported the draft resolution and the amendment proposed by Côte d'Ivoire.

Dr KILIMA (United Republic of Tanzania) said that malaria accounted for 31% of all outpatient consultations and 15% of deaths among children under five in his country, where it was transmitted perennially. Areas that had in the past been free of malaria were experiencing epidemics, as the disease spread to non-immune populations. An accelerated control programme was being implemented with the assistance of WHO, and he hoped that additional funds would become available when it ended in December 1997. Community-based methods were being emphasized, as that was the only means to ensure sustained control.

As was noted in paragraph 17 of document A50/7, the Director-General had been requested to explore the possibility of establishing a special programme on malaria and to intensify efforts to increase resources for the work. He asked what decision had been taken, as such a programme would renew interest in the problem and incite organizations to invest funds specifically for malaria control.

The available malaria control measures, including impregnated bednets, integrated case management and proper diagnosis, would be used in his country. A particular effort would be made to monitor the resistance both of parasites to drugs and of vectors to insecticides, within his country and across borders. He requested technical assistance from WHO in that endeavour. The United Republic of Tanzania would also be willing to participate in innovative research into other measures, including the development of a vaccine. Thanking WHO and other international agencies, which had given unwavering support for malaria control, he supported the amended draft resolution.

Dr HAPUGODA (Sri Lanka) reported that malaria control continued to receive the highest priority from her Government. About 10 million of the total population of 18.4 million lived in areas where the disease was endemic, but the malaria mortality rate was much lower than in many neighbouring countries, and morbidity had decreased during the period 1987-1996. After the adoption of WHO's new global strategy for malaria control in 1992, Sri Lanka had reorganized its own programme; the use of residual insecticides had been drastically reduced, and insecticide spraying was carried out only in areas where the dynamics of malaria
transmission required vector control. Early detection and prompt treatment of cases had been reinforced in several ways: mobile malaria clinics covered populations in remote villages with limited access to medical facilities; primary health care workers in malarious districts identified cases during home visits; families settling in new areas under development schemes were covered by voluntary treatment centres, where uncomplicated cases of malaria were treated. As a temporary strategy to overcome a shortage of microscopists in rural areas, science teachers were to be asked to examine blood smears from persons suspected of having malaria. None of the malaria control measures was fully effective, however, without active participation of the community, which was therefore involved in the planning and implementation of district programmes. Participation was ensured by village leaders and voluntary health workers. Two activities currently being stressed were larval control, with the introduction of larvivorous fish, and promotion of the use of personal protection against mosquitos.

WHO had assisted Sri Lanka in malaria control in the past, and she asked for that support to be strengthened and maintained in respect of human resource development, improvement of infrastructure, surveillance and research.

Mr PARK (Republic of Korea) noted that malaria was not confined to Africa south of the Sahara but was an emerging or re-emerging problem in many other subtropical and tropical regions. In the 1960s, malaria due to *Plasmodium vivax* had been endemic in his country, with more than 1000 cases annually. In the early 1970s, the Government, with financial and technical assistance from WHO, had eradicated malaria, and no cases had been found for 20 years. Vivax malaria was now re-emerging, however, although the number of cases was small. Prompt, extensive action had been taken. Most of the cases had occurred in a limited area along the border in the north of the country, and it was assumed that malaria existed in the northern part of the Korean peninsula. Supporting the amended draft resolution, he asked the Director-General to reassess the global malaria situation, with particular reference to the re-emergence of the disease in countries other than those in the tropical belt.

Dr ALI (Iraq) supported the draft resolution. Implementation of programmes for the prevention and control of endemic malaria in Iraq since the 1950s had resulted in eradication of the disease. The embargo that had been imposed on his country had, however, resulted in its re-emergence and spread in many regions. In 1996, there had been more than 48 000 cases. Contracts had been concluded to import insecticides and pesticides in exchange for oil, but the Sanctions Committee of the United Nations Security Council, responsible for decisions concerning the embargo, had approved only 80 of the 500 contracts. It was therefore not possible to implement control and prevention programmes in 1997, and the number of cases of malaria would certainly increase. That would pose a threat for neighbouring countries as well. In view of the seriousness of the situation, he asked the Director-General to intervene with the responsible committee, so that Iraq could import the necessary pesticides and drugs.

Dr SUKWA (Zambia) commended the Director-General for having mobilized extrabudgetary funds for malaria control in the African Region, from which his country was benefiting. The epidemiology of malaria in his country was similar to that in other countries of central and southern Africa. The disease accounted for 30% of all outpatient consultations and 15% of inpatient care and was a major cause of morbidity and mortality, especially among children under five. He paid tribute to the Special Programme for Research and Training in Tropical Diseases for the assistance that his country had received over the past 10 years, but noted that that support had declined. He urged that the Division of Control of Tropical Diseases should invest in operational and clinical research that was pertinent to effective malaria control strategies. The accelerated malaria control initiative would have a significant impact only if the available tools were adapted to local situations. He supported the draft resolution and the amendment proposed by Zimbabwe.

Dr MESHKHAS (Saudi Arabia) said that the importance of the problem of malaria for all countries called for worldwide solidarity. The malaria control programme in his country had resulted in eradication of the disease in several regions, although drug resistance remained a problem. He supported the draft resolution but would have liked to see a reference to political commitment to health in paragraph 4 and a reference to strengthening of research in paragraph 3.
Professor AYUB (Pakistan) said that India and Pakistan faced common problems and similar diseases. Now that those two neighbouring countries were reaching an understanding, he wished to record that he fully supported the comments of the delegate of India about the common problem of malaria. He hoped that the disease would be eradicated through mutual cooperation, with the help of WHO.

Dr HEMATRAM YADAV (Malaysia) supported the draft resolution. A programme for the eradication of malaria had begun in Malaysia in 1967, when some 450,000 cases had been recorded. When it had become clear that eradication was unlikely, a control programme had been started and had resulted in a reduction of the number of cases to some 51,000 in 1996. As most of the cases detected were in the state of Sabah, priority was given to the programme there, especially among high-risk groups such as aborigines, land-scheme workers and migrant workers, who were examined regularly. The national programme included promotion of community participation and expanded regional cooperation. There was a need for participation by the private sector and nongovernmental organizations and for international commitment to providing funds and developing human resources for malaria control in countries where it was endemic. WHO could lead by giving technical assistance to Member States.

Mr SALIH (Maldives) recalled that WHO had conducted a survey on the prevalence of malaria in his country in 1952, only four years after the Organization had been founded, and had provided continuing support. With that help, malaria had been eradicated in the Maldives 10 years previously. A few imported cases had been reported annually during the past few years, but they had been identified and treated promptly. As his country was in the middle of an endemic area, however, he asked for a concerted effort on the part of WHO to control the disease in South-East Asia. International traffic had increased enormously, and cargo was now often transported in containers. Countries from which goods were exported should ensure that malaria vectors were not transported with them. He supported the draft resolution.

Dr MELONI (Peru) said that he too supported the draft resolution, as amended, and wished to be named among its sponsors. Malaria was an important problem, and implementation of WHO's global strategy should be extended, emphasizing technical cooperation and training.

Dr HENDERSON (Assistant Director-General), replying to questions and comments, said that the Director-General had recently approved an administrative reorganization creating a full malaria prevention and control programme to succeed the current Malaria unit. To maintain the objective of the integrated control of tropical diseases, that programme would remain within the Division of Control of Tropical Diseases but would be substantially strengthened. The action to be taken by the new programme was very much in line with the recommendations of the Task Force on malaria prevention and control, which would itself continue its work; its next meeting was scheduled for October 1997 in Cairo. As for comments regarding the continued provision of resources for the programme, there was a common interest in their being sustained from year to year; while no guarantee could be given because of financial constraints, it was his belief that they would become available. The Division of Control of Tropical Diseases enjoyed very close collaboration with the Special Programme for Research and Training in Tropical Diseases, from whose work on impregnated bed nets and the community approach to disease management it had benefited. It also had close collaboration with the Division of Child Health and Development on the integrated management of the sick child. Its collaboration with the World Bank, UNICEF, UNDP and other organizations had been mentioned, and it had also signed a Memorandum of Understanding with UNESCO in May 1997. Iraq's request for help with the importation of insecticides and drugs raised a very difficult problem; the Director-General had been exercising his influence with regard to it, and would continue to do so.

Dr GODAL (Special Programme for Research and Training in Tropical Diseases), replying to the question from the delegate of Turkey about the current status of antimalaria vaccines, said that after 15 years of research eight different candidate vaccines were currently undergoing clinical testing. In some of them new adjuvants were used, and one of them had given particularly promising trial results. If one of the eight candidates secured registration easily, it was still possible that the target of having an antimalaria vaccine available by 2003 might be reached. It remained essential, however, to base worldwide malaria control strategies on the control tools that were currently available. The candidates were all Plasmodium falciparum vaccines, and little effort was
being put into vaccines against *P. vivax*, which was the main problem in several countries, including Turkey. As for collaboration between the Division of Control of Tropical Diseases and the Special Programme for Research and Training in Tropical Diseases, after initial attempts to draw a sharp distinction between the respective responsibilities it had been decided that a phased transition was required. The concern expressed by Zambia with regard to the special programme on malaria and declining resources would be dealt with directly between the Organization and the country concerned.

Dr THYLEFORS (Secretary) said that the large number of delegates who had spoken on the subject of malaria clearly indicated its priority. They had all expressed general support for the amended draft resolution introduced at the previous meeting, to which further amendments had been proposed by four delegations. He understood that those of Côte d'Ivoire had been withdrawn, and those of the Russian Federation somewhat simplified. There was no contradiction between the latter and the amendments put forward by the Netherlands and Zimbabwe.

The CHAIRMAN then invited the Committee to consider the draft resolution with the amendments referred to by the Secretary, as follows:

The Fiftieth World Health Assembly,
Recalling resolution WHA46.32, which endorsed the World Declaration on the Control of Malaria and asserted the gravity of malaria as an unacceptable and unnecessary burden upon human health and as a serious obstacle to social and economic fulfilment of persons and States;
Recalling resolution WHA49.11, which noted the concern of the Health Assembly regarding malaria, recognized that further delay in intensifying the struggle against malaria could cost millions more lives, urged Member States to take action, Regional Committees to ensure that programmes are vigorously pursued, and the Director-General to explore ways and means of intensifying the programme,

1. ENDORSES the leadership role given to WHO by the United Nations Economic and Social Council (ECOSOC) in global malaria control in its resolution 1995/63;

2. THANKS the Director-General for his prompt action in establishing a Task Force to conduct an external review of the malaria problem and progress being made towards its control;

3. NOTES that the Task Force confirmed that the Global Malaria Control Strategy is the best control approach available today;

4. NOTING that the Organization of African Unity is to consider a pan-African declaration on malaria at its 33rd Heads of State and Government meeting in Harare on 2-4 June 1997;

5. URGES Member States to renew their political commitment to malaria control, to accord the highest priority to the control of malaria mortality in Africa south of the Sahara and in other highly endemic areas of the world, and also in countries where local transmission of malaria has begun again; and to guarantee core funding and sufficient competent staff and other resources for national programmes;

6. URGES Regional Committees to fully support the global effort for malaria control by promoting increased political awareness and commitment, and ensuring adequate resource allocation;

7. REQUESTS the Director-General to continue intensifying efforts to increase resources for WHO’s action in malaria control including:
   (1) seeking a long-term financial commitment to consolidate the initial effort and results achieved;
   (2) pursuing his actions to reinforce the implementation of the malaria control strategy with special emphasis on the training programme at country, regional and global levels.
The draft resolution was approved.¹

Eradication of dracunculiasis (Resolution EB99.R19)

Professor ABERKANE (representative of the Executive Board) said that in 1997 dracunculiasis was still endemic in 18 countries - 16 of them in Africa, plus Yemen and India. Between 1989 and 1996 the number of recorded cases had fallen by 90%. Pakistan had reached zero level in 1993 and had been certified as free from dracunculiasis. Kenya had recorded zero indigenous cases since 1995. Total recorded cases in 1996 had been 140 700, with case reduction in all countries except one ranging from 21% to 85%, and case containment ranging from 55% to 100% in 15 countries. Programme objectives were to provide technical, logistic and financial support to national dracunculiasis eradication programmes, to ensure optimal implementation of the case-containment strategy, and to reinforce and maintain surveillance in all present and formerly endemic areas, maintaining monitoring and verifying elimination of transmission country by country until the achievement of global eradication. Efforts being made in pursuance of the current surveillance and case containment strategy should be maintained in order to continue to reduce incidence. If surveillance and case containment decreased, the number of cases would increase, as had been observed transiently in Ghana. Many associations, foundations and nongovernmental organizations were collaborating in national eradication programmes, which were in constant need of technical and financial support, and WHO must be in a position to respond rapidly with the provision of advice and support to activities relating to surveillance and eradication. WHO must also sustain the certification process and verify the absence of transmission country by country, particularly in countries recently recording zero cases. In order to ensure eradication, surveillance was crucial during the three-year dracunculiasis-free period in endemic countries that had interrupted transmission. To assist with that surveillance, WHO and UNICEF had in 1993 set up a joint project on data management and mapping (Health Map) at WHO headquarters. Resolution EB99.R19 contained a resolution on eradication of dracunculiasis which the Health Assembly was recommended to adopt.

Mr CHAUHAN (India) outlined the comprehensive strategies implemented by his country's national dracunculiasis eradication programme, which had been launched in 1983-1984, when there had been some 40 000 cases in seven endemic states. The programme had proved a great success, as only nine cases had been reported in 1996. Tamil NACU, Gujarati, Maharashtra and Andhra Pradesh had been removed from the list of endemic states, having been free from the disease for more than three years. No case had been reported from any part of India so far during 1997, and it was hoped that the objective of interrupting disease transmission in the whole country would be achieved. With a view to satisfying the International Commission for Certification of Dracunculiasis regarding the status of India as a whole, surveillance was being extended to all parts of the country by including dracunculiasis in the list of diseases to be notified by each state and publicizing an appropriate cash reward through the mass media for reporting cases, as well as undertaking an active nationwide search for cases. India supported the resolution recommended in EB99.R19.

Dr LARIVIÈRE (Canada) expressed his support for the draft resolution. His country was concerned that, as the eradication of dracunculiasis grew closer, the cost per case prevented would increase, which might make other health priorities seem more attractive. That would waste a good part of the work done so far and would allow reservoirs of infection to remain, paving the way for its possible re-emergence at a later date. He asked whether there were any animal reservoirs of infection.

Mrs MARIAMA (Niger) said that, although dracunculiasis was still a serious public health problem in her country, statistics from 1996 showed that just under 3000 cases had been detected, compared with a peak of almost 14 000, which gave hope that the disease could soon be eradicated completely. Her country had recently played host to an intercountry meeting of national coordinators of dracunculiasis programmes, and thus been enabled to share experiences with others. If Niger was to eradicate dracunculiasis, it would require more technical and financial assistance from its partners in development, including WHO and UNICEF. She supported the draft resolution.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA50.34.
Professor AYUB (Pakistan) said that no cases of dracunculiasis had been detected in his country since 1993, and it had been certified free of the disease. He thanked WHO for its support in that campaign, and hoped that Pakistan's next priority, the eradication of poliomyelitis, would enjoy similar success.

Mr LEGESSE (Ethiopia) expressed his support for the resolution recommended by the Executive Board. The number of cases of dracunculiasis had fallen sharply in his country, but those that did still occur were in remote rural areas with poor communications, and complete eradication would therefore be difficult. Continued material, financial and technical support from WHO and other partners would be essential. He called upon the Director-General to increase support for dracunculiasis surveillance and to facilitate meetings between countries in order to improve cross-boundary control of the disease.

Dr OTOO (Ghana) said that his country's dracunculiasis control programme had achieved a 97% reduction in the prevalence of the disease, except in a few areas. However, as cases grew fewer, it became more difficult to identify them, and volunteers working at the community level needed incentives if they were to maintain their vigilance. He therefore called upon WHO to redouble its efforts to mobilize resources in support of endemic countries where the disease had almost been eradicated. Despite the International Drinking Water Supply and Sanitation Decade in the 1980s, many rural communities lacked safe water supplies and continued to rely on polluted surface waters which were sources of dracunculiasis and other water-borne diseases. WHO should lobby donor agencies for increased resources for water and sanitation programmes.

Dr BEHBEHANI (Division of Control of Tropical Diseases), replying to the delegate of Canada, said that there was no known animal host that could act as a reservoir of infection for dracunculiasis. A working group was investigating the matter further and was expected to report in the next few months.

The draft resolution recommended in resolution EB99.R19 was approved.1

African trypanosomiasis: (Resolution EB99.R20)

Professor ABERKANE (representative of the Executive Board) said that African trypanosomiasis was endemic in 36 countries of sub-Saharan Africa. More than 30,000 cases had been reported in 1996, and they undoubtedly formed only a small proportion of the real number, since most cases occurred in rural areas without any health facilities where deaths from the disease went unreported. African trypanosomiasis seriously affected social development and economic growth in those rural areas. Only drastic changes in the traditional use of land and improvement in the socioeconomic situation of rural Africa could provide a long-term solution to the problem. The main principle of control at present was the reduction of the human reservoir of infection through medical surveillance and treatment of infected individuals in conjunction with vector control. WHO's current target was to achieve surveillance coverage of 70% of the population at risk.

WHO had undertaken the global coordination of African trypanosomiasis control activities and advocated intercountry projects. The possibility of an African Trypanosomiasis Day to increase awareness among populations at risk and potential donors would be discussed with countries of the African Region. Control of the disease was a component of the joint OAU/FAO/IAEA/WHO project on sustainable agricultural development and socioeconomic development in Africa. WHO had also launched an initiative in central Africa which had already been extended from 10 countries to 16. A regional trypanosomiasis control project covered four East African countries: Ethiopia, Kenya, Uganda and United Republic of Tanzania. Another regional programme to control tsetse fly and trypanosomiasis covered eight countries of South-East Africa, and an animal trypanosomiasis control programme in West Africa was now being extended to cover human trypanosomiasis.

The Executive Board had adopted resolution EB99.R20 containing a draft resolution for consideration by the Health Assembly.

Dr DE LA MATA (Spain) proposed that in paragraph 2(2) of the draft resolution the words "FAO and OAU" should be replaced by "FAO, OAU and other international agencies including UNICEF and UNDP".

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA50.34.
Paragraph 2(3) should mention the existence of the card agglutination test for antibodies, which was valuable in the diagnosis of African trypanosomiasis.

Dr OTOO (Ghana) said that for many years there had been no cases of African trypanosomiasis in his country and accordingly no surveillance activities. However, there were now indications that the disease was about to return and surveillance would therefore have to be resumed with the cooperation of the veterinary services. He called upon WHO to mobilize resources to support Member States in their surveillance and control programmes. He supported the draft resolution.

Mr EISS (United States of America) expressed support for the draft resolution. Cooperation between international agencies was important if African trypanosomiasis was to be controlled successfully. WHO’s proposed action, including the maintenance of stocks of supplies and equipment, would clearly have resource implications, on which he would welcome further information. Existing drugs were too expensive for the countries most affected, were sometimes toxic and were generally ineffective against the late stages of infection. More research was needed, particularly in the areas of drug development and evaluation.

Dr BIKANDOU (Congo) said that African trypanosomiasis was re-emerging in parts of his country where it had been eliminated and was spreading to new areas. The Government’s control programme aimed at reducing prevalence through active screening in foci of infection by a joint central-level and intermediate-level team. Screening and treatment centres had been established in affected areas, and former foci of infection were being watched for re-emergence of the disease. Vector control programmes were also being established. He called upon WHO to continue its assistance to national trypanosomiasis control programmes.

Dr HENDERSON (Assistant Director-General) said delegates’ comments had been noted. Trypanosomiasis was a terrible disease for those communities affected and WHO was making every effort to mobilize international support in order to reinforce national control programmes.

With the agreement of Dr de la Mata he suggested that her proposals to amend the draft resolution might be altered to reflect the situation more precisely. In paragraph 2(2), “establish closer links with FAO and OAU” would thus be amended to read: “reinforce its links with FAO, OAU and other international agencies, including UNICEF”. Paragraph 2(3) would be amended by inserting “and diagnostic reagents” after “drugs”.

The draft resolution recommended in resolution EB99.R20, as amended, was approved.

2. THIRD REPORT OF COMMITTEE A (Document A50/38)

Dr ZOBRIST (Switzerland), Rapporteur, read out the draft third report of Committee A.

The report was adopted.¹

The meeting rose at 11:40.

¹ See page 238.
TWELFTH MEETING

Wednesday, 14 May 1997, at 9:00

Chairman: Dr R. CAMPOS (Belize)

1. FOURTH REPORT OF COMMITTEE A (Document A50/42)

Dr ZOBRIST (Switzerland), Rapporteur, read out the draft fourth report of Committee A.

Dr STAMPS (Zimbabwe), referring to paragraph 1 of the draft resolution on African trypanosomiasis, asked whether the Health Assembly was competent to urge Member States in endemic areas to act through agencies other than WHO.

Ms MAZUR (Office of the Legal Counsel), responding affirmatively, explained that the paragraph in question referred to a joint project of WHO and other agencies. WHO frequently collaborated in that way with other organizations.

The report was adopted.¹

2. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 9:20.

¹ See page 238.
COMMITTEE B

FIRST MEETING

Tuesday, 6 May 1997, at 14:30

Chairman: Dr T. TAITAI (Kiribati)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 21 of the Agenda (Document A50/27)

The CHAIRMAN expressed gratitude for his election and welcomed all those present. He then drew attention to the third report of the Committee on Nominations (document A50/27) in which Dr M.N. Savel’ev (Russian Federation) and Dr S.R. Simkhada (Nepal) were nominated for the offices of Vice-Chairmen of Committee B and Dr W. Ammar (Lebanon) for that of Rapporteur.

Decision: Committee B elected Dr M.N. Savel’ev (Russian Federation) and Dr S.R. Simkhada (Nepal) as Vice-Chairmen and Dr W. Ammar (Lebanon) as Rapporteur.2

2. ORGANIZATION OF WORK

The CHAIRMAN suggested that the normal working hours should be from 09:00 to 12:30 and from 14:30 to 17:30.

It was so agreed.

3. FINANCIAL MATTERS: Item 22 of the Agenda

Interim financial report on the accounts of WHO for 1996 and comments thereon of the Administration, Budget and Finance Committee; External Auditor’s report on his work: Item 22.1 of the Agenda (Resolution EB99.R5; Documents A50/8 and Add.1, A50/22, A50/23 and A50/24)

Mr AITKEN (Assistant Director-General), introducing the interim financial report for 1996 (documents A50/8 and Add.1), recalled that since the adoption of biennial budgeting, there had been interim reports in even-numbered years, followed by final reports covering the entire previous two-year period in odd-numbered years. Unlike final reports, interim reports, being in essence mid-biennium progress reports, were not subject to external audit opinions.

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1 See page 236.
2 Decision WHA50(4).
In terms of its overall financial situation midway through the current biennium, WHO was making reasonable progress towards meeting its financial programme for 1996-1997. As a measure of financial prudence, a 2.5% (US$ 21 million) holdback on expenditure had been imposed, on the ground that payment of contributions up to that amount was likely to be delayed beyond the end of the forthcoming biennium. A highlight of the regular budget accounts for 1996 (document A50/8) had been the reduction in internal borrowing: the figure of US$ 178 million for the 1994-1995 period had been brought down to some US$ 13 million as a result of payments made by Member States. However, the overall contribution situation was still by no means ideal. The rate of collection of contributions as at 31 December 1996 had been 77.7% in comparison to 56.3% at the end of 1995; thus there was still a shortfall of approximately 20% and Member States were being urged to meet their current obligations. At the end of 1996, the overall cash flow situation had been positive and had showed a surplus of over US$ 30 million. Hence the regular budget could be described as reasonably on course, although it was serious that some contributions were still not being paid on time.

The detailed report on extrabudgetary and voluntary contributions (document A50/8 Add.l) showed that estimates of contributions expected in 1996 had been fairly accurate; there had been no substantial increase at a time of budgetary restraint. The largest growth sector had been that of emergency assistance. The considerable length of the document was due to the legal obligation to provide full details of any extrabudgetary expenditure in both interim and final accounts. However, some of WHO’s sister organizations had stopped producing such interim accounts.

The previous year, 1996, had been the first in which the current External Auditor had worked with the Organization. Cooperation between Mr Kluever and his team and WHO had been good. The Secretariat had already made some preliminary comments on the External Auditor’s report, but would also, as was customary, be submitting a further report on the matter to the Executive Board at its January 1998 session.

He drew attention to two comments in the report of the Administration, Budget and Finance Committee of the Executive Board (document A50/24) to which the Secretariat would be responding. Firstly, the Committee had felt that an effort should be made before presentation of the final accounts to iron out the divergence of views apparent in some instances between the reports of the External Auditor and of the Secretariat. Secondly, it had expressed the wish that establishment of an audit committee, as suggested by the External Auditor, should be explored and a report on the matter submitted by the Secretariat to the Executive Board at its January 1998 session. There had been some differences of opinion with the External Auditor concerning both accounting and policy, but he was confident that every effort would be made to resolve them during the coming year.

Mr KLUEVER (External Auditor), introducing his interim financial report on the accounts of WHO for 1996 (document A50/22), said that in his experience it was unprecedented for the head of an organization to comment (as had been done in document A50/23) on such a report. The practice would serve only to confuse the Health Assembly. Although the question of closer and more frequent communication between WHO and his office could be pursued further, concentration on that aspect might well divert attention from substantive findings. Moreover, his staff had gone to considerable lengths to ensure proper communication, using a mix of formal and informal contacts as deemed appropriate to circumstances in the regions and at headquarters. Further communication would not have changed the thrust of the findings, which had been reached by due process, as set out in the Financial Regulations. He hoped that establishment of an audit committee would help to overcome such difficulties in future.

His report had to be viewed in the light not only of the Financial Regulations but also of a number of Health Assembly resolutions, in particular resolution WHA46.35, in which the Director-General was requested to improve budget and accounting processes, inter alia, in line with United Nations common accounting standards, clarifying and simplifying presentation and allowing closer monitoring of progress towards realistic and measurable targets. He continued to favour greater involvement of Member States in overseeing the finances of the Organization, as that would facilitate timely communication and allow appropriate action to be taken. While agreeing with the Director-General’s claim in paragraph 11 of document A50/23 that the Organization’s accounting system was generally reliable and accurate, he emphasized that the matters dealt with in his report were not just routine issues, such as the recording of basic accounting transactions, but indicators of possible material weaknesses calling for consideration and action.
He stressed that the interim financial report for the year 1996 was unaudited, as could be inferred from section 1 of his report; that information would appear on the title page of future interim reports. In section 4.1 of his report, he had argued that it was vital to establish an audit committee. Such a committee should provide a forum to deal with complex technical auditing and accounting questions without becoming involved in policy matters or management tasks. He had forwarded draft guidelines for the establishment of the committee to the Director-General during the initial stages of the audit. As noted in section 4.3 of his report, it might be advisable for the proposed reforms of internal audit and oversight functions to be entrenched by Health Assembly approval of their addition to the Financial Regulations.

Perhaps the most serious problem concerned financial statements (section 5), which were extremely difficult to understand in their current format. The proposed new format would improve transparency as well as understandability. The United Nations common accounting standards were clearly designed to achieve more than just comparability and uniformity, and the governing bodies of the Organization could legitimately be expected to be involved in the reforms required by the common standards, which needed to be defined clearly in advance to all stakeholders. So far, he had seen no evidence of structured progress in that direction by the Organization. No amount of detailed disclosure subsequently could remedy inappropriate accounting and reporting in financial statements.

With regard to management arrangements (section 6.1), he remarked that visits to the regions, observations at headquarters, management reports rendered and responses received indicated that the pace of renewal needed to improve budgeting and accounting was a cause for concern. Another concern with regard to the financial situation (section 6.2) was that the treatment of internal borrowing in interim reports was inconsistent with that in final reports and could lead to confusion.

On the question of bulk purchasing (section 6.6), he cited a written reply to his earlier inquiries admitting that much remained to be done to ensure that the benefits of bulk purchasing, particularly with respect to computers, would be noticeable by the end of the current biennium. Although he had been informed in November 1996 that no further action was planned to establish a code of purchasing ethics and register of financial interests, some action had recently been taken and progress was being monitored. With regard to inventory control (section 6.7) there was still a possibility that there would be insufficient evidence available for the required disclosure in financial statements at the end of the current biennium.

He had carefully considered the largely informative comments of the Director-General, and found that they did not refute the evidence of the audit; he was satisfied with the content, context and factual accuracy of the report he had submitted.

Mr MOUT (Netherlands) said that a more timely distribution of the relevant documents would contribute to better informed debates. With regard to the format of the interim financial report, he suggested it should be broken down into the 19 categories of major programmes to facilitate comparison with the programme budget. The question of internal borrowing was confusing; Mr Aitken had said that the level of internal borrowing was US$ 13 million, while the Administration, Budget and Finance Committee put it at US$ 14.2 million in paragraph 6 of its report (document A50/24). He asked the External Auditor how the level of internal borrowing for 1996 would have compared with the level of the previous year if both had been calculated using the same method. What was the most appropriate method to use in that regard? He hoped that the questions the External Auditor had raised in relation to procurement would be solved before the end of the current biennium.

Mr KNOTT (Australia) said that the main problem with the interim financial statement was not what was in it but what was missing from it; it had fallen behind reforms elsewhere in the Organization. He therefore warmly welcomed the approach taken by the External Auditor, which helped to bring complex matters into focus, and hoped he would continue to submit reports on an annual basis. He asked for clarification of the apparent discrepancy between the “utmost seriousness” with which the situation concerning assessed contributions was viewed in the last sentence of paragraph 5 of the interim financial report (document A50/8) and the relatively low figure given, and would appreciate figures allowing comparison of the situation at end 1996 with that at the end of 1994. He was concerned that internal borrowing, which was at a high level and showed no signs of falling, had not been paid off by the end of the first year of the biennium and that the US$ 31 million in the Working Capital Fund remained fully drawn. Not only was there a need for greater comparability between interim and biennial financial statements, there was also a need for greater understandability and transparency.
Mrs BEAULIEU (Canada) endorsed the comments of the delegate of Australia, in particular, his request that the External Auditor should continue to report annually on significant matters. She would welcome an explanation of how internal borrowing was calculated; the amount should be consistent with that given for the end of the previous biennium. The problem of obligations for items which were planned but not necessarily committed activities should also be tackled. She asked for the most recent estimate for the figure expected to accrue in 1997 as a result of exchange rate fluctuations.

Mr POINSOT (France) agreed that it was regrettable that WHO should have to resort to internal borrowing every year, but pointed out that that situation was not the result of any uncontrolled spending on its part, but was rather due to the fact that assessed contributions were not being paid regularly, so that there was no other way of balancing the budget. The problem was a fundamental one. As he saw it, once Member States had adopted a budget, and had asked an Organization to put in place a certain number of programmes, it was up to them to take responsibility for the consequences of their decision and to pay their assessed contributions. That was part of the basic philosophy of United Nations budgeting. It would be dangerous to resort to what was, in a sense, a reverse procedure, and to ask organizations to base their budgets on their expected income, which was entirely at variance with United Nations traditional practice. France supported the proposal for the establishment of an audit committee, and agreed that the question should be further explored by the Executive Board, since it was not within the remit of the Administration, Budget and Finance Committee. It also considered that the submission of an annual external audit report would be a very useful exercise.

Mr KRIEBLE (New Zealand) endorsed the views of France and Canada on the question of an annual external audit report, and also endorsed the recommendation that an audit committee should be set up to help the Secretariat improve the quality of its financial statements. WHO should be in a position to know what it earned, spent, owned and owed; that would help it deal, for instance, with the problem of inventory control referred to by the External Auditor in paragraph 6.7 of his report.

He stressed that accounting matters were not merely of technical interest, but were fundamental to good management practice, in that they enabled decisions to be taken to maximize resources for health programmes and health initiatives throughout the world.

Dr RAHIL (Libyan Arab Jamahiriya) suggested that in view of the lack of expertise of many Member States in accounting matters, a small group should be set up to work with the External Auditor, which could subsequently report to the Health Assembly.

Mr BOYER (United States of America) supported the suggestion that a report by the External Auditor should become a regular feature of the Health Assembly. He had been struck by the somewhat caustic tone of the Director-General’s comments on the External Auditors’ report, and would have preferred a less defensive response. However, he would encourage the Director-General to continue to give written replies to points raised in that report, since those replies would be helpful to delegates in focusing on the issues before the Health Assembly. He also supported the proposal to establish an audit committee, which should consist of delegates with some experience of financial matters.

He had been struck by the statement in paragraph 5 of the interim financial report that in 1996 there had been a contribution shortfall of US$ 93 million, that by the end of the year the Working Capital Fund had been totally depleted, that WHO had been obliged to resort to internal borrowing to implement the approved programme budget, and that the Director-General had had to maintain a contingency reserve of US$ 21 million. He had also been concerned to learn that 63 Member States had made no payment whatever in 1996, that by the end of that year 41 had made no payment for over two years, and that 27 had lost the right to vote at the current Health Assembly. He had also been concerned to learn that 63 Member States had made no payment whatever in 1996, that by the end of that year 41 had made no payment for over two years, and that 27 had lost the right to vote at the current Health Assembly.

The United States was proposing a 5% reduction in the WHO budget for 1998-1999 in order to bring assessments down to a level at which Member States could afford to pay, thus reducing the need for internal borrowing. He noted that the level of casual income earned at the end of 1996 had been higher than anticipated, and suggested that the Health Assembly should decide to use as large a share as possible of that money to help in reducing the assessments of Member States. In view of the difficult financial situation, it was not the right time for WHO to embark on capital expenditure in the form of construction of a new office building.
Referring to the consolidated statement of income and expenditure contained in Statement II of the interim financial report, he said that he was puzzled by the figures under section 3.1 indicating that US$ 17 million was being held at the end of 1996 for the Global Programme on AIDS, although that programme had ceased to operate a year earlier. Paragraph 7 stated that WHO had had a cash balance of US$ 37 million at the end of 1996, which seemed surprising in view of the earlier statement that it had had to resort to internal borrowing and had had to impose a contingency reserve because of the contribution shortfall.

The report also indicated that there had been a serious decline in extrabudgetary contributions by governments from US$ 230 million in 1995 to US$ 167 million in 1996, a drop of 32%. Contributions to the Voluntary Fund for Health Promotion had fallen from US$ 145 million to US$ 119 million, and those to the Onchocerciasis Control Programme from US$ 20 million to US$ 15 million. Only contributions to the Special Programme for Research and Training in Tropical Diseases had defied that trend with an increase of 61%, largely due to support from the Nordic countries. He would appreciate comments from the Secretariat on the reasons for the overall decline. Could extrabudgetary programmes generally be expected to suffer the same shortfall as regular budget programmes, and were there any steps Member States could take to remedy the situation?

Dr SUZUKI (Japan), agreeing that the establishment of an audit committee would help the many participants in the Health Assembly who were not familiar with accounting practices to become better informed, remarked that the creation of a new body might impose an additional financial burden, and suggested as an alternative that the Administration, Budget and Finance Committee might be asked to make a preliminary review of the External Auditor's report and report back to the Health Assembly.

Japan shared the views of France on the matter of internal borrowing - a useful facility to which the Director-General could resort, if so authorized by the Health Assembly, in order to cope with financial problems caused by delayed payment of assessed contributions, and which would not affect the soundness of WHO's financial management, provided that the unpaid contributions were collected in reasonable time. Unpaid assessments, for which internal borrowing was a compensation, represented the debts of Member States: the Organization itself was not at fault. If internal borrowing were to be ruled out or unduly restricted there would be serious management problems and, for example, cuts in programme implementation at country level.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland) considered the practice of having the External Auditor present an interim financial report to be useful and well worth repeating, and one which should lessen the risk of unpalatable surprises in years when full reports were considered by the Health Assembly. The proposal for an audit committee was an interesting one, and the Secretariat should continue to discuss with the External Auditor ways of improving communication between themselves and with Member States. He, too, had been surprised at the tone of some of the Secretariat's comments on the report, and notably by the assertion that difficulties in working relations had been due to insufficient understanding of methods of work which had stood the test of time, some dating from as far back as 1980. Working methods ought not to be judged by their age, but by their efficacy.

While he could accept the practice of internal borrowing as a prudent and necessary management tool, he would urge the exercise of proper control over its use.

Dr SAMBA (Regional Director for Africa) recalled that the External Auditor's report to the Committee some two years earlier had been very critical of the African Region: he himself, as Regional Director, had promised that everything possible would be done to ensure that future reports were less negative. Immediately following the visit by the External Auditor's team to Africa, a committee had been set up to implement its recommendations. Action had now been taken, for instance, to ensure that Member States were more involved in the audit exercise by having copies of all relevant correspondence exchanged forwarded to them. As a result, there had been improvements in three of the major problem areas highlighted by the External Auditor: the question of local cost subsidies had been squarely addressed; accounting backlogs had been eliminated; and whereas two years earlier only four States of the Region had had properly functioning fellowship committees, 43 had now established such bodies. He thanked the new external auditors for their help in making their work comprehensible to non-specialists, and voiced the hope that in the foreseeable future all audit reports on Africa would be positive.
Mr KLUEVER (External Auditor) welcomed the expressions of support for the recommendations contained in his interim report.

The problem of comparability of internal borrowing figures had been caused by differences in the treatment of unliquidated obligations. Certain calculations had been made in that regard, but could not be divulged because agreement had not yet been reached with the Secretariat concerning the exact figure. Reminding the Committee that the financial statements included in the interim financial report for 1996 had not been audited, he suggested that queries in that connection should most properly be addressed to the Director-General, rather than to the External Auditor.

Mr AITKEN (Assistant Director-General), in response to the request by the delegate of the Netherlands for a more detailed presentation of the accounts by programme, said that a full breakdown by programme headings was normally only given at the time the final accounts were presented every second year, and not in the interim report.

As to the matter of internal borrowing, he explained that the first figure given to the Administration, Budget and Finance Committee had been for 1994-1995, at a period when, because the major contributor had paid nothing, the Organization had been constrained to borrow up to US$ 178 million. By the time of that Committee’s meeting in the previous week, that figure had been reduced to US$ 14 million, and it now stood at some US$ 13 million, thanks to further arrears payments. It was true, as the delegate of Australia had pointed out, that the amount in question was still outstanding more than a year after the period to which the internal borrowing applied; but the Secretariat was relieved that the amount had fallen so significantly.

It should be remembered that the External Auditor had been referring in his interim report to internal borrowing in the course of a biennium. The Organization had adopted biennial accounting some 20 years earlier, so that programmes were budgeted for and delivered, and accounts were presented, on a biennial basis. By definition, interim reporting at the half-way point could not give the whole picture; the call for such reporting imposed on the Secretariat the difficult task of treating a biennium both as a single entity and on a “year-plus-year” basis.

Responding to the remarks by the delegate of the United States of America, he said that obligations entered into for an entire two-year period had to be accounted for, whether or not the monies in question had actually been disbursed. Figures for internal borrowing therefore showed all of WHO’s financial obligations on paper, but not all of its actual disbursements. The cash flow situation, on the other hand, showed the amount of money in WHO’s accounts at a given time. It was logical to have a cash balance (positive) in the accounts, and at the same time to show, on paper, possible internal borrowing (negative) to meet future bills. During the course of a biennium, however, the amount of the internal borrowing was not as critical to the delivery of the Organization’s programme as it was at the end of the biennium period. In short, his principal contention was that biennial budgeting and accounting must go hand in hand. Although it was quite in order for the External Auditor to report on an interim basis on the broader aspects, a request for annual accounting for a biennial budget would make it difficult to deliver a biennial programme. He pointed out that because so few Member States were prompt in paying their assessed contribution in full, on 1 January of the first year of a biennium the Organization would be regarded as internally borrowing hundreds of millions of dollars because it opened two-year obligations for staff salaries in anticipation of monies due. What needed to be looked at, perhaps, and presented more clearly in the reports to WHO’s membership, was whether those monies were coming in over the first 12 months or during the totality of the two-year exercise.

In response to questions concerning a code of ethics for procurement, he said that WHO had considered existing staff regulations and rules to be adequate. However, the United Nations had decided to expand its own code of ethics, and WHO had agreed to consider its proposals, including the possibility of requiring financial declarations by senior staff and staff in positions particularly at risk. If and when a common view was reached within the system, it would be necessary to modify the Organization’s staff regulations and rules accordingly.

The amount of casual income likely to accrue as a result of currency fluctuations in the current year was estimated as being in the region of US$ 18 million, provided there was no significant change in exchange rates.

With regard to monies still accruing to the Global Programme on AIDS, which had been wound up at the end of 1995, he recalled that a sum had had to be set aside pending the outcome of an appeal by staff members whose positions had been terminated with the demise of the Programme. In addition, a small amount had been set aside, with the approval of UNAIDS, to wind up the final accounts of the Global Programme on AIDS. Almost all of the remaining balance had, however, already been transferred to the UNAIDS programme.
With reference to extrabudgetary resources, the table on page 28 of document A50/8 Add.1 set out contributions since the inception of the Voluntary Fund for Health Promotion. From 1995 to 1996 the fund had been about US$ 5 million down, although some US$ 40 million had additionally been pledged. In reply to the more specific question by the United States delegate concerning the decline in contributions by governments to WHO's special programmes, he said that monies received for HIV/AIDS activities were no longer recorded as accruing to WHO; such contributions, which amounted to some US$ 120 million per biennium, were credited to a separate UNAIDS account, maintained by WHO. Other government contributions for 1996 would be the subject of a report to the forthcoming session of the Executive Board, during the analysis of the extrabudgetary resource situation.

The resolution recommended by the Administration, Budget and Finance Committee of the Executive Board in its first report (document A50/24) was approved.¹

Mr NGEDUP (representative of the Executive Board) recalled that the Director-General had proposed that the sum of US$ 100 000 in the Executive Board Special Fund, which had not been tapped since 1977, should be transferred to the Special Account for Disasters and Natural Catastrophes in the Voluntary Fund for Health Promotion to supplement voluntary contributions used in emergency and humanitarian actions. Since most of WHO's activities in emergency situations were financed through voluntary contributions and resources provided by relief agencies under the Voluntary Fund, the requested transfer would be fully justified from both the operational and the administrative points of view. The Executive Board therefore commended for adoption by the Health Assembly the resolution contained in resolution EB99.R5.

The resolution recommended by the Executive Board in resolution EB99.R5 was approved.²

Status of collection of assessed contributions including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: Item 22.2 of the Agenda (Resolution EB99.R3; Documents A50/9 and A50/10)

Mr NGEDUP (representative of the Executive Board) said that the Director-General's report on the status of collection of assessed contributions as at 31 December 1996 had been reviewed by the Executive Board at its ninety-ninth session. The Board had expressed deep concern at the level of outstanding contributions and the impact of the shortfall on the programme of work approved by the Health Assembly. The Board had noted: that at 31 December 1996, the rate of collection of 1996 contributions in respect of the effective working budget had amounted to 77.72%, which had resulted in a contribution shortfall of US$ 93 394 425; that only 102 out of 190 Members and two Associate Members contributing to the effective working budget had paid their 1996 contributions in full; that 63 Members had made no payment towards their 1996 contributions; that unpaid arrears of contributions to the effective working budgets for 1995 and prior years exceeded US$ 76 000 000; and that consequent to the adoption (by resolution WHA41.12) of an incentive scheme to promote the timely payment of assessed contributions, those Members which paid their assessed contributions early in the year in which they were due would have their future contributions notably reduced, whereas Members which paid late would see their contributions only slightly reduced, if at all.

In view of the Organization's financial situation, the Board had proposed that those Members which regularly paid their contributions late should make every effort to ensure prompt and regular payment. The text of a draft resolution for consideration by the Health Assembly was recommended in resolution EB93.R3. The Director-General's report to the Executive Board's January 1997 session showed the status of Member States' financial indebtedness to the Organization as at 31 December 1996. The status of contributions as at 30 April 1997 was shown in document A50/9.

Mr AITKEN (Assistant Director-General) said that at the end of April 1997, 33% of total contributions had been received. Subsequently, just over US$ 2 million in payment of their 1997 contribution had been

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.5.
² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.6.
received from 10 Members: Belize, Cook Islands, El Salvador, Ghana, Greece, Guyana, Jamaica, Lao People’s Democratic Republic, Mongolia and Turkey. In addition, almost US$ 8 million had been received in respect of arrears since 30 April 1997 from Antigua and Barbuda, Brazil, Cuba, Ecuador, Guatemala, Haiti, Jamaica, Lithuania, Madagascar, Mauritania, Peru, Romania, Russian Federation, Togo and Turkey. Countries which had commendably and consistently paid in full, either on the due date or in advance, over the past five years included: Bhutan, Brunei Darussalam, Canada, Egypt, Indonesia, Kuwait, Mauritius, Myanmar, New Zealand, Saint Lucia, Sweden, Tonga and Zimbabwe; he hoped that others would emulate their performance.

Paragraph 10 of the second report of the Administration, Budget and Finance Committee (ABFC) of the Executive Board (document A50/10) contained a draft resolution concerning a number of Members in arrears in the payment of their contributions to an extent which would justify the suspension of their voting rights. Since the meeting of ABFC on 2 May 1997, Togo had, however, made sufficient payments to warrant automatic restoration of its voting rights.

Since Guatemala and Haiti had also made additional payments and were consequently no longer at risk of losing their voting rights, their names should be deleted from the list of countries in paragraph 6(1), and a further preambular paragraph should be inserted immediately prior to paragraph 1, to read:

Having been informed that as a result of payments received after the opening of the Fiftieth World Health Assembly, the arrears of contributions of Guatemala and Haiti have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

Two other draft resolutions recommended by ABFC concerned Cuba and Bosnia and Herzegovina. The governments of both countries had written to the Director-General requesting a scheduled payment plan whereby their voting rights would be restored subject to a commitment to pay their current contributions in full as well as a tenth of their arrears each year for the next 10 years. There were precedents for such plans; the Organization had last been requested to approve one some 10 years previously.

Professor LI Shichuo (China) said that the status of collection of contributions as at 30 April 1997 remained a cause for serious concern. Although the amount collected was higher than that collected by 30 April 1996, it was still one of the lowest figures for 10 years, and total arrears amounted to some US$ 191 million in 1996. Three Member States together owed as much as US$ 97 million, and they could hardly be described as developing countries. China had always insisted that Members be urged to honour their obligations in timely fashion, particularly if they had strong economies. Even partial arrears had a considerable impact on WHO’s activities. Regarding suspension of voting rights, the same standards could not be applied to every case. Certain developing countries experiencing particular difficulties should be granted an extension in arrears payments. China supported the draft resolutions concerning Cuba and Bosnia and Herzegovina which reflected such a spirit of flexibility and understanding.

Mr VAN REENEN (Netherlands), rising to a point of order, said his delegation did not wish to stand in the way of debate on the main part of document A50/10 and on the corresponding draft resolution. It wished, however, consideration of the requests contained in Annex 2 to be postponed for at least 24 hours to allow delegations more time to examine the matter, which had only just been brought to their attention, and to seek instructions from their governments.

Mr ROBERTSON (Australia) said that as the Health Assembly embarked on its consideration of the proposed programme budget, the time was ripe for reflection on the fact that support for the budget, including the cost increase component, must be directly translated into a commitment to pay. On 30 April 1997, arrears had amounted to almost US$ 165 million, equal to approximately 15% of the biennium budget - a continued source of concern. WHO appeared incapable of acquitting itself of what had become an embedded, underlying debt offering no immediate prospect of being significantly reduced and appearing, on the contrary, to be growing.
While welcoming the efforts of Bosnia and Herzegovina and Cuba to pay their arrears, Australia sought an assurance that they would adhere strictly to the conditions contained within the proposed resolutions. Their situation could perhaps be reviewed on a two-yearly basis.

Agreeing with the previous speaker that Members needed adequate time to consider requests for special treatment, he suggested that such applications might be examined at the January sessions of the Executive Board.

In response to a question by Ms KIZILDELI (Turkey), Mr TOPPING (Legal Counsel) said that the references to Bosnia and Herzegovina and Cuba in the third preambular paragraph of the draft resolution recommended in paragraph 10 of document A50/10 reflected existing circumstances, and were of no new legal import.

The resolution recommended by the Administration, Budget and Finance Committee of the Executive Board in paragraph 10 of its second report (document A50/10), as amended, was approved.\footnote{Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.5.}

The resolution recommended by the Executive Board in resolution EB99.R3 was approved.\footnote{Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.6.}

The CHAIRMAN said that discussion of the draft resolutions on the proposals by Cuba and by Bosnia and Herzegovina (document A50/10, Annex 2) would be resumed at a later date.

(For continuation, see summary record of the second meeting, section 3.)

**Report on casual income: Item 22.3 of the Agenda (Document A50/11)**

Mr NGEDUP (representative of the Executive Board), introducing the item, said that the Board had been informed at its ninety-ninth session in January 1997 that the estimated balance of casual income available as at 31 December 1996 was US$ 27 689 514. As indicated in the interim financial report (document A50/8), the actual amount of casual income available as at 31 December 1996 had amounted to US$ 29 467 019. If account was taken of the recommendations of the Executive Board in resolutions EB99.R2, EB99.R6 and EB99.R7 that a total of US$ 16 850 000 of casual income be appropriated for the financing of the WHO worldwide management information system and to the Real Estate Fund, the available balance amounted to approximately US$ 12 617 000, which could be used to help reduce Members' assessed contributions to the regular programme budget for the coming biennium. The interest earned during 1995 and 1996 and credited to casual income, namely US$ 9 994 020 of the above sum, would be apportioned among Members in accordance with the financial incentive scheme adopted by resolution WHA41.12. The balance of US$ 2 622 980 would be deducted from appropriations for the 1998-1999 regular budget approved by the Health Assembly, prior to the calculation of assessed contributions for that financial period.

Mr AITKEN (Assistant Director-General) added that the three main uses of casual income recommended by the Executive Board to the Health Assembly would be specified in resolutions and discussed in committee. Committee A would consider a resolution recommended by the Board in resolution EB99.R2 concerning the financing of the WHO worldwide management information system within the framework of its examination of the proposed programme budget; Committee B would discuss the appropriation of casual income to the Real Estate Fund under a separate agenda item. The extent to which monies from casual income could help reduce Members' contributions had already been illustrated in Committee A. Under the present agenda item, Committee B was being asked to endorse the Director-General's proposal (document A50/11), which would then be taken forward to the substantive debate leading up to the adoption of the appropriation resolution.

Mr ROBERTSON (Australia) commented that for the first time in the decade, exchange rates had yielded a positive inflow to casual income, affording a welcome degree of flexibility. Two years previously, the Committee, foreseeing the situation, had decided that US$ 10 million, if available, would be allocated in each
year of the current biennium to priority country programmes. Applauding the fact that such a sum had indeed been allocated to country programmes in Africa in 1996, Australia looked forward to a further US$ 10 million being similarly allocated to priority country programmes during 1997.

He noted that the proposed deduction from appropriations for the 1998-1999 regular budget amounted to US$ 2.6 million - a rather disappointing figure when compared with the US$ 7.6 million in 1995.

Given that a major part of the WHO reform programme relied on improved information, Australia strongly supported the proposal to use a proportion of available casual income for the WHO worldwide management information system; it was - on the other hand - doubtful concerning the wisdom of regularly apportioning casual income to the Real Estate Fund.

Since it was likely that the strong flow of casual income would continue through the coming biennium, it was to be hoped that a reasonable proportion would be used to decrease the level of Members' assessed contributions.

Mr KOVALENKO (Russian Federation) endorsed the previous speaker's remarks. There had been a disquieting tendency in recent years to treat casual income as a second budget to meet expenditures which should ordinarily be covered by the regular budget. Currently, an insignificant amount of available casual income was being used for what should be its main purpose: to reduce Members' assessed contributions over and above any reductions arising from the incentive scheme, the objective being to alleviate the burden on those Member States which were not in a position to meet arrears and which had thereby lost or were being threatened with loss of their voting rights.

Mr BOYER (United States of America) remarked that any decision regarding the use of casual income to finance the regular budget would depend on the fate of the proposals contained in resolutions EB99.R2, EB99.R6 and EB99.R7, which had yet to be discussed; it would thus be premature for the Committee to come to any conclusion on the figures proposed in document A50/11.

Mr AITKEN (Assistant Director-General) acknowledged that the general use of casual income was a matter which lay at the discretion of the Health Assembly. As the Australian delegate had pointed out, the Forty-eighth World Health Assembly had decided that US$ 20 million of such income would be allocated to priority country-level programmes during 1996-1997. A total of US$ 10 million had indeed already been allocated to malaria control in Africa, and it was likely that a further US$ 10 million would be available for such programmes at the end of 1997, in accordance with the decision of the Health Assembly.

He fully understood the concern voiced by Australia and the Russian Federation that casual income should also be used to reduce the contributions of Member States, and called attention to the fact that the total reduction in appropriations being proposed from casual income was already 6.5% more than in the previous biennium.

Concurring with the delegate of the United States of America that the three draft resolutions recommended by the Executive Board in connection with the use of casual income would have to be considered before the amount to be deducted from appropriations could be determined, he suggested that the Committee might wish to take note of the proposal by the Director-General in document A50/11; delegates could return to the matter during the budget debate in Committee A.

Ms PERLIN (Canada) echoed the notes of caution voiced by the delegates of Australia and the Russian Federation. Casual income should be returned to Member States, and must not be treated as just another source of regular programme budget funding. Member States might, however, decide that casual income could be used for exceptional purposes or for special initiatives; there existed a number of precedents in that connection. It would be preferable if management information services were financed under the regular budget since they properly constituted “technical improvements”, which were a part of office management and administration.

The CHAIRMAN asked whether the Committee wished to take note of the proposal for the use of casual income available as at 31 December 1996, as contained in document A50/11.

It was so agreed.

The meeting rose at 17:30.
SECOND MEETING
Wednesday, 7 May 1997, at 14:30
Chairman: Dr T. TAITAI (Kiribati)

1. SCALE OF ASSESSMENTS: Item 24 of the Agenda

Assessment of new Members and Associate Members: Item 24.1 of the Agenda (Document A50/12)

Mr AITKEN (Assistant Director-General), introducing document A50/12, which contained a draft resolution on the assessment of Andorra, said that, in accordance with usual practice concerning Members of the United Nations which became Members of the World Health Organization, Andorra would be assessed on the basis of its assessment under the latest United Nations scale at an annual rate of 0.01%, reduced to eleven-twelfths of 0.01% for 1997, its year of admission to WHO.

The draft resolution contained in document A50/12 was approved.¹

Scale of assessments for the financial period 1998-1999: Item 24.2 of the Agenda (Document A50/13)

Mr AITKEN (Assistant Director-General) said the scale of assessments proposed for the coming biennium was based on the latest United Nations scale available, which was the 1997 scale, adjusted mathematically to take account of WHO's larger membership. A revised scale for the second year of the biennium, 1999, could be approved by a vote of the Health Assembly at its next session if Members wished to take into account subsequent changes in the United Nations scale. A draft resolution was submitted in paragraph 6 of document A50/13.

Mr UEDA (Palau) said that, in the Annex to document A50/13, his country was erroneously flagged as not being a Member of the United Nations; the error should be corrected to reflect the fact that Palau had joined the United Nations in December 1994.

Mr AITKEN (Assistant Director-General) said that would be done.

Mr MOEINI (Islamic Republic of Iran) expressed concern at the level of assessment assigned to his country in the Annex to document A50/13. The United Nations General Assembly was expected to approve a new scale of assessments at the end of 1997, and the draft resolution should be amended to indicate that WHO's scale of assessments for 1998 should be adjusted to match exactly the new United Nations scale.

Mr BOYER (United States of America) introduced an amendment proposed by the delegations of the Russian Federation and the United States of America to the draft resolution contained in document A50/13. The following new paragraph 3 would be added:

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA50.9.
3. REQUESTS the Director-General to adjust the WHO scale of assessments for the years 1998 and 1999 to reflect any new scale of assessments for those years fixed by the United Nations General Assembly at its fifty-second session, if such a new scale, when applied to WHO in accordance with principles established for adjusting the WHO scale of assessment to take into account differences in membership, results in a scale different from that contained in paragraph 1. Requests for payment to Member States for the first year of the biennium would be in accordance with the scale of assessments in paragraph 1 of this resolution. Requests for payment to Member States for the second year of the biennium would be adjusted to take into account the contribution that would have been payable under the revised scale of assessments for 1998, as well as the revised scale for 1999.

According to the draft resolution contained in document A50/13, the changes mentioned by the delegate of the Islamic Republic of Iran could only be followed up by the Organization with effect from 1999. The proposed amendment would allow the Director-General to align WHO's scale with the new United Nations scale of assessments in both 1998 and 1999 by retroactively taking any changes into account when requesting payment in 1999. He understood that a number of countries stood to benefit from lower assessment rates under the proposed changes and it was logical that the Organization should adopt the new scale at the same time as the United Nations, as it was, generally speaking, the same governments voting for the changes in the two bodies.

Mr MOUT (Netherlands), speaking on behalf of the Member countries of the European Union, proposed that a decision on the proposed amendment be taken at the same time as the decision on the adoption of the 1998-1999 programme budget, as the two subjects were closely related. However, the proposed amendment would create unnecessary uncertainty and retrospective payment might run counter to the domestic budgetary procedures of Member States; there was no need for a departure from the current rules.

Mr KANEKO (Japan) said that resolution WHA24.12 clearly stated that it was the latest available United Nations scale of assessments which should be used as a basis for the Organization's scale. It would be unwise and unprecedented to base the latter on an unknown and as yet undetermined quantity. That would compromise the independence of the Organization, and could negatively affect the collection of contributions. The Health Assembly was a supreme decision-making body with responsibility for determining the minima and maxima as well as the scale per se. Adjustment of the scale during the two-year budget cycle should be strictly limited to cases where new Members were admitted. Japan favoured the proposal by the Secretariat and believed that any discussion of changes adopted by the United Nations, and of a revision of WHO's own scale of assessments, for possible application from the 2000-2001 biennium, should be deferred until the Fifty-first World Health Assembly.

Mr JUDIN (Russian Federation) said that, if adopted, the scale proposed in document A50/13 would mark a departure from the basic principle that WHO should follow the prevailing United Nations scale. The amendment proposed by the Russian Federation and the United States of America was designed to remove that inconsistency by making it possible to reflect the revised scale that the United Nations General Assembly would adopt at the end of 1997. One of the fundamental principles on which contributions were assessed was a government's ability to pay. On that basis, it could be safely assumed that the United Nations General Assembly would make a wise decision which would significantly dispel concerns about unfairness in the current scale of assessments and indirectly reduce the number of countries deprived of, or threatened with the loss of their voting rights at the Health Assembly as a result of difficulties in paying their contributions; ability to pay was the best guarantee of a stable financial basis for the Organization. He urged the Committee to support the proposed amendment.

Mr ROBERTSON (Australia) agreed with the delegate of the Netherlands that further consideration of the matter should be deferred until the programme budget was discussed, adding that he saw some merit in the amendment proposed by the delegations of the United States of America and the Russian Federation, although it was important not to prejudge the outcome of negotiations at the fifty-second session of the United Nations General Assembly.
Mr AITKEN (Assistant Director-General) briefly summarized the various viewpoints that had emerged in the discussion. As to postponement of the item, he remarked that discussions on the programme budget could be lengthy; waiting for their outcome might leave the Committee short of time for the necessary debate on the scale of assessments.

The CHAIRMAN suggested that the debate might be deferred until the following day.

In response to a request for clarification by Mr MOUT (Netherlands), Mr AITKEN (Assistant Director-General) explained that such a deferral would allow those concerned to consult together and see if they could come closer to agreement.

Mr ROBERTSON (Australia) said that to adjourn the matter until the following day was unlikely to produce any changes of position; it might be preferable to postpone further debate until the Committee was better placed to assess the direction the budget discussions were taking.

Mr MOEINI (Islamic Republic of Iran) queried the relation between discussion of the budget and discussion of the scale of assessments. Whatever the level of the budget might turn out to be, the scale of assessments would not be affected. He did not see why consideration of the item needed to be postponed.

Mr MOUT (Netherlands) said that although there was no technical connection between the two issues, he believed there was a political relation. Clearly, the United States delegation was under pressure from Congress to adopt a position in relation both to the budget level and to the scale of assessments.

Mr JUDIN (Russian Federation), speaking on behalf of the cosponsors of the amendment to the draft resolution, said he was prepared to accept the proposal that further consideration of the issue be deferred until the beginning of the following week.

Mr MOEINI (Islamic Republic of Iran) thanked the delegate of the Netherlands for his explanation, but reiterated that his delegation's concern was with the scale of assessments for 1998-1999 as proposed in document A50/13, which could surely be discussed before the debate on the budget. At all events, Iran was not prepared to become involved in a political discussion.

Mr BOYER (United States of America) said that his delegation was not aware of any political pressure, but believed, like that of the Russian Federation, that postponement of the discussion would allow time for further reflection.

After an exchange of views on timing, in which Mr MOEINI (Islamic Republic of Iran), Mr AITKEN (Assistant Director-General) and Mr ROBERTSON (Australia) participated, the CHAIRMAN asked whether the Committee would agree to a 24-hour adjournment of the debate on item 24.2.

It was so decided.

(For continuation, see summary record of the fifth meeting, section 2.)


Dr SHIN (representative of the Executive Board) said that the Board had considered two reports by the Director-General concerning the use of the Real Estate Fund for various building projects.

The Board had noted the status of implementation of the approved projects for the period up to 31 May 1997, in particular, progress made in the replacement of the Local Area Network at headquarters. It had also noted that construction of the Caribbean Programme Coordination Office in Barbados had started, and that the costs were expected to be about 25% higher than previously estimated. The Director-General had presented
six projects for the Regional Office for Africa for financing from the Real Estate Fund and requiring an appropriation from casual income, covering the period from 1 June 1997 to 31 May 1998. The Board had adopted resolution EB99.R6, in which it recommended that the Fiftieth World Health Assembly authorize the financing of the proposed projects from the Real Estate Fund, and appropriate US$ 815 000 to that fund from casual income.

The second report on the Real Estate Fund, concerning the relocation of the Regional Office for the Eastern Mediterranean from Alexandria to Cairo, had been provided following a request from the Forty-ninth World Health Assembly that detailed logistical and financial implications of the proposal be established. The report had been reviewed by the Administration, Budget and Finance Committee, which had forwarded it to the Board with a favourable recommendation. After a discussion of the merits and costs of the proposal, the Board had adopted resolution EB99.R7, in which it recommended that the Fiftieth World Health Assembly authorize the financing of the proposed construction of a new building for the Regional Office in Cairo from the Real Estate Fund, and appropriate US$ 9.89 million to the Fund from casual income. The resolution also stipulated that that appropriation should be the maximum amount provided under the regular budget, the understanding being that extrabudgetary funding would have to be used if it did not prove sufficient.

Dr ZAHRAN (Egypt) said some considerable time had elapsed since the proposal for the relocation of the Regional Office for the Eastern Mediterranean from Alexandria to Cairo had first come up for discussion. The Egyptian Government had offered to donate land for the construction of the new premises, and had also offered to make a financial contribution. The proposal had been approved in principle by the Executive Board at its session in January 1996, and by the Forty-ninth World Health Assembly in May of that year. In January 1997 the Board, in resolution EB99.R7, had recommended that the Health Assembly authorize the necessary financing for the project. The Regional Office for the Eastern Mediterranean was alone in never having benefited from any appropriation from the Real Estate Fund. He urged the Committee to endorse the recommendation by the Executive Board, so that implementation of the project might begin.

Dr HAJAR (Yemen) urged all Member States to support the resolution recommended by the Executive Board. Its implementation would help to improve the performance of the Regional Office in accordance with the principles of justice and fairness that were the hallmark of the Organization. The countries of the Region wished to thank the Government of Egypt for its past generosity in making the premises at Alexandria available at a nominal rent.

Ms INGRAM (Australia) noted that WHO was still facing severe budget difficulties, with an underlying debt of over US$ 100 million; the Interim Financial Report (document A50/8) described the situation as being of the utmost seriousness. Against that background, future real estate projects needed to be critically reviewed to see whether expenditure could be deferred in order to preserve the limited funds available for priority programme activities.

While her delegation endorsed the first part of paragraph 3 of the recommended resolution, authorizing financing from the Real Estate Fund in the amount of US$ 9.89 million for the new premises in Cairo, it was not too happy with the formulation of the second part, according to which any costs over and above that estimate “would not be met from the regular budget of the Organization”. Australia’s understanding of the discussion in the Executive Board was that the Board would not wish any increase in expenditure to be covered from funds available for the regular budget; casual income, used to replenish the Real Estate Fund, could be so described, as the transfer, during the present biennium, of US$ 10 million from that income in support of priority country programmes showed. Accordingly, and to make the matter perfectly clear, Australia proposed that the wording be amended to read, “would be met from extrabudgetary resources”.

Dr BOUFFORD (United States of America) remarked that the recommendation before the Committee had been some time in development; a previous draft had been submitted to the Health Assembly in 1996, and had been approved in principle, subject to the understanding that any proposal for specific financing would have to be approved by the Health Assembly in 1997. Questions had been raised about the cost implications of the proposal, and the Secretariat had provided further details at the ninety-ninth session of the Executive Board.

The estimated project cost of US$ 9.89 million covered only a very general estimate for architect’s fees, project management, and inflation over the three years of the project’s life. In addition, the Regional Office
would have to absorb in its regular budget an estimated US$ 2.7 million in one-off relocation costs in addition to the costs of furnishings, equipment and associated non-real estate expenditures. A recurrent increase in salaries and staff allowances necessitated by the higher cost of living in Cairo would involve a further US$ 1.1 million. In view of concerns expressed over the rather open-ended nature of those calculations, the Board had resolved that US$ 9.89 million would be the maximum contribution permitted from WHO funds; she consequently supported the amendment proposed by Australia.

The United States appreciated the generosity of the Government of Egypt in making a site available for the new premises in Cairo, which would result in savings of time and money in connection with travel to and from the Regional Office. However, it believed that approval of capital expenditure of nearly US$ 10 million would divert resources at regional level from health programmes on a short-term and potentially long-term basis, and would be unwise in the light of WHO's current financial difficulties and critical competing priorities. It further considered that the casual income requested for the project would be much better spent if applied to the financing of the 1998-1999 budget. For those reasons, the United States could not support the proposal.

Dr RAI (Indonesia), Dr SULAIMAN (Oman), Professor ALI (Sudan), Professor FIKRI-BENBRAHIM (Morocco), Professor GUIDOU (Algeria), Dr AL-SAKKA (Syrian Arab Republic), Mrs AZHAR (Pakistan), Dr RAHIL (Libyan Arab Jamahiriya), Dr AL-SWAILEM (Saudi Arabia), Dr FIKRI (United Arab Emirates), Dr ABDIYAM (Tunisia), Dr KOMODIKI (Cyprus), Dr AL-KURDI (Jordan), Dr NICKNAM (Islamic Republic of Iran), Mrs DHAR (India), Dr AL-KUWARI (Qatar), Dr ALI (Iraq) and Mr ABDALLAH (Djibouti) spoke in support of the resolution recommended by the Executive Board, severally calling attention to the generosity of the Egyptian Government, the expediency of the proposed relocation of the Regional Office for the Eastern Mediterranean from Alexandria to Cairo, the need for speedy implementation in order to avoid additional costs, and the appropriateness of recourse to the Real Estate Fund as a source of finance for the operation.

Dr BEGUM (Bangladesh) suggested that the discussion might be closed and the resolution approved without further delay.

The draft resolution recommended by the Executive Board in resolution EB99.R6 was approved.¹

The draft resolution recommended by the Executive Board in resolution EB99.R7, as amended, was approved.²

3. **FINANCIAL MATTERS:** Item 22 of the Agenda (continued)

**Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution:** Item 22.2 of the Agenda (Document A50/10) (continued from the first meeting)

Mr MOUT (Netherlands) said that it would be preferable for the arrangements envisaged by Cuba and Bosnia and Herzeovina in the two draft resolutions before the Committee to be brought into the context of a general arrangement applicable in all cases where Member States were in a position that compelled them to apply for a settlement of outstanding contributions. Such general arrangements should be drawn up by the Director-General for submission to the Executive Board and subsequently the Health Assembly for consideration and approval. He would be submitting proposals to that effect for consideration at a subsequent meeting of the Committee.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.10.
² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA50.11.
Mr FADZAN (Bosnia and Herzegovina) welcomed the opportunity to bring further information to the Committee’s attention on the economic and social situation in Bosnia and Herzegovina. The period since the signing of the Dayton Peace Agreement in December 1996 had been peaceful, enabling elections to be held and institutions and authorities to function again. It had also been a time of transition. Electric power was now available to everyone and many had access to water and other services. Sarajevo airport had re-opened for limited commercial traffic and roads and bridges were being reconstructed. Housing stock, damaged schools and health facilities, however, were still mainly in the initial stages of reconstruction. Despite the considerable achievements, needs were still enormous: 90% of destroyed and damaged housing was still in need of repair and 30% of inhabited homes had no window glass; industrial production was only 15% of the pre-war level; unemployment exceeded 60%; average income of those with jobs was a mere US$ 130 and the average pension US$ 70. Some 1.4 million refugees (about one-third of the population) had still not returned and some 360 000 people were displaced and homeless within the country. More than 60% of the population lived either on humanitarian aid or very low welfare payments.

It had therefore been impossible for Bosnia and Herzegovina to make regular contributions to WHO and other international organizations. Although it would not be feasible to pay its arrears all at once, an arrangement of 10 annual repayments beginning in 1997 had been proposed which it was hoped would be acceptable to WHO.

Dr AMAT FORÉS (Cuba) also welcomed the opportunity to describe the situation in Cuba that had directly resulted from the 35-year-old economic blockade. Following a fall in GDP and import capacity of 35% and 75% respectively, Cuba had had to strive to maintain the levels of health care for its 11 million citizens. It had had to choose between paying its contributions to the international organizations or continuing to maintain a high quality national health system. With restricted access to credit facilities, Cuba had had to keep in reserve some US$ 20 million in order to pay for expensive imported health care items. Notwithstanding, Cuba had made every effort to make health for all a reality. It had also devised a strategy for paying its arrears and keeping up its contributions on a yearly basis as set out in Annex 3 of document A50/10. Even though the proposed resolution had not yet been adopted, Cuba had made a clear commitment to fulfilling its obligations. Those countries who always paid their contributions on time should be aware that Cuba had been willing and able to provide health aid to countries experiencing natural catastrophes. There was a difference between Cuba and countries that did not pay their debts even though they had ample economic resources. He appreciated the justifiable concern felt by some Committee members over creating a precedent. Nevertheless, the Organization had a duty to try every case on its merit.

The CHAIRMAN invited the Committee to defer further consideration of the item pending the submission of proposals by the delegate of Netherlands.

It was so agreed.

(For continuation, see summary record of the fifth meeting, section 1.)

4. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 27 of the Agenda

General matters: Item 27.1 of the Agenda (Documents A50/16 and Add.1 and A50/INF.DOC./2)

Dr SHIN (representative of the Executive Board) said that the Executive Board had reviewed and endorsed the Director-General’s report (document A50/16) which presented a summary of actions taken in accordance with policy guidance provided by the Executive Board and the Health Assembly. In accordance with the major programme orientations of the Ninth General Programme of Work, the main objectives of collaboration were:

1 Document WHA50/1997/REC/1, Annex 1.
to place and maintain health at the centre of national development and regional and global cooperation; to ensure complementarity and cost-effectiveness in the allocation and use of resources for health; and to promote the continued development of strategic alliances with intergovernmental organizations and other important institutions with a view to meeting the health needs of Member States. The Board had centred its discussion mainly on the Organization’s deepening links with the World Bank, which was pursuing a policy of strong partnership with the United Nations system as a whole; several Board members had welcomed that strengthening collaboration and applauded the increasing amount of resources the Bank was allocating to health, nutrition and population sectors. Fiscal year 1996 had seen the highest lending to the health sector in the history of the Bank, with US$ 2.3 thousand million of new commitments.

In response to a request to WHO from the United Nations Commission on Narcotic Drugs for an opinion on growing advocacy for the non-medical use of heroin and its controlled supply to drug addicts, the WHO Expert Committee on Drug Dependence, meeting in October 1996, had reached consensus that such use without medical supervision was not founded on any scientific or practical experience and was likely to be deleterious. WHO could take no other stance but, since the matter was one of national policy and not exclusively a medical question, governments should be encouraged to explore proven methods of treatment and rehabilitation rather than undertake programmes that ran counter to the spirit of the United Nations drug control conventions.

The Board had also noted that the new Secretary-General of the United Nations had been alerted to the fact that the ban on smoking in all buildings of the United Nations had unfortunately not yet been fully implemented.

Dr KAWAGUCHI (Division of Interagency Affairs), reporting on major developments since the ninetieth session of the Executive Board, said that at its April meeting in Geneva, under the chairmanship of the new United Nations Secretary-General, ACC had focused on the United Nations reform process, under way on a two-track basis, and its implications for reform throughout the United Nations system. The first track of the process related to the managerial initiatives and other decisions that came within the Secretary-General’s authority and on which he had taken action; of those, consolidation of departments in the economic and social fields under one Under-Secretary-General, establishment of executive committees on four areas, and the reforms introduced in the Resident Coordinator system were of special importance to WHO and other specialized agencies. As for the second track, the Secretary-General would, in July 1997, be submitting proposals to the United Nations General Assembly concerning more fundamental issues to be reviewed and decided upon by Member States.

As a follow-up to adoption of resolutions WHA49.19 and WHA49.20, WHO had forged new links with universities, nongovernmental organizations and other private support groups as part of a drive to identify and mobilize a broad range of intellectual capital and new resources. At a time of “aid fatigue”, such global partnership initiatives for health development were crucial to meeting the health priorities of Member States, particularly with regard to health capacity-building in developing countries; they were focused in particular on the countries of the African Region in line with resolution WHA49.20.

WHO’s policy orientation in support of African recovery and development had received high priority; the Organization had started to play a key role in developing the health sector reform component of the United Nations System-wide Special Initiative on Africa.

Dr HENDERSON (Assistant Director-General), referring to the Agreement on the Establishment of the International Vaccine Institute (annexed to document A50/16 Add.1), which the Committee was being asked to approve, said that WHO welcomed the establishment of the Institute and congratulated UNDP and the Government of Korea on their initiative. By 6 May 1997, the Agreement had been signed by WHO and 24 governments. Two governments had ratified it and deposited their instruments of ratification with the United Nations. A third government was expected to follow suit shortly, permitting the Institute to be established as a legal entity.

WHO approval of the Agreement was important in order to show support for the Institute and enable the Organization to play an active role in ensuring that the Institute’s activities were complementary to those of WHO and that it served the best interests of all Member States. The Institute would neither set biological standards nor manufacture vaccines for commercial purposes; any intellectual property rights would be
governed by international laws and treaties. WHO had no financial obligation to contribute either to the fixed or to the recurring costs of the Institute, but it did have the opportunity of appointing two members to the Institute’s Board of Trustees, an important factor in ensuring the closest possible collaboration with the Institute. He urged the Committee to endorse the draft resolution contained in document A50/16 Add.1.

Dr SUZUKI (Japan), stressing the importance of WHO maintaining its leading role in international work on health, applauded the progress made by the Organization in extending collaboration within the United Nations system and with other intergovernmental organizations. Recalling resolution WHA49.19, he noted the significant progress made in the Organization’s wider “partnership” initiatives. The partnership arrangements with the World Bank and the extended new WHO framework on health policy with UNICEF and UNFPA were especially to be commended; he looked forward to further information on those developments.

He welcomed the increasing support being given to Africa in partnership initiatives in line with resolution WHA49.20. Given that such initiatives were becoming the main thrust of WHO policy in support of Member States, he would welcome further progress and sustained development in those areas, with additional financial support. It would be useful if clear, illustrative examples could be provided of successful cooperation in specific technical areas such as disease control at country level.

He reiterated the importance of ensuring complementarity between activities of the proposed International Vaccine Institute and those of WHO.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) urged the Organization to continue actively participating in the deliberations being led by the United Nations Secretary-General, since closer cooperation within the United Nations system was crucial. It was also important to ensure that WHO had a voice in the affairs of the International Vaccine Institute from the beginning. The United Kingdom strongly endorsed the draft resolution contained in document A50/16 Add.1.

Mr BAYARSAIKHAN (Mongolia) said that the establishment of the International Vaccine Institute would have a significant impact on overall health improvement, particularly in developing countries. UNDP and the Government of the Republic of Korea were to be commended on their initiative. Mongolia endorsed the legal status, aims, guiding principles and functions of the Institute as set out in its Constitution. The Agreement had been signed by Mongolia in October 1996 and ratified by its Parliament in April 1997. He fully endorsed the draft resolution.

Dr BOUFFORD (United States of America) said that the United States recognized the potential of the proposed International Vaccine Institute in expanding world capacity for prevention of disease and greatly appreciated the generous contribution made to that effort by the Government of Korea. However, at a briefing in late 1996 on the status of the Institute it had been suggested that there was a need to review the Constitution of the Institute to take account of concern for intellectual property rights. The Constitution as it stood at present did not limit technology transfer to voluntary open market licensing arrangements and made no provision for policies and procedures to prevent possible appropriation and transfer of proprietary technology and protect commercial data. Similarly, there were no provisions covering the legal status of intellectual property created through collaboration, using a third party. The United States was willing to assist in developing such additional provisions. She was, however, pleased that the Institute’s Board of Trustees had recognized the need to include statements in the Constitution regarding the importance of intellectual property rights. Her delegation strongly endorsed the programme.

Dr TEMU (Papua New Guinea) said that collaboration within the United Nations system had had a positive impact at the international level and had proved beneficial to his country. It was now easier to mobilize support at country level, minimize duplication through donor coordination and persuade agencies to adhere to Papua New Guinea’s national policy directives. As countries such as his were beginning to attract more donor support, they were being stretched to the limit in trying to understand individual agency requirements and conditions for assistance. Improved structuring of such arrangements would thus be welcomed.

Papua New Guinea was a signatory to the Agreement on the Establishment of the International Vaccine Institute. The national medical research institute had experienced difficulties in negotiating support from some private institutions; it had been in the forefront of research relating to the development of certain new vaccines,
but had lacked the capacity to meet the financial and legal requirements of such private institutions. The present initiative was therefore most welcome and should be hailed as a fine example of collaboration and cooperation at the international level. His delegation urged Member States to support the proposal to establish the Institute and thanked UNDP and the Government of the Republic of Korea for their commitment to providing infrastructure support and covering a considerable part of the operational costs.

Mr SUN (Republic of Korea) said that the International Vaccine Institute was being created as an international research institute, the first of its kind, dedicated to strengthening the capacity of developing countries in the field of vaccine technology and in carrying out vaccine-related research and development, in particular in relation to the Children’s Vaccine Initiative. In June 1994, his Government had agreed to host the Institute and attached great importance to its successful inauguration and future development. It had made a commitment to cover 30% of the Institute’s annual operating budget, while providing it with adequate grounds, permanent facilities and equipment. Over the past two years, his Government had contributed approximately US$ 1.8 million to preparatory activities for the establishment of the Institute, and planned to contribute more than US$ 1 million for the same purpose in 1997. In 1996, a contract for the construction of the Institute’s future complex in Seoul had been concluded; construction work was expected to be completed by the end of 1999.

He reiterated his Government’s determination to do its utmost to fulfil the commitment it had made as the host government. Approval by the Health Assembly of the Agreement on Establishment of the Institute would ensure that the future work of the Institute would be as envisaged in its Agreement and Constitution, in line with WHO’s mandate. He thanked the delegates who had made statements in favour of that approval and urged all delegations to pledge their support.

Dr LARIVIÈRE (Canada) associated himself with the positive comments made on the International Vaccine Institute. His country saw it as an extremely exciting contribution to the Children’s Vaccine Initiative established in 1992, which Canada had supported. He had visited the temporary facilities at the University of Seoul and was extremely pleased with the progress made in setting up the Institute. He joined in the thanks already expressed to the Government of the Republic of Korea and endorsed the draft resolution.

Mrs DHAR (India), welcoming the establishment of the Institute as a positive step towards elimination of various diseases, particularly those affecting children and other vulnerable groups, asked for clarification on a number of points. What was the role of Member States in decision-making, management and procedures for appointment to the Board of Trustees? Were Board members appointed in their individual capacity or as representatives of States and what were their rights and privileges? She was also unclear as to the meaning of Article XI, paragraph 1, of the Agreement on Establishment of the Institute. Finally, she asked about the extent of the financial obligations of Member States. The Government of the Republic of Korea had agreed to cover 30% of the costs; she would like to know whether the other signatories’ contributions would be voluntary or obligatory.

Dr RAI (Indonesia) said that there was general agreement on the need to improve available vaccines and discover new ones. His Government had therefore decided to participate in the activities of the International Vaccine Institute and had signed the Agreement to establish it. He urged others to follow suit.

Mr GREBLA (Romania) said that Romania attached great importance to the establishment of the Institute and endorsed the draft resolution.

Mr KALIMA (Malawi) endorsed the draft resolution. The establishment of the Institute would help to ensure that vaccines, especially children’s vaccines, were both readily available and also affordable throughout the world, particularly in developing countries where vaccine-preventable childhood diseases were still widely prevalent.

Dr TIN WIN MAUNG (Myanmar), noting that immunization had saved the lives of countless children throughout the world, said that his country had drastically reduced the prevalence of vaccine-preventable diseases. He strongly endorsed the draft resolution.
Dr BRASSEUR (France) mentioned that he had had considerable difficulty in understanding the Agreement on the Establishment of the Institute as it was in English; he would have appreciated a French version. He associated himself with previous speakers in considering that the current initiative should be seen in the context of international regulations relating to intellectual property. He asked what means had been envisaged for engaging the sponsorship of UNICEF, the World Bank and the Rockefeller Foundation, as well as the timing of such sponsorship. France recognized the importance of international cooperation in the field of vaccines and congratulated the Government of the Republic of Korea on its initiative.

Mr THINLEY (Bhutan) joined previous speakers in endorsing the establishment of the International Vaccine Institute and commended the Government of the Republic of Korea on that initiative.

Ms INGRAM (Australia), referring to the Global Commission on Women’s Health established in pursuance of resolution WHA45.25, said that the link between health and development had been stressed throughout the deliberations of the current Health Assembly; it was important to reflect on the role of women in that context. She asked for some comment on the work of the Global Commission to date, as well as on its future prospects.

Dr AKBARI (Islamic Republic of Iran) welcomed the report contained in document A50/16 and joined previous speakers in their thanks to the Government of the Republic of Korea. He asked for clarification on the participation of other countries in the International Vaccine Institute with regard to the number of their staff members and the amount of their contributions and on the relations envisaged between the Institute and countries, such as his own, which were already producing vaccines.

Dr BEGUM (Bangladesh), recognizing the importance of establishing the Institute, welcomed the cooperation between WHO and the Government of the Republic of Korea on the subject and suggested that there should also be close collaboration with the United Nations, the World Bank and various teaching institutions, so as to ensure that international law and United Nations norms were complied with.

Dr SULAIMAN (Oman) said that the International Vaccine Institute would be a glowing example of constructive cooperation between an international organization and Member countries, thereby obviating any duplication of studies and contributing to progress in the eradication of diseases. He thanked the Government of the Republic of Korea for covering 30% of the Institute’s costs, but asked where the remaining 70% would come from, since WHO would not be making any financial commitment.

Dr BERLIN (European Commission) said that, as mentioned briefly in the Director-General’s report (document A50/16), the European Commission had established close relations with WHO headquarters in Geneva, most of the WHO regional offices and IARC in Lyons. The presence of the personal representative of the Director-General in Brussels had proved most helpful.

During the past year, those relations had expanded into new areas and cooperation with WHO in a number of instances had become essential for the discharge of the European Commission’s broad mandate in the health field. The European Union had been faced with a major health-related crisis, the BSE epidemic. The measures it had adopted in the past 14 months had been based on scientific advice obtained inter alia at several expert meetings called by WHO. With regard to food safety, Commission staff participated in the Codex Alimentarius Joint FAO/WHO Food Standard Programme and the Joint FAO/WHO Expert Committee on Food Additives. In the area of health statistics and health indicators, there had been enhanced technical collaboration with WHO headquarters concerning both exchanges of data and improvements in methods. In the environmental health field, the European Commission collaborated actively with WHO on persistent organic pollutants, quality standards for drinking-water and air quality guidelines; it also participated in the European Environmental Health Committee. The Commission had, for example, agreed to co-finance the rolling revision of the WHO guidelines for drinking-water quality up to the next whole-scale revision in 2003.

As mentioned in document A50/16, a framework partnership agreement had recently been signed between the Commission and WHO in the field of humanitarian assistance, covering action in Albania (poliomyelitis vaccinations), Palestine (poliomyelitis and hepatitis B vaccinations), Cape Verde (cholera), and Rwanda (urgent medicsosocial assistance) amounting to a total of approximately US$ 4 million. The possibilities of cooperation
between the European Commission and WHO in the field of surveillance and response to communicable
diseases in Africa were being explored; a regional programme for West Africa had been approved, to support
the development of national systems for the surveillance and response to epidemics.

In the field of health promotion, long-standing close collaboration continued in regard to health-promoting
schools, healthy cities and health-promoting hospitals. The Commission was providing support and would play
an important role in the forthcoming Fourth International Conference on Health Promotion.

The European Commission programme “Europe against Cancer” maintained close links with IARC and
provided financial support to a number of activities of joint interest. There was also continuing collaboration
in the International Programme on Chemical Safety. The European Commission had recently adopted a research
initiative on vaccines; once the International Vaccine Institute had become operational, it would constitute a
valuable partner for cooperation.

Mr GASHUT (Organization of African Unity) said that during the past 10 years there had been a
considerable increase in collaboration between OAU and WHO on various programmes of mutual importance,
owing to the unspiring efforts of the chief executives of both organizations, who shared a common vision of
health for all Africans by the year 2000. He accordingly paid tribute to Dr Nakajima for his willingness to foster
closer cooperation with the OAU during his tenure of office, on such important issues as HIV/AIDS, a
continental health policy, health care of women and children, and malaria control.

The OAU was aware of the immense difficulties involved in reaching the goal of health for all Africans
by the year 2000, but felt that with further and closer cooperation, it was not totally beyond the bounds of
possibility. The WHO Representative’s office at Addis Ababa had become a focal point for cooperation in the
African and Eastern Mediterranean Regions.

Dr KAWAGUCHI (Division of Interagency Affairs), responding to Papua New Guinea’s comment
regarding arrangements for donor support, said that guidelines were currently available to members of the
Committee which illustrated the Organization’s engagement in cooperation at global, regional and country level.
They showed how relevant policy was decided and assisted country-level action with other agencies including
those in the United Nations system. Two mechanisms existed within the United Nations system for facilitating
donor coordination, in which WHO and its regional and country offices were involved. Under the partnership
between WHO and the World Bank, a monitoring system covering a number of projects was being established
with all regional offices, which would also increase transparency and promote closer collaboration between
WHO and Member States.

Dr HENDERSON (Assistant Director-General), responding to India’s question regarding the role of
Member States in the management of the International Vaccine Institute and the appointment of its Board of
Trustees, said that the point of the Agreement the Health Assembly was being asked to approve was to
encourage as many Member States, institutions and other collaborators as possible to show their support and
cooperation for the Institute without financial obligations. To be effective, the Institute would have to be fully
independent. Provision had therefore been made for a Board of Trustees to oversee the work of a Director
appointed to manage the Institute. Member States signing the Agreement would not thereby become actively
involved in such management. An advisory board of distinguished individuals had already been established in
consultation with WHO, UNDP and the Government of Korea, and that initial group would strive to appoint the
best possible Board. Thereafter, the Board itself would have the obligation of renewing memberships or
appointing new members.

As to whether Board members would be representing their countries or acting in a personal capacity, there
would be up to 10 members-at-large serving in their personal capacity, two institutional representatives
appointed by WHO to represent the Organization, and one representative of the Government of Korea (the host
country). In addition, there would also be two ex officio members, namely the Director and a representative of
the Children’s Vaccine Initiative.

Responding to Oman and India, he said that neither WHO nor the signatories of the Agreement would
thereby incur any financial obligation. The Government of Korea had pledged 30% of funds; the Board of
Trustees and Director of the Institute would have the difficult task of raising the remaining 70%. UNDP and
other signatories would help in seeking funds - a resource mobilization activity similar to that used by WHO for
raising extrabudgetary funds.
In reply to the concerns raised by France and the United States, he explained that intellectual property rights would be fully protected by existing international law and agreements. Assistance from the United States in a review of the Constitution of the Institute in that regard would be welcomed by the Board of Trustees.

Responding to a question raised by the French delegation, he said that neither UNICEF nor the World Bank were signatories. For the time being, they would be participating through their involvement in the Children’s Vaccine Initiative, which was a sponsor of the Institute and a member of its Board of Trustees.

Iran had asked about country contributions and country representation among the staff of the Institute. As in any international organization, it would be necessary to ensure a balance between individuals who would bring the best of science to the Institute and those who would ensure that science was put to work for the benefit, in particular, of developing countries. There would be no specific quotas relating to staff unless the Board of Trustees were to make a decision to that effect. The Institute must be seen to belong to the international community and to be working for all.

Contributions would be voluntary; it would be up to the Director, Board of Trustees and sponsors to raise the necessary funds. As to relations between the Institute and countries already producing vaccines, it was expected to help them in their efforts to meet international quality control requirements and become involved in producing new vaccines.

Dr HAMMAD (Health Policy in Development) said that the Global Commission on Women’s Health had made considerable progress since its inception. It was a unique interagency group dealing with issues on an advocacy basis within WHO at headquarters, regional and country level, and with countries, other agencies and nongovernmental organizations. Although its mandate did not entail duplication of WHO’s activities in technical areas, the Commission was able to pinpoint gaps in programmes, areas which needed emphasis and ways in which women’s health issues could be furthered at a variety of levels.

Mrs DHAR (India), referring to Article XI, paragraph 1 of the Agreement on Establishment of the Institute, requested clarification of the seemingly ambiguous phrase: “The Board shall elect one member except the Director as Chairperson”.

Mr TOPPING (Legal Counsel) explained that the intention of the phrase was to exclude the Director as a possible Chairperson.

The CHAIRMAN took it that the Committee wished to note the Director-General’s report on collaboration within the United Nations system and with other intergovernmental organizations.

It was so agreed.

The CHAIRMAN invited the Committee to consider the draft resolution contained in paragraph 8 of document A50/16 Add.1.

The draft resolution was approved.¹

The meeting rose at 18:00.

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA50.12.
THIRD MEETING
Thursday, 8 May 1997, at 9:00
Chairman: Dr S.R. SIMKHADA (Nepal)

1. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 27 of the Agenda (continued)

General matters: Item 27.1 of the Agenda (Documents A50/16 and A50/INF.DOC./2) (continued)

Mr JOUBLANC (Mexico), referring to document A50/INF.DOC./2, recalled that in resolution WHA46.40 the Health Assembly had requested an advisory opinion from the International Court of Justice on the question of whether, in view of the health and environmental effects, the use of nuclear weapons by a State in war or other armed conflict would be a breach of its obligations under international law including the WHO Constitution. That request, together with the question formulated by the United Nations General Assembly in resolution 49/75, section K, had aroused unprecedented interest in the international community.

The hearings had taken place in 1995. Mexico had been among the 40 or so States which had presented written submissions and it had made a statement to the plenary session of the Court on 3 November 1995, in which it had emphasized that if peace were to be established on a solid basis, the rule of law had to prevail and that while, by itself, law did not guarantee peace, a departure from its tenets would render any action to achieve peace arbitrary and subjective. Mexico had reaffirmed the absolute nature of the principle embodied in the United Nations Charter which prohibited the threat or use of force in international relations and hence the use of nuclear weapons. The threat to humanity posed by nuclear weapons entitled the international community to adopt a position on the unlawfulness of such weapons.

The International Court of Justice had found, on 8 July 1996, that it was unable to give the advisory opinion requested, since the question put by the Health Assembly did not arise within the scope of the Organization's activities; the Court had, however, replied to the question raised by the United Nations. Its failure to respond to the Health Assembly's request was worrying for several reasons. The Charter of the United Nations (Article 96, paragraph 2) established that other organs of the United Nations and specialized agencies could also request advisory opinions of the Court on legal questions arising within the scope of their activities. Mexico had contended in its written submission that the definition of health contained in the preamble to the Constitution of WHO was particularly relevant in determining the Organization's competence to request an advisory opinion. In exercise of its responsibility for taking all the requisite steps to ensure the attainment by all peoples of the highest possible level of health, WHO had published two reports on the effects of nuclear war on health and the environment. They had been approved by Health Assembly resolutions which had concluded that the only effective means of addressing the effects of a nuclear conflict and its impact on health lay in the prevention of such explosions and nuclear war itself.

If WHO Members believed that in order to prevent such effects it was first necessary to decide whether the use of nuclear weapons was lawful under international law, the Court should have considered that the Organization was implicitly competent to submit a request to the Court. Indeed, the Court itself had recognized, for example, in its advisory opinion of 23 July 1926 concerning the International Labour Organization, that in order for international organizations to achieve their objectives it might be necessary for them to assume subsidiary responsibilities not expressly provided for in their basic texts.

The reports he had just mentioned demonstrated WHO's genuine interest in a matter which was not only of scientific significance, but which could have consequences so far-reaching as to prevent the Organization from fulfilling the purposes for which it had been set up. The Court's reasoning that the steps which WHO would have to take to combat the effects of the use of nuclear weapons would be the same, regardless of whether
such use were in accordance with international law, was inapposite given the unique character of nuclear weapons, acknowledged by the Court in its advisory opinion in response to United Nations General Assembly resolution 49/75, section K; there it had held that nuclear weapons were potentially catastrophic, that their destructive power was not limited in space or time, that they could destroy all civilization and the ecosystem of the planet, and that nuclear radiation would cause widespread damage to health, agriculture, natural resources and the population, seriously jeopardize future generations, impair the environment food chain and future marine environment, and give rise to defects and diseases in future generations.

Mexico, which maintained that some provisions of international law made it clear that the use or threat of the use of nuclear weapons was unlawful in all circumstances, welcomed the Court’s response, especially its three most momentous conclusions. The Court had strengthened the basic standards of international humanitarian law which had to be respected by all States, irrespective of whether they had signed the international conventions embodying those norms, essential principles, the most important of which was that the standards of international humanitarian law had to apply fully in all circumstances regardless of the nature, causes or reasons given for conflicts. That was the cornerstone of international humanitarian law. There were no circumstances justifying failure to respect humanitarian standards. The Court had denied that the use or threat of the use of nuclear weapons was lawful even in extreme circumstances to secure the survival of a State and had unanimously affirmed that all States were obliged to carry out international negotiations in good faith to obtain full nuclear disarmament.

Mrs HAUSERMANN (Global Commission on Women’s Health), speaking at the invitation of the CHAIRMAN, stressed that the Global Commission operated within the context of WHO’s endeavours to place health at the centre of economic and social development. Among its main achievements had been the definition of the human rights framework for women’s health and the joint publication, with WHO, of the key text “Women’s health and human rights”. It had likewise underscored the lifelong right of women to the highest attainable standard of physical and mental health, widening the previously narrow focus on reproductive health. By highlighting the disadvantaged health status of girls and women throughout their lives, the Commission had prompted a deeper analysis of several aspects of women’s health, including the effects of violence against women and girls, women’s occupational health and the health of ageing women.

The Global Commission had insisted on the formulation of practical strategies for action and had produced an “agenda for women’s health” with six priority areas set out in the Commission’s first report “Women’s health: towards a better world”. Its advocacy had been crucial in securing the inclusion of women’s health in the action plans adopted by a number of United Nations conferences. Those achievements should not, however, mask the fact that much remained to be done, and the Commission would continue to pinpoint inadequacies in policy and action (both within WHO programmes and globally) and to devise strategies for action. That was a prerequisite for success in the global mission of ensuring health for all women and equity as a basis for health and development.

Mrs POBEE (Ghana) said that her delegation took great pride in the active part played by the First Lady of Ghana in the Global Commission’s work. The Commission was a most effective advocacy instrument which had helped to bring concern for women’s health to the fore at regional and international levels. Its programmes were laudable. She urged WHO to continue to provide the Commission with the technical and other support that would enable it to carry out its programmes and activities to promote health for women.

Mrs AL-GHAZALI (Oman) praised the Global Commission for its role in accelerating progress in women’s health and endorsed WHO’s efforts to assist and cooperate with the Commission.

Mrs MANYENENG (Botswana) urged WHO to continue to support the Commission, which took a commendably broad view of women’s health.

(For continuation, see summary record of the seventh meeting, section 4.)
Environmental matters: Item 27.2 of the Agenda (Document A50/17)

Dr SHIN (representative of the Executive Board), referring to part II of document A50/17 concerning promotion of chemical safety with special attention to persistent organic pollutants, said that the threats posed by those substances to human health and the environment had become the subject of worldwide political attention. The Executive Board had endorsed the recommendations of the Intergovernmental Forum on Chemical Safety (IFCS) as contained in the Annex to the document. WHO played an important role in promoting independent scientific risk assessment of chemicals, and in passing on that information. The Executive Board had recommended for adoption by the Health Assembly the draft resolution set out in resolution EB99.R25, which reflected the broad scope of WHO’s chemical safety activities and was designed to ensure full WHO participation in any international negotiations concerning chemicals requiring health expertise.

Referring to part III of document A50/17, he said that the Executive Board had been informed that, in December 1996, the United Nations General Assembly had adopted resolution 51/189 on the institutional arrangements for the implementation of the Global Programme of Action for the Protection of the Marine Environment from Land-based Activities, which called on Member States to take action in the governing bodies of the appropriate agencies to ensure that they contributed in the areas of their mandate and that those organizations took the lead in coordinating the development of the clearing-house mechanism essential for the Programme. The resolution had identified WHO as the lead organization for information on sewage. The Executive Board had noted that WHO possessed the requisite expertise and had expressed the hope that the necessary resources could be found for that activity. The Health Assembly was invited to consider the draft resolution set out in paragraph 50 of document A50/17.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) noted with satisfaction that in part II of document A50/17, the adverse effects of persistent organic pollutants were rightly emphasized, the risks of specific chemicals described and the uses of some products listed. While effective insecticides obviously had to be available, the fact that those chemicals were labelled “persistent” illustrated the enduring consequences of their use and the potential risk to human health. The United Kingdom consequently favoured the development and evaluation of new classes of insecticides but recognized, with the authors of the report, that work might be slower than the development of resistance by certain organisms. His delegation therefore strongly supported the recommendations for action by the Health Assembly set out in part IV of document A50/17.

Mr ESKOLA (Finland) remarked that air pollution significantly reduced life expectancy and caused disease; he described the findings of the Environmental Health Centre of WHO’s Regional Office for Europe in that connection. WHO rightly placed emphasis on protecting people from hazards such as water-related diseases and the effects of pesticides, but should keep abreast of the latest findings on health and the environment. Urban air pollution would be a major problem for years to come, owing to increasing industrialization, energy production and traffic. While Finland endorsed the resolution recommended in resolution EB99.R25 and the draft resolution on the protection of the marine environment, it would also urge WHO to take the lead in establishing the extent and nature of newly recognized environmental health risks, and to provide technical assistance and guidance to Member countries. That would also be in line with the stress laid in Agenda 21 on strengthening the role of the health sector in national development planning.

Dr NIGHTINGALE (United States of America) commended WHO on its role as task manager for the health component of Agenda 21 and on the interregional initiative. It would be useful to know the geographical distribution of the 16 countries planning to incorporate health in their sustainable development plans. It appeared from the report before the Committee that regional conferences had been held only in the European and Eastern Mediterranean Regions and the Region of the Americas. Were other measures being taken elsewhere? His delegation would welcome more information about the panel scheduled to meet in New York in June 1997 in connection with the progress review on Agenda 21. It was important to link the follow-up to the Rio Conference with the renewal of the health-for-all strategy. The United States had favoured the involvement of IFCS in assessing the 12 identified persistent organic pollutants. United Nations Environment Programme Governing Council Decision 19/13(C) provided an excellent mandate for an intergovernmental negotiating committee to discuss the specific persistent organic pollutants that caused global problems.
His delegation proposed a number of minor amendments, in the interests of clarification, to the resolution recommended in resolution EB99.R25. First, it wished the words “currently identified” to be inserted before the words “persistent organic pollutants” in paragraphs 2(1) and 3(1), thereby indicating that additional substances would be reviewed for consideration at some future date only if they met agreed scientific criteria for the identification of substances whose risks would best be dealt with in a global context. Secondly, an insertion would be made in paragraph 2(6) to indicate that the programmes referred to were those “that take an integrated approach”. And thirdly, to ensure that WHO would perform most efficiently and would call upon the most relevant expertise, the phrase “including engagement of appropriate WHO collaborating centres in this effort” would be added at the end of paragraph 3(2).

He pointed out that the report suggested, inaccurately, that DDT was the only insecticide still in use for public health purposes; paragraphs 30 and 31 surprisingly failed to recognize the role of organophosphates and pyrethroids. Rather than promoting the continued use of DDT, WHO should be advocating its restricted use.

Dr JEAN (Canada) unreservedly supported the resolution recommended in resolution EB99.R25. Although DDT remained significantly cheaper than currently available substitutes, Canada would urge WHO and other United Nations agencies concerned to collaborate in finding a viable alternative. It did not appear possible to maintain national DDT procurement and distribution systems for exclusive public health use without the eventual leakage or diversion of the insecticide into other areas, with negative effects on the environment.

Ms STEGEMAN (Netherlands), commending the report, said that her country was preparing a plan of action on the environment and health aspects, to be finalized at the end of 1997. Further information concerning the panel meeting scheduled for June 1997 would be welcome. As regards the promotion of chemical safety, WHO should continue with assessments of national needs before initiating training. In the area of capacity-building, more collaboration between those concerned was desirable. All 12 persistent organic pollutants mentioned in the report, including DDT, should be phased out. The Netherlands supported the resolution recommended in resolution EB99.R25, including at first glance the amendments proposed by the United States of America, as well as the proposed resolution on the marine environment, which should be implemented as rapidly as possible.

Dr MWANZIA (Kenya) endorsed the report before the Committee. The bulk of the disease burden in Africa, including the principal scourge, malaria, sprang directly or indirectly from the environment. In the past year, Africa had faced both drought and flood which had caused human suffering and loss of life, and its countries obviously needed to be better prepared to cope with environment-related problems if their development and indeed their survival were to be ensured. His delegation supported the resolution recommended in resolution EB99.R25, as amended by the United States delegation.

Professor ALI (Sudan) remarked that the Director-General’s report failed to tackle the administrative and structural problems caused by the multiplicity and diversity of centres and organizations dealing with environmental planning. That made it difficult to exchange information and to assess environmental issues properly. Laws enacted by one ministry could be in conflict with practices in another. Some attention ought therefore to be given to the elaboration of a structural model to help countries overcome those difficulties. Sudan nevertheless supported the resolution recommended in resolution EB99.R25.

Mrs DHAR (India) said that India had fallen into line with the international decision to phase out DDT, an interministerial committee having been set up to ensure that it was used very selectively. From 1 April 1997, hexachlorocyclohexane, previously banned for agricultural use, had been banned for public health programmes. In addition, India’s strategy for vector-borne diseases was in line with global strategy. India had just finalized a very comprehensive World Bank project for the control of malaria, focused initially on the seven states where the disease was endemic, to run for five years from June 1997. New bio-environmental measures would be widely introduced, including the use of medicated mosquito nets and the introduction of larvivorous fish and safer insecticides such as synthetic pyrethroids, which - as the ultimate weapon in the fight against malaria - had to be used in a highly selective fashion to avoid the development of resistance that could be disastrous.

India supported the Global Programme of Action and the several mechanisms formulated for implementing it. India however had some reservations which - it was confident - would be shared by many other
developing countries regarding the phasing-out of the 12 identified persistent organic pollutants. In the event that a safer alternative was found for DDT, the cost of using such an alternative would be economically very prohibitive and therefore unviable. Hence, there should be a proviso that if DDT were to be finally phased out, the technology for the new product should be transferred to developing countries on a noncommercial basis.

Mr KNOTT (Australia) favoured the preparation of the report on the role of health and environment in sustainable development and highlighted the role of the International Programme on Chemical Safety, particularly with regard to Chapter 19 of Agenda 21.

Australia supported the resolution recommended by the Executive Board in resolution EB99.R25. In the interests of accuracy, however, and in connection with the reference therein, and in the body of the Director-General’s report, to the deliberations and conclusions of IFCS, he pointed out that the only recommendations of the IFCS on which consensus had been reached, and which had since been endorsed by UNEP’s Governing Council, were those reproduced in the Annex to the report. Many of the conclusions discussed in part II of the Director-General’s report related to issues on which no consensus had been reached and were based on the deliberations of the expert meeting held prior to the IFCS Ad Hoc Working Group on persistent organic pollutants.

Professor FIKRI-BENBRAHIM (Morocco) commended WHO’s endeavours since the Rio Conference. The Organization must continue to play a coordinating role in matters related to health and the environment. Since Rio, Morocco had created a Ministry of the Environment, revived the National Council for the Environment, drawn up a national action plan and prepared relevant legislation. DDT remained a major weapon against malaria and the sole user, the Ministry of Public Health, used it with great care, in accordance with the recommendations of WHO. His delegation endorsed the resolution recommended in resolution EB99.R25.

Mrs CODFRIED-KRANENBURG (Suriname), commending the Director-General’s report, stressed that indoor residual DDT spraying must remain an option for selective use in government-authorized programmes only.

Dr TAHA (Malaysia), referring to part I of the Director-General’s report, said that confronted with increasing environmental threats to human health, Malaysia was reacting through the endeavours of many national agencies which collaborated closely with the private sector and the community. The Ministry of Health had incorporated environmental factors into health programmes relating to disease control, food quality control, environmental sanitation, occupational and environmental health and drinking-water quality surveillance. Environmental health had been identified as one of the seven priorities for funding and research. An environmental health research centre had been set up, as had a centre to monitor and investigate environmental and occupational poisoning. An environmental toxicology laboratory was planned. “Healthy cities” projects were making health and the environment integral components of sustainable development. Malaysia pledged its close cooperation with WHO.

Dr BEGUM (Bangladesh) expressed her country’s support for the resolution recommended in resolution EB99.R25. In Bangladesh, which had eradicated malaria for a while but where sporadic outbreaks had recently occurred, the use of DDT for public health purposes was noted with great concern. She agreed that any substitute which might be developed should be made available to the developing countries in a subsidized form.

Dr MERCIER (International Programme on Chemical Safety) said that there seemed to be general support for the resolution recommended in resolution EB99.R25, for the United States delegate’s amendments and for comments on the use of DDT. Clearly, what was being asked for was a period of grace for DDT. Some degree of caution was required, for although the ultimate objective was to phase it out as a means of combating vector-borne diseases, it still proved useful in certain circumstances. He nevertheless hoped that DDT would soon be replaced by a substance which would be less harmful to people’s health and the environment.

Dr HELMER (Urban Environmental Health), referring to the matter of the incorporation of health and environmental issues in national plans for sustainable development, explained that WHO was working at national and regional levels. With regard to the latter, the 16 countries involved in the interregional initiative
were fairly equally distributed among the regions, on the basis of two to three countries per region. A number of regional meetings had already taken place and a major conference in the Western Pacific would be held in August 1997 involving ministries of health under the Healthy Cities - Healthy Islands Programme. A regional meeting was planned for South-East Asia in October 1997 and in Africa national programmes were in progress in connection with the Africa 2000 initiative.

The main purpose of the high-level panel to be convened in conjunction with the forthcoming special session of the United Nations General Assembly (June 1997) was to place health issues at the centre of Agenda 21. The comprehensive report to be submitted by WHO to the special session in that connection was currently being finalized. The composition of the panel was being decided in consultation with the Director-General’s Council on the Earth Summit Action Programme for Health and Environment as well as the group responsible for the renewed health-for-all strategy at WHO headquarters; moreover, efforts were being made to ensure continuity with the panel on health and environment set up during the 1992 United Nations Conference on Environment and Development.

Dr KLEIN (Regional Office for Europe) welcomed the comments on developments in environmental health in relation to Agenda 21 and expressed appreciation of headquarters support for initiatives in that connection in the European Region. Networking on national environmental health action plans was well under way in the Region and the high-level panel could expect strong backing from the European countries at the June special session. Thirty-seven of the European Member States had implemented such plans following the Second European Conference on Environment and Health (Helsinki, 1995) and in the run-up to the next conference to be held in 1999.

Concerning a question raised at the previous meeting concerning cooperation with donors, he suggested that regional networking on environmental health programmes might serve as a basis for cooperation at national level with the World Bank. In conclusion, he recommended that the European experience with the interregional initiative be shared with the other regions.

The CHAIRMAN invited the Committee to approve the resolution on the promotion of chemical safety with special attention to persistent organic pollutants recommended by the Executive Board in resolution EB99.R25, as amended by the delegate of the United States. In response to a statement by Mrs DHAR (India), he said that the reservations she had voiced in connection with the eventual phasing-out of DDT would duly figure in the summary record of the proceedings.

The recommended resolution, as amended, was approved.¹

The CHAIRMAN invited the Committee to approve the draft resolution on protection of the marine environment as set out in paragraph 50 of document A50/17.

The draft resolution was approved.²

Health assistance to specific countries: Item 27.3 of the Agenda (Document A50/18)

Dr AMMAR (Lebanon) expressed grave concern about the health situation of the people of southern Lebanon as a result of the Israeli occupation of that territory. Their lives were constantly at risk and the number of handicapped was increasing daily - victims of land-mines laid by the Israeli army. People were forced to flee their villages and take refuge in the towns, which made it difficult to implement rural health programmes. The international community should pay particular attention to their plight.

Ms KIZILDELI (Turkey) endorsed the report contained in document A50/18 and favoured the continuation of WHO’s activities in the countries listed therein. As part of the reform process the Organization was reconsidering its role and participation in United Nations emergency and humanitarian assistance assistance

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.13.
² Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.14.
programmes. In that connection, it might also wish to review the matter of health assistance to Member States in general by assessing past activities and redefining criteria and objectives for the future. Health assistance to specific countries should be based on sound and justifiable grounds and focused on developing countries, especially the least developed countries. Such an approach would seem to be more in keeping with the current spirit of reform and would ensure more effective use of the Organization’s dwindling resources.

Mr GUN (Democratic People’s Republic of Korea) voiced his country’s gratitude to WHO for making available the sum of US$ 65,000, donated by the Italian Government, to assist victims of the severe floods which had occurred in 1995 and 1996, devastating the greater part of the country’s territory, including much of the densely populated and industrialized areas, and bringing about considerable human suffering. The extent and severity of the damage caused to national infrastructures was such that, for the first time in its history, his country had been unable to cope alone and had appealed to the international community for aid. With hospitals, clinics, health research centres, laboratories, medical equipment and pharmaceutical factories and stores submerged in floodwater, the health sector had been the hardest hit. Although some infrastructures had since been restored, it would take some time before things returned to normal. He therefore welcomed the Organization’s latest appeal to collect more than US$ 5 million, following an assessment mission to his country, and expressed the hope that the international community would rally to the call so as to alleviate the continued suffering of the victims.

Dr ZAHRAN (Egypt) thanked the Director-General for all WHO’s efforts to provide vital humanitarian aid to the States and population groups listed in the report before the Committee. The Lebanese delegate had drawn attention to the deteriorating health situation in southern Lebanon as a result of the occupation and persistent aggression of the local population by the Israeli armed forces, and the ravages caused by land-mines. That state of affairs should have been reflected in the report and steps should be taken to remedy the situation. Likewise, mention should have been made of those countries affected by trade embargoes such as Iraq and the Libyan Arab Jamahiriya, and efforts should be deployed to make the necessary resources available to enable WHO and other international organizations to meet the needs of the populations concerned.

Dr BEGUM (Bangladesh) said that hers was a small country that was often the victim of great calamities. She hoped that it would not be forgotten in its times of need by those responsible for dispensing humanitarian assistance.

Mr KALIMA (Malawi) said that floods in Malawi that year had driven more than 500,000 people from their homes. In addition, those who had been similarly displaced owing to the floods in neighbouring Mozambique had settled in the southern part of Malawi. An appeal had been made to the international community to help alleviate the suffering and, in view of the situation, he asked that Malawi be included in the list of specific countries receiving health assistance.

Professor ALI (Sudan) thanked the Director-General and the Regional Director for the Eastern Mediterranean for the special assistance received by Sudan, notably in its efforts to control malaria, diphtheria and diarrhoeal diseases. Much progress had been made during the previous year, but malaria, meningitis, dracunculiasis and other dangerous diseases were still prevalent. Recent peace initiatives should make it possible to improve the health situation throughout Sudan, where there was no shortage of personnel but rather a lack of financial resources.

Dr AL-KURDI (Jordan) noted with satisfaction the health assistance given to specific countries as detailed in the report and said that collaboration in humanitarian matters should certainly be continued.

Dr HLA MYINT (Myanmar) thanked WHO for its assistance in the implementation of national health plans for his country. Since peace had been achieved, it had been possible to reach more areas with health care projects. He trusted that aid would continue to be forthcoming, notably in connection with the struggle to eliminate malaria and tuberculosis and with the strengthening of primary health care.
Mrs WU Jihong (China) expressed concern at the health situations in the countries listed in document A50/18, and voiced the hope that WHO and the international community would continue to provide assistance: China would play its part in that undertaking.

Dr BASSANI (Division of Emergency and Humanitarian Action) thanked delegates for their comments, which would be taken fully into account as WHO pursued its commitment to improving the health situations in those countries where help was needed.

Dr BERLIN (European Commission) said that the report before the Committee contained an impressive list of countries which had received health assistance from the United Nations system and other intergovernmental bodies. Collaboration had been established, too, between the European Commission and WHO to implement health assistance programmes in numerous countries. During the previous two years, for example, the Commission had invested some 50 million ecus (approximately US$ 60 million) to promote the health sector in Angola, working closely with WHO and other development partners to rebuild the health system following the internal conflicts. In Zaire, the Commission was implementing a transitional programme of assistance for the health sector, which would also be carried out in cooperation with WHO and other external partners. The first phase had cost 25 million ecus (US$ 30 million) and a second programme would have funds of US$ 55 million. Those examples demonstrated the importance of WHO’s collaboration and of the technical backing it provided for the health programmes of the European Community in developing countries.

The CHAIRMAN took it that the Committee wished to take note of the report by the Director-General on health assistance afforded to specific countries.

It was so decided.

2. FIRST REPORT OF COMMITTEE B (Document A50/29)

Dr AMMAR (Lebanon), Rapporteur, read out the draft first report of Committee B.

The report was adopted.¹

3. PERSONNEL MATTERS: Item 29 of the Agenda

Recruitment of international staff in WHO (Geographical representation; Employment and participation of women in the work of WHO): Item 29.1 of the Agenda (Resolutions EB99.R9 and EB99.R10)

Dr SHIN (representative of the Executive Board) recalled that resolution WHA48.28 had requested the Director-General to report to the Executive Board and to the Health Assembly in 1998 on the recruitment of international staff. The number of regular budget posts had since been reduced; it had therefore been proposed that the number of geographically distributable posts used to calculate the desirable ranges should be adapted to reflect that. A report on the progress made in improving geographical representation had been provided to the Board, which had adopted resolution EB99.R9.

The Director-General had reported to the Board on further progress made concerning the employment and participation of women in the work of WHO. The representative of the Board on the Steering Committee on the Employment and Participation of Women in the Work of WHO, while appreciative of the efforts being made to improve the situation, which included the appointment of a staff member as a full-time coordinator for that

¹ See page 239.
purpose, had observed that there had been an increase of only 0.5% over the previous two years. WHO was still 3% short of its long-established target of having 30% of all professional posts filled by women by September 1995. Even though the target of 30% recruitment had not yet been met, she had proposed that the Board should recommend the resolution contained in resolution EB99.R10, which called for an increase of the target to 50%, in order to comply with the spirit of equity by the year 2000 inherent in United Nations General Assembly resolution 49/167. However, no date had been set for that target, in order not to exacerbate problems of geographical distribution, and the request in paragraph 3 of the resolution to raise the minimum threshold for recruitment had been left in general terms.

The Committee was invited to consider the draft resolutions recommended by the Board in resolutions EB99.R9 and EB99.R10.

Mr KANEKO (Japan) said that considering the contribution made by his country to WHO, Japan was underrepresented within the Organization. He urged WHO to continue to improve geographical representation.

Dr LARIVIÈRE (Canada) applauded the initiative taken by the Executive Board to promote parity in the employment of men and women in the Organization. Progress in that area had been slow and insufficient. He thanked the Director-General for his efforts to recruit women and to identify and eliminate the obstacles inherent in the career progression of women. Unfortunately, the recent appointment of some women to high-level posts within the Organization was not indicative of a trend. It was to be hoped that such a trend would be developed. It was obvious that the new target of 50% employment of women could not be achieved by the Organization alone: individual countries also had a responsibility to ensure a 50% representation by women among their nationals appointed to the staff of WHO. He endorsed the resolution recommended in resolution EB99.R10.

Dr DURHAM (New Zealand) said that although she supported the intention to increase the representation of women in professional categories to 50%, she was concerned that the target could not be achieved with speed in an environment in which staff numbers overall were being reduced. It might, however, be possible to achieve parity in new appointments to the professional categories by 2002. WHO should also take concurrent action to improve the representation of women as temporary advisers, consultants and on scientific and technical advisory groups with a view to achieving parity by the same date. In that regard, she proposed that the resolution recommended in resolution EB99.R10 be amended to include a new fourth preambular paragraph which would read: "Recognizing that women can also participate in WHO as temporary advisers, consultants and on scientific and technical advisory groups". She further proposed that a new operative paragraph 2 should read "CALLS FOR targets to be set at 50% by 2002 for new appointments of women to professional categories, representation of women as temporary advisers, consultants and on scientific and technical advisory groups;", with consequent renumbering of subsequent paragraphs. There would also be a new paragraph 4(3) to read "to set minimum thresholds for participation of women as temporary advisers, consultants and on scientific and technical advisory groups;". Finally, she proposed that the words "and as temporary advisers, consultants and on scientific and technical advisory groups" should also be added to the end of the renumbered paragraph 4(4).

She asked whether high-level advisory committees had been established at headquarters and in the regions to promote the participation of women at all levels within the Organization as requested of the Director-General and the Regional Directors in paragraph 4(3) of resolution WHA49.9.

Dr BOUFFORD (United States of America) thanked the Director-General for his commitment to the issue of the representation of women and for appointing a full-time staff coordinator to promote the recruitment of women in WHO. She acknowledged the responsiveness of the Regional Directors to that difficult issue - she understood that strategies appropriate to each region were being studied. She concurred with the views of the delegate of Canada with regard to the responsibility of each country in ensuring equality of representation. She endorsed the resolution recommended in resolution EB99.R9 with the amendments put forward by the delegate of New Zealand, in particular those relating to the appointment of consultants and temporary advisers. A 3000-strong pool of such advisers was available to the Organization each year; it could be used to enhance the opportunity of employment for women, especially at a time of economic restraint.

Dr BEGUM (Bangladesh) welcomed the proposal to raise the target employment level of women from 30% to 50%. She assured delegates that in the developing world women who were given responsibility worked
efficiently. Unfortunately, few women could be found at the Regional Office for South-East Asia. However, for the previous seven years, Bangladesh had had women leading both the Government and the opposition -in her view with success.

Dr RIVAS (Uruguay) said that representation should not be measured in percentages, but in terms of the quality of the persons appointed for particular tasks. It was important that women should have the same opportunity as men to represent their country at the Health Assembly, but in her view that should not be because governments had imposed the selection of women, but rather because of the ability of the women concerned to participate and to defend the interests of their country, their region or even the world.

Mrs DHAR (India) welcomed the recommendation that representation of women at WHO should be gradually increased from 30% to 50%. Contrary to what had been said by the delegate of Uruguay, numbers were important. As in all underprivileged and deprived sections of society, nothing could be achieved if targets were not set in advance. It was essential too for national governments to be involved in the process of selecting highly competent, professional women. Even in developing countries, in particular in Asia, well trained and highly skilled women were widely available.

Dr SHISANA (South Africa) echoed the sentiments expressed by the delegate of India. Targets were essential if WHO were to achieve the goal of increasing the representation of women among its employees. Women brought a different perspective to organizational management and programme reviews and should be adequately represented.

Dr SEVER (Israel) stressed the importance of increasing representation of women at WHO at all levels, particularly in senior posts. He also endorsed the amendments to the resolution recommended in resolution EB99.R10 proposed by New Zealand.

Ms INGRAM (Australia), endorsing the views expressed by the delegate of India, said that target numbers and time lines were very important since they motivated change; excuses could always be found for failure to achieve mere aspirations. It was very important to establish concrete measurable targets and aim with great vigour to attain them. The women present at the Health Assembly were an impressive, powerful and thinking force. By aiming to increase the representation of women and setting a timescale for that process, it was possible to draw out the talent which existed and to ensure that women occupied their rightful place in various forums, thereby bringing their very different and valuable perspectives to the work of the Organization. She endorsed the amendments to the draft resolution proposed by New Zealand.

Mrs NKUEBE (Lesotho) joined other speakers in welcoming the proposal to raise the target for representation of women in WHO to 50%. As the delegate of New Zealand had pointed out, it was important to explore every option in seeking to increase the number of women working in the Organization, in view of the valuable contribution they could make to the success of its activities.

Mr AITKEN (Assistant Director-General) said that WHO was committed ultimately to achieving the target of 50% representation of women in the Organization, although that might not be feasible by 2002. The amendments proposed by New Zealand were therefore important in that they focused on new appointments, where reaching the goal by a target date of 2002 could be envisaged. By contrast however, it was difficult to achieve a balance between geographical distribution and the need to achieve targets for women. It would therefore be appreciated if countries which were underrepresented in both respects could try to combine the two when submitting candidates for specific posts. Currently, when choosing between applicants placed on short lists, priority was given to women in cases of equal qualifications. Efforts would be made in future to implement the New Zealand proposal on the minimum threshold for the participation of women as temporary advisers or consultants and in scientific and legal advisory groups. However, it might be difficult at times to apply that concept since the groups were often convened at short notice. It would therefore be necessary to consider the matter and report to the Executive Board in due course on the best approach to adopt towards a threshold for such groups.
In response to the question from the delegate of New Zealand on the high-level committees to be set up to advise the Director-General and Regional Directors on participation of women, he pointed out that even before the adoption of resolution EB99.R10, two such committees had already existed, at the regional offices in South-East Asia and the Americas. Subsequently, a specific coordinator on the employment and participation of women had been appointed at headquarters. That official had global responsibility and thus would bring relevant points to the attention of Regional Directors and regional committees. The process was further enhanced at headquarters by being under the consideration of a committee which included Executive Board members. In view of those developments, no further action had been taken to introduce other committees at regional level.

Mr TOPPING (Legal Counsel) said that one of the amendments proposed by New Zealand to the draft resolution contained in resolution EB99.R10 called for the setting of minimum thresholds for the participation of women as consultants and advisers. However, the concept of a minimum threshold might be difficult to accept since its inflexibility might force the Director-General to violate the general constitutional requirements that appointments should be based on integrity and efficiency, and be of an internationally representative character. On those grounds, and also since the regulations for expert advisory panels and committees referred primarily to technical ability and experience, the term “target” would be preferable to any mention of a minimum threshold.

Dr DURHAM (New Zealand) said that the question of the methods used by WHO to identify the people working in scientific and technical advisory groups was an important one. At national level, requests were often received to sanction a WHO decision rather than the Organization specifying the criteria that the person concerned should meet and that the country should adopt in selecting that person from the existing pool of expertise. The intent was to encourage WHO not to continue to draw exclusively on what was essentially an old boys' network since there were many women with a high level of scientific capability and integrity.

Dr STAMPS (Zimbabwe) said that since the Director-General had seen fit to ignore the requirements of reasonable geographical representation for the duration of his term of office, it was difficult to understand the Legal Counsel's suggestion that it was impossible to ignore other constitutional guidelines and requirements. He fully endorsed the New Zealand proposal for a minimum threshold; as had been seen two years previously in relation to the assurances given regarding African representation at headquarters, targets were meaningless.

Dr BOUFFORD (United States of America) expressed surprise that the concept of a minimum threshold should be considered improper since it was already in use in relation to the representation of women at regional level. She pointed out that when the Board had been considering its resolution, although it had decided not to give a numerical value to the threshold it had retained the concept. Minimum thresholds were essential for transparent monitoring of the progress made in bringing women into the relevant professions.

Ms INGRAM (Australia) said she shared the views of the previous speaker and also endorsed the comments made by the representative of New Zealand on the process of selecting women for technical advisory committees. Changes to ensure the achievement of parity of representation of the sexes within the Organization would necessarily include changes in structural mechanisms. If problems were being experienced in finding suitably qualified women to serve on such committees, perhaps it was also necessary to examine WHO's human resources development programme; in other words, to target women with a view to enhancing their skills through fellowship programmes and other mechanisms designed to increase the pool of women capable of serving not only on committees but also in temporary and permanent positions within the Organization.

Mr TOPPING (Legal Counsel) said that from the explanations given, it appeared that the concept of a minimum threshold had been interpreted as a target. On that basis, it was therefore acceptable.
On that understanding, the resolution recommended by the Executive Board in resolution EB99.R10, as amended, was approved.¹

The resolution recommended by the Executive Board in resolution EB99.R9 was approved.²

Confirmation of amendments to the Staff Rules: salaries for ungraded posts and the Director-General: Item 29.2 of the Agenda (Resolution EB99.R12)

Dr SHIN (representative of the Executive Board) said that with effect from 1 January 1997 the United Nations General Assembly had approved a revised base salary scale for the professional and higher categories reflecting an increase of 5.68%, of which 5.26% constituted a consolidation of post adjustment on a “no loss-no gain” basis and 0.4% constituted a real salary increase. Subject to that decision, the Director-General had proposed, in accordance with Staff Regulation 3.1, that the Executive Board should recommend to the Fiftieth World Health Assembly modifications of the salaries of the posts of Deputy Director-General, Assistant Directors-General and Regional Directors. The modifications in those salaries called for similar adjustments to the salary of the Director-General, bearing in mind the terms of paragraph III of his present contract. The Committee was invited to consider the draft resolution recommended by the Board in resolution EB99.R12.

The resolution recommended to the Executive Board in resolution EB99.R12 was approved.³

The meeting rose at 12:20.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.16.
² Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.15.
³ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.17.
FOURTH MEETING
Thursday, 8 May 1997, at 14:30
Chairman: Dr T. TAITAI (Kiribati)

1. UNITED NATIONS JOINT STAFF PENSION FUND: Item 30 of the Agenda


Mr AITKEN (Assistant Director-General) said members of the Committee would see from the report (document A50/20) that the United Nations Joint Staff Pension Fund now had 68 000 members; the increase over the previous year was primarily the consequence of a rise in the number of staff involved in United Nations peacekeeping activities. WHO staff represented some 10% of the total membership of the Fund.

The Fund was generally in good financial order, and its small actuarial deficit had decreased. The decisions of the United Nations General Assembly in regard to the Fund were reported in paragraphs 6 to 9 of the document.

The CHAIRMAN said that, in the absence of any comments, he would assume that the Committee wished to take note of the report for the year 1996 of the United Nations Joint Staff Pension Board (document A50/20), including the status of the United Nations Joint Staff Pension Fund.

It was so decided.

Appointment of representatives to the WHO Staff Pension Committee: Item 30.2 of the Agenda (Document A50/21)

The CHAIRMAN said that since document A50/21 had been issued, the Secretariat had been notified that Dr Taha, who had been appointed an alternate member of the WHO Staff Pension Committee by the Forty-ninth World Health Assembly for a term of three years from 1996, had retired from the Government of Tonga and was not a member of the delegation of Tonga to the Fiftieth World Health Assembly. It was proposed that Dr Malolo (Tonga) serve on the Committee for the remaining two years of the term of office.

Dr TAHA (Malaysia), Dr GONEYALI (Fiji), Mr FINIKASO (Tuvalu) and Mr UEDA (Palau) seconded that proposal.

The CHAIRMAN said that the terms of office of Professor Roos (Switzerland), appointed in a personal capacity, and of the alternate member designated by the Government of Kuwait were due to expire at the closure of the Fiftieth World Health Assembly. In the light of the precedent whereby members were appointed in a personal capacity to ensure continuity in such a complex issue, the Committee might therefore wish to submit nominations by name of delegates from regions no longer represented on the Committee - the Eastern Mediterranean Region and the European Region - for the offices of member and alternate member.

Dr RAHIL (Libyan Arab Jamahiriya) proposed Dr Sulaiman (Oman) as a member of the WHO Staff Pension Committee representing the Eastern Mediterranean Region.
Dr NOOR (United Arab Emirates) seconded that proposal.

Mr DEBRUS (Germany) proposed that Professor Roos (Switzerland), who had already served on the Committee for three years, be appointed for a further term, to serve as a member of the WHO Staff Pension Committee representing the European Region.

Dr FRITZ (Austria) and Ms NOVÁK (Hungary) seconded that proposal.

The CHAIRMAN said that, in the absence of objections, he would take it that the Committee wished to convey the following draft decision to the plenary:

Decision: The Fiftieth World Health Assembly appointed Professor B.A. Roos, delegate of Switzerland as a member of the WHO Staff Pension Committee, and Dr A.J.M. Sulaiman, delegate of Oman, as alternate member of the Committee, the appointments being for a period of three years; Dr L. Malolo, delegate of Tonga, was appointed to replace Dr S. Tapa, the appointment being for a period of two years.¹

2. METHOD OF WORK OF THE HEALTH ASSEMBLY: Item 31 of the Agenda (Resolution EB99.R28)

Mr NGEDUP (representative of the Executive Board) said that at its ninety-eighth session, held immediately after the Forty-ninth World Health Assembly, the Executive Board had noted the improvement in the Assembly’s working methods and its reduced duration, had made suggestions for further improvements, and had requested the Director-General to prepare a report on the method of work and the experience of the shorter Assembly in 1996 in order to facilitate discussion on further rationalization by the Board at its ninety-ninth session.

On the basis of the Director-General’s report,² the Board had adopted resolution EB99.R28 recommending to the Health Assembly a resolution revising certain aspects of its method of work, which would, in particular, limit to five minutes the statements of delegates in plenary; allow the inclusion of technical programme items in the agenda of the Health Assembly only in non-budget years; and fix the timetable for the opening day of the Health Assembly so as to conclude opening formalities as early on the opening day as possible.

The last point would require revision of the Rules of Procedure of the Health Assembly with respect to the Committee on Nominations (Rules 24 and 25). In addition, the shorter duration of the Assembly would require a change in the notice period for submission of suggestions regarding the annual election of Members entitled to designate a person to serve on the Executive Board (Rule 101).

Professor FIKRI-BENBRAHIM (Morocco) said that a number of delegations had noted that the various official languages of the Organization were too often given unequal treatment. While he fully appreciated the constraints under which WHO was operating, those constraints ought not to jeopardize the fundamental principles which were the cornerstone of an international organization in which the use of official languages was a guarantee of equality for all, and thus of democracy. The same held true for simultaneous and timely distribution of documentation for the Health Assembly and the Executive Board in WHO’s six official languages.

A draft resolution on the proper use of official languages had been prepared by a number of delegations, and he hoped that the Committee would be able to consider and approve it as soon as possible.

Mr CLERC (France) fully endorsed the views expressed by the delegate of Morocco.

¹ Decision WHA50(9).
Mr GONZÁLEZ DE LINARES (Spain) welcomed the initiative announced by the delegate of Morocco. Spain intended to give active support to the proposed draft resolution.

Ms TOSONOTTI (Argentina) said her delegation endorsed in principle the resolution recommended by the Executive Board. She associated herself with the statement made by the delegate of Morocco in regard to the Organization’s official languages. At the current Health Assembly many of the main documents had not been distributed in all languages: for instance, the Executive Board’s report on the budget (document A50/4) had only been made available in Spanish on the first working day. Her delegation would be glad to participate in work on the draft resolution on the subject which was to be submitted.

Professor ALI (Sudan) endorsed the resolution recommended by the Board. He suggested that it might further hasten Health Assembly proceedings if the statements by heads of delegations were to be printed and distributed to Members rather than delivered verbally in plenary meetings.

Ms SOSA MÁRQUEZ (Mexico) endorsed the remarks of previous speakers on equal treatment for all the official languages. It had happened, for example, on occasion that important information on complex budgetary and other matters had been only circulated in English.

Mrs WU Jihong (China), speaking as a sponsor of the draft resolution mentioned by Morocco, endorsed the view that all six official languages should receive equal treatment. Judicious use of and distribution of documents in all the official languages would ensure the effective participation of all Member States in the Organization’s decision-making process. The Secretariat should make appropriate arrangements and report to the 1998 Health Assembly on progress made.

Dr BADRAN (Egypt) endorsed the remarks made by the delegate of Sudan concerning the length of statements by heads of delegations in plenary meetings. Instead of devoting the first three or four days of the Health Assembly to statements by Ministers and other national representatives as had once been the case, it was now customary for such statements to be confined to particular topics. However, the ambiguous nature of some of the topics discussed at the current Health Assembly had resulted in the statements being used instead as a vehicle for reiterating the health service achievements of the country concerned. Some solution should therefore be found to deal with the problem.

Dr MUÑOZ (Chile) joined previous speakers in expressing the view that working documents should be made available in good time in all the official languages in order to avoid the difficulties some countries had experienced.

He too would like to see provision made for the delivery of official statements so as to make the most efficient use of available time. Although progress had been made in limiting both the content and length of such statements, little had been achieved in increasing the productivity of discussions relating to The world health report. The three days available for that debate should be focused on matters on which decisions were most needed. Items for discussion could be divided on the basis of health programmes, reform of the Organization and topics particularly relevant to The world health report. To save time, general statements should be required to be submitted in writing, thus enabling discussions to be concentrated on the Organization’s programme.

Mr SÁENZ VARGAS (Colombia), endorsing the views expressed by previous speakers, observed that Colombia had stressed, in other forums, the need for equal treatment of all official languages; WHO should not be the exception.

Mrs TINCOPA (Peru), Mrs PERLIN (Canada), Mr NÜNLIST (Switzerland) and Mr KOVALENKO (Russian Federation) endorsed the views of previous speakers in support of the draft resolution to be submitted on equal treatment of all official languages.
Mr AITKEN (Assistant Director-General) regretted that there had been a delay in reproducing documents in all official languages; immediate action would be taken to remedy the situation. The draft resolution on the treatment of official languages would be before the Committee for consideration shortly.

Regarding procedure in plenary meetings, the matter would be reviewed by the Executive Board at its forthcoming meeting in the light of the comments made by Sudan, Egypt and Chile.

The resolution recommended by the Executive Board in resolution EB99.R28 was approved.¹

(For continuation, see summary record of the seventh meeting, section 5.)

The meeting rose at 15:20.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA50.18.
FIFTH MEETING
Friday, 9 May 1997, at 9:00

Chairman: Dr T. TAITAI (Kiribati)

1. FINANCIAL MATTERS: Item 22 of the Agenda (continued)

Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: Item 22.2 of the Agenda (Document A50/10) (continued from the second meeting)

The CHAIRMAN invited the Committee to consider the draft resolution on the proposal of Bosnia and Herzegovina contained in Annex 2 to document A50/10 as amended by the delegations of Australia, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland, which read:

The Fiftieth World Health Assembly,
Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, with respect to Bosnia and Herzegovina's proposal for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report of the Director-General to the Administration, Budget and Finance Committee (document A50/10, Annex 3, paragraph 23),

1. DECIDES on an exceptional basis to restore the voting privileges of Bosnia and Herzegovina at the Fiftieth World Health Assembly;

2. ACCEPTS as an interim measure, the proposal of Bosnia and Herzegovina for the settlement of its outstanding contributions, namely, payment of the 1997 contribution of US$ 46 355 before the end of 1997 and liquidation of the arrears of contributions which remain outstanding for the period 1992-1996 inclusive, totalling US$ 535 995, in five annual instalments of US$ 107 200 (except that the last instalment will be US$ 107 195) payable in each of the years 1997 to 2001, subject to the provisions of Financial Regulation 5.6, in addition to the annual contributions due during the period;

3. DECIDES that in accordance with Article 7 of the Constitution the voting privileges and other services to which a Member State is entitled, will be automatically suspended again if the Member State in question does not meet the requirements laid down in paragraph 2, and that, notwithstanding the provisions of Financial Regulation 5.8, payment of the 1997 instalment of Bosnia and Herzegovina's contribution for the financial period 1996-1997 and contributions for subsequent periods shall be credited to the financial period concerned;

4. REQUESTS the Director-General to report to the Fifty-first and four subsequent World Health Assemblies on the situation in respect of Bosnia and Herzegovina's settlement of its arrears;

5. REQUESTS the Director-General to communicate this resolution to the Government of Bosnia and Herzegovina.
Mr GONZÁLEZ DE LINARES (Spain) requested that Spain be added to the list of sponsors.

Mr VAN REENEN (Netherlands), introducing the amended draft resolution on behalf of Member countries of the European Union and the other sponsors, said that while they appreciated the sincere efforts made by Bosnia and Herzegovina to meet its financial obligations they felt that any scheme of settlement of outstanding contributions should be governed by stricter conditions than those contained in the original proposal of that Member State. They further deemed it necessary to emphasize the exceptional nature of the decision to restore voting rights. The amended draft resolution thus proposed reducing the repayment period from ten annual instalments to five, with automatic loss of voting privileges in case of non-compliance with payment conditions. With regard to paragraph 3, which had been reworded, the Secretariat had drawn his attention to the fact that suspension of other services to which a Member State was entitled, although indeed provided by Article 7 of the Constitution, had never been applied in practice; he therefore proposed, provided the other sponsors agreed, that the reference to other services be deleted. Other minor amendments were the deletion of paragraph 4, and a change in the wording of paragraph 5 which had become paragraph 4.

He regretted that the original proposal from Bosnia and Herzegovina had not been submitted to the Executive Board at its January session but only to its Administration, Budget and Finance Committee, at a meeting immediately before the current Health Assembly.

Ms KIZILDELI (Turkey) observed that over 20 countries were in arrears to an extent that would justify invoking Article 7. Should that number increase further, a far from negligible proportion of Member States might thereby be alienated from the Organization's decision-making process. Turkey endorsed the draft resolution as amended, which was constructive and might encourage countries in similar situations to meet their obligations. Rescheduling of payments also provided the Organization with an opportunity to recover unpaid arrears.

Mr MOEINI (Islamic Republic of Iran) endorsed the draft resolution which provided a useful approach to solving the difficulties of countries in exceptional circumstances.

Dr DURHAM (New Zealand) was reluctant to see any weakening of what little leverage the Health Assembly had in extracting payment of arrears. New Zealand did not therefore endorse the draft resolution, which it considered would set an unhelpful precedent, but would not oppose a consensus.

Mr AMAT FORÉS (Cuba) pointed out that neither the present draft resolution nor the similar one relating to Cuba to be considered later had respected the time frame of submission for consideration and vote specified in Rule 52 of the Rules of Procedure of the Health Assembly. Furthermore, in the case of the draft resolution on Cuba, the original draft resolution (Annex 2, document A50/10) had been drafted by the Executive Board and not by Cuba itself.

Mr AITKEN (Assistant Director-General) explained that since the text circulated generally proposed amendments to an existing draft resolution, the Committee could if it so wished consider it at once. It was, however, open to the Committee to ask for more time to consider it.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to continue to consider the draft resolution on Bosnia and Herzegovina.

It was so agreed.

The draft resolution, as amended, was approved.¹

The CHAIRMAN invited the Committee to consider the draft resolution on the proposal of Cuba contained in Annex 2 to document A50/10 as amended by the delegations of Austria, Belgium, Denmark,

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA50.22.
Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland, which read:

The Fiftieth World Health Assembly,
Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, with respect to Cuba’s proposal for the settlement of its outstanding contributions, and the terms of that proposal as set forth in the report of the Director-General to the Administration, Budget and Finance Committee (document A50/10, Annex 3, paragraph 23),

1. DECIDES on an exceptional basis to restore the voting privileges of Cuba at the Fiftieth World Health Assembly;

2. ACCEPTS as an interim measure, the proposal of Cuba for the settlement of its outstanding contributions, namely, payment of the 1997 contribution of US$ 211 195 before the end of 1997 and liquidation of the arrears of contributions which remain outstanding for the period 1993-1996 inclusive, totalling US$ 1 264 468, in five annual instalments of US$ 250 000 (except that the last instalment will be US$ 264 468) payable in each of the years 1997 to 2001, subject to the provisions of Financial Regulation 5.6, in addition to the annual contributions due during the period;

3. DECIDES that in accordance with Article 7 of the Constitution the voting privileges and other services to which a Member State is entitled, will be automatically suspended again if the Member State in question does not meet the requirements laid down in paragraph 2, and that, notwithstanding the provisions of Financial Regulation 5.8, payment of the 1997 instalment of Cuba’s contribution for the financial period 1996-1997 and contributions for subsequent periods shall be credited to the financial period concerned;

4. REQUESTS the Director-General to report to the Fifty-first and four subsequent World Health Assemblies on the situation in respect of Cuba’s settlement of its arrears;

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

Mr GONZÁLEZ DE LINARES (Spain) requested that Spain be added to the list of sponsors.

Ms KIZILDELI (Turkey) and Mr MOEINI (Islamic Republic of Iran) endorsed the draft resolution as amended.

Mr AMAT FORÉS (Cuba) said that, while he had no objection to the Committee discussing the draft resolution as amended, he would request postponement of any decision thereon until he had had an opportunity to consult the Cuban authorities on the subject. Cuba’s original proposal had suggested a rate of repayment that, after careful consideration, it was confident it could meet in its current critical economic circumstances. There was no certainty that it would be in a position to comply with the accelerated rate of repayment now proposed. It was not a question of failure of political will; Cuba was not a country that wished to undertake commitments it could not fulfil. It had in the past, before the crisis, always paid its dues in full. Should its economic prospects improve, as they had shown signs of doing in the past two years, Cuba was fully prepared to pay off its arrears ahead of time. Cuba had no objections to the other stipulations in the draft resolution and accepted the exceptional nature of the measures proposed.

Dr KALUMBA (Zambia) asked the Committee to show understanding for the special circumstances of Cuba. He supported Cuba’s request for more time to pay its debts.

The CHAIRMAN suggested that in the light of the previous statements the Committee might wish to postpone discussion of the draft resolution to a later meeting.
It was so agreed.

(For continuation, see summary record of the seventh meeting, section 3.)

2. SCALE OF ASSESSMENTS: Item 24 of the Agenda (continued)

Scale of assessments for the financial period 1998-1999: Item 24.2 of the Agenda (Document A50/13) (continued from the second meeting)

The CHAIRMAN invited the Committee to continue its consideration of the draft resolution contained in paragraph 6 of document A50/13, as amended by the delegations of the Russian Federation and the United States of America to include an additional paragraph 3 which had been introduced at the second meeting.

Mr BOYER (United States of America) recalled that the intent of the proposed amendment was to bring WHO's scale of assessments for 1998-1999 into line with that currently being negotiated for the United Nations at its headquarters in New York. However, he suggested that consideration of the agenda item and relevant draft resolution should be deferred, yet again, so as to allow for further consultations with other interested delegations. The United States delegation, for its part, would have great difficulty in agreeing to the proposed programme budget unless the amendment relating to the scale of assessments was adopted. He hoped that the Committee would eventually consider the proposed amendment favourably, particularly since the assessments of several Member States might be scaled down as a result.

Dr KALUMBA (Zambia) asked for a legal opinion on whether the amendment proposed to the draft resolution violated the provisions of Regulation 5.3 of the Financial Regulations. He would also welcome further information on the exact implications of the possible revised scale of assessments.

Mr BOYER (United States of America) agreed that the proposed amendment as currently formulated might constitute a violation of the provisions of Regulation 5.3 of the Financial Regulations, since it would entail the payments of unequal annual instalments in the next biennium. However, perhaps the deletion of the second and third sentences from the text of the proposed amendment would meet that concern.

As to the implications of the revised scale of assessments, the United States had come to the conclusion that such a revision was far too complex a matter to be debated at the Health Assembly and was best left to the experts at United Nations headquarters in New York. Since WHO Member States were also represented at the United Nations in New York, delegates should have no difficulty in endorsing the agreement reached by their government counterparts.

Dr SUZUKI (Japan) asked whether the intent was to continue the discussion on the substance of the proposed amendment while postponing a decision on the draft resolution to a later meeting.

Dr KALUMBA (Zambia) expressed concern that discussion of the issue of scale of assessments might be deferred indefinitely without any review of its implications for WHO's mandate.

Mr AITKEN (Assistant Director-General) said that as it was not possible to respond to the points that had been raised without entering into the substance of the issue, it might be preferable to defer those responses until the draft resolution was again before the Committee.

The CHAIRMAN suggested, in the light of what had been said, that any further discussion should be deferred on the understanding that the item would be placed before the Committee again not later than the following Monday, 12 May 1997.

It was so agreed.
Mr MOEINI (Iran) announced his delegation’s intention to submit a further amendment to the draft resolution.

(For continuation, see summary record of the seventh meeting, section 2.)

3. SECOND REPORT OF COMMITTEE B (Document A50/31)

Dr AMMAR (Lebanon), Rapporteur, read out the draft second report of Committee B.

Dr KALUMBA (Zambia) recalled with regard to item 29.1 of the agenda that, during a meeting of health ministers from Member States of the Organization of African Unity (OAU) a specific question had been addressed to the Director-General concerning his commitment to ensuring equitable geographical distribution of posts. A reply to that question would be welcome.

Mr TOPPING (Legal Counsel) explained that because the report covered resolutions already approved and subjects already dealt with by the Committee, further discussion of those items was closed at committee level. What the Committee was being asked to do at present was to approve the presentation of the report - the substance had already been agreed.

Dr STAMPS (Zimbabwe) said that he was not surprised to learn that discussion on agenda item 29.1 would not be reopened, as that might place some members of staff in an uncomfortable position. Some 90% of top administrative posts at headquarters were held by nationals from one country, which was constantly in arrears with its contributions and which had undermined the financial security of the Organization for the previous 10 years. That country had, in addition, consistently criticized the management of the Organization, suggesting that there had been waste, inefficiency and an inability to pursue policies. That view would suggest either that the country in question had no faith in the ability of its own nationals or that those nationals were not competent to fulfil their roles within the Organization.

The Member States of the African Region took the strongest exception to the refusal to honour the commitment, given to the Health Assembly by the Director-General in 1995, that the adverse geographical distribution of posts, particularly at high level, would be rectified. Moreover, the situation had deteriorated, so that staff responsible for a division had been replaced by persons from outside the Organization and from the same country as that whose staff members currently dominated the administration. He objected to the persistent racism exhibited by the administration of the Organization. The imbalance in the geographical distribution of staff necessarily affected the weight lent to health policies: discrimination was destroying the effectiveness of WHO to deal with those issues which were central to health in Africa.

Mrs DHAR (India) expressed surprise that her remarks during the discussion of the draft resolution on promotion of chemical safety, with special attention to persistent organic pollutants (agenda item 27.2) had not been taken into account. She stressed the importance, in particular to the developing countries, of acquiring on a non-commercial basis any technology related to the production of an eventual successor to DDT.

Mr ASAMOAH (Secretary) said that there had obviously been an unfortunate misunderstanding with regard to the remarks by the Indian delegate during the discussion of the draft resolution; the Secretariat had not taken them as constituting a formal proposal for amendment. Would the delegate be satisfied with the answer that her remarks had been fully reflected in the relevant summary record?

Mrs DHAR (India) signified her assent.
Dr KALUMBA (Zambia) suggested that the Secretariat should make the procedure for submitting amendments perfectly clear to delegates, so that further misunderstandings would not occur.

The report was adopted.¹

4. REPORT OF COMMITTEE B TO COMMITTEE A (Document A50/32)

Dr AMMAR (Lebanon), Rapporteur, read out the draft report of Committee B to Committee A.

The report was adopted.²


Dr HU Ching-Li (Senior Adviser to the Director-General), noting that WHO would reach its fiftieth anniversary in the following year, pointed out that many political, social and economic changes had taken place during the life of the Organization: enormous advances had been made in the medical sciences and new technology was appearing at an ever-increasing rate. The process of reform at WHO had been initiated in order to meet the challenge inherent in those changes.

Reform would continue under the leadership of the next Director-General as it was essential in order to respond to the changing health needs of Member States and of people throughout the world. Reform was central to the management of WHO and would help to achieve the objectives of the health-for-all policy and strategy in the twenty-first century. Reform involved the Member States, governing bodies and the Secretariat. Member States contributed to the reform process both individually and in country groupings. WHO was unique among the United Nations agencies in taking policy reform as the essential point of the reform. The policy of health-for-all for the twenty-first century, including the Tenth General Programme of Work, underlay all thinking on the issue. The formal policy of health-for-all would be reviewed by the Executive Board at its session immediately following the Health Assembly. The 47 recommendations drawn up by the Executive Board Working Group on the WHO Response to Global Change, and action by the Director-General, as well as external contributions from the United Nations and the specialized agencies, nongovernmental organizations, and other interested bodies, also formed part of the process. Reform did not merely involve the downsizing of WHO’s functions and activities; it was taking place at intergovernmental, organizational and management and administrative levels, and affected policy, governing bodies, priorities, budget, management, programme structure, regular budget posts, administrative arrangements and partnerships.

Reform was a continuous process which had always been part of the work of WHO; it had not started with the major reform effort represented by the 47 Board recommendations, almost all of which had been implemented since 1994. However, the data which enabled Member States to evaluate strategies were more easily available and more comprehensive than in the early 1970s. The bases for reform were accurate data analysis, a scientific agenda involving the advisory committees on health research at global and regional levels, the taking into account of ethical concepts and the inclusion of new partnerships to develop and implement health-for-all policy for the twenty-first century. Governing bodies had been streamlined, more efficient working methods had been introduced, the duration of meetings had been reduced and costs had been cut. The creation of the Programme Development Committee and the Administration, Budget and Finance Committee of the Executive Board had assisted the Board and the Health Assembly to work more effectively.

Priority-setting had also been the subject of reform. Goals were identified during preparation of WHO’s long-term policies to give a general orientation. General programmes of work established priorities and targets over a six-year period. Funds were allocated to priority programmes and products during preparation of a

¹ See page 240.
² See page 242.
proposed programme budget, and the governing bodies could select activities and propose reallocation of resources.

Budgetary reforms included the use of strategic budgeting which was being used for the second successive biennium in order to prepare the programme budget. Plans of action were developed and products identified which would enable monitoring and evaluation to be carried out more easily. The management information system would shortly be fully operational. A Global Policy Council had been formed to review policy issues. Global, headquarters and regional management development committees had been set up to handle day-to-day management issues. Personnel policies and the WHO country offices had also been reformed. A number of programmes had been restructured or combined as part of the streamlining process and over the past three years, the new format of The world health report had been very much appreciated.

Changes in regular budget posts had been made throughout the Organization. The overall projected decrease in posts was just under 200 between the 1996-1997 and 1998-1999 bienniums, with greater cuts in the number of headquarters administrative posts than in those of non-administrative posts. The same was also true at regional level. However, the number of staff working on intercountry and country activities had increased compared to the 1994-1995 level. To strengthen support to Member States the number of staff working in the WHO Representatives' offices would continue to increase, as had been the case for the past two bienniums.

For the reform of administrative and other arrangements, a range of measures had been introduced to reduce costs without compromising quality, in particular by the Division of Budget and Finance and the Division of Conference and General Services. Those measures would lead to appreciable savings. Similar measures would be taken at regional level.

All WHO's activities and reform measures must be coordinated with other partners including United Nations organizations, collaborating centres, nongovernmental organizations, certain partners in the private sector and representatives of other non-States entities, to avoid duplication of effort.

Finally, measures would be continued to maintain the impetus for organizational reform. The health-for-all policy would be finalized and the health-for-all strategy developed, and structures would be redefined according to functions and activities. Closer budgetary and operational monitoring and evaluation would be ensured, a new personnel policy finalized and implemented, efficiency savings identified and the sharing of expertise and further streamlining of activities would be encouraged.

In fact, the processes encompassed in the reforms outlined were captured in the words of Confucius. Two thousand years earlier he had said that when a person reached the age of 30, he had gained enough knowledge to stand firmly in society and by 40 he would know what he wanted to achieve and would not be easily diverted. Thus, during the 1970s and 1980s, WHO had known what it wanted to achieve; it had set goals and targets, and developed a health-for-all strategy. By 50, a person should not only know the world but also the rules of nature; in other words, he knew the wishes of God. That meant he ought to know what his future work would be. That was the stage WHO had reached; its future path should be clear.

Renewing the health-for-all strategy, including report of the task force on health in development: Item 26.1 of the Agenda (Resolutions EB99.R8 and EB99.R15; Documents A50/14 and A50/15)

Mr NGEDUP (representative of the Executive Board) said that the Board’s extensive discussions on renewal of the health-for-all strategy had focused on the role that renewal would play in the future activities, credibility and financial liabilities of WHO. The Board had emphasized the need for a clear, coherent framework for the new policy; that it should reflect the diverse regional and country needs and priorities; that primary health care should act as an organizational framework for implementing the new policy; and that the policy should be technically sound and politically viable. Other key questions were the roles of government, nongovernmental organizations and the public and private sectors; the political will of governments; the vision and objectives of health for all; equitable access to health care; and ethical principles and human rights. Five principles had been highlighted: human-centred sustainable development, health policies based on sound evidence, the “gender perspective”, the primary health care approach, and partnerships. Determinants of health and health-for-all strategies and targets had also been discussed.

The Committee was invited to consider the draft resolution contained in resolution EB99.R15, which would ensure convergence between work on the new policy, constitutional reform, development of the Tenth General Programme of Work and the efforts of the task force on health in development. In addition, resolution
EB99.R16 had been adopted to expedite the process of consultation with all Member States and other bodies, and to request the Secretariat to prepare a draft policy for review by the Board in May 1997. It had also been noted that a global health charter would be elaborated later in 1997.

The Board had reviewed the report of the task force on health in development and had considered that it had accomplished, in a visionary and comprehensive manner, the challenging mandate received in 1992 from the Forty-fifth World Health Assembly. In particular, the Board had endorsed the task force’s vision for health leadership in the twenty-first century, had urged Member States to take the task force’s report into account in the planning of development strategies, and had requested the Director-General to integrate the task force’s recommendation into WHO’s strategic planning processes, and in particular the renewal of health for all. The draft resolution on the subject, which was recommended to the Health Assembly in resolution EB99.R8, had been amended by the delegations of Antigua and Barbuda, Belgium, Cameroon, China, Egypt, Finland, France, Germany, Ghana, Jordan, Lesotho, Mauritius, Qatar, Seychelles, South Africa, Sri Lanka, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America, Zambia and Zimbabwe to read:

The Fiftieth World Health Assembly,

Noting that the WHO Constitution states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”;

Recalling resolution WHA45.24 on health and development, requesting the Director-General to establish a task force to undertake a comprehensive review and analysis of factors which could improve the health of the most vulnerable and disadvantaged populations;

Having considered the report by the task force on health in development;

Acknowledging that the development of the Tenth General Programme of Work will be affected by matters concerning vision and mandate raised in the report;

Recalling resolutions WHA48.14 and WHA48.16 concerning review of the Constitution of the World Health Organization and renewal of the health-for-all strategy;

Deeply concerned about the worsening health status of many of the world’s most disadvantaged and vulnerable groups;

Recognizing that poverty, unemployment, economic adjustment, and the emergence and re-emergence of new health problems add to the health crisis;

Reaffirming that public health measures can be a powerful bridge to peace by helping to mitigate the negative effects of conflict and social and economic inequities;

Aware of the need for global health leadership to provide guidance in responding to the worsening health crisis in a rapidly changing world;

Convinced that WHO is in a unique position to lead and advocate for global health, and that in this role of global leader WHO will interact with a variety of partners in implementing global health initiatives and programmes;

Convinced also that WHO must continuously adapt its work in order to respond to the public-health and development exigencies of the twenty-first century,

1. COMMENDS the task force on health in development for its commitment and creativity and for producing an excellent action-oriented report;

2. ENDORSES the components of the task force’s vision for health leadership in the twenty-first century:

(1) to promote a global “agenda for health”;
(2) to continue to set high standards in health;
(3) to monitor changes in health status;
(4) to develop health-promotive and disease-preventive diplomacy;
(5) to work with WHO’s partners to ensure that health status is promoted and protected in economic policies and development strategies;
(6) to act as the world’s “health conscience”;
opportunities to uphold the cause of health. That could be seen in the resurgence of some diseases, many of advancements in its fight to eradicate and control diseases. However, the Organization had missed many opportunities to achieve health objectives. It had done so by making use of the most up-to-date scientific and technological knowledge as a way of life for humanity.

of health status, giving health its rightful place in the lives of human beings, and creation of a culture of health for decision-making that would gain the respect of the world community. That would come from improvement in promoting health had to realize that they were working from a position of strength and cease coming to the table as mendicants. Health was a powerful unifying force which transcended all boundaries. It was essential to recognize and use its tremendous potential as a political platform. Health must not be traded against economic gains; efforts should instead focus on feasible ways of accommodating health imperatives within economic and social realities. It was not the adoption of market language, or even purely economic methods to recognize and use its tremendous potential as a political platform. Health must not be traded against suffering as opposed to experiencing a sense of wellness. That had been the experience of the way the Organization functioned and others with an outside perspective on its place in the international arena. In the course of its work, the task force had come to a true unity of thought on critical issues of health development. A clear vision had evolved for WHO, which should contribute to making the Organization one of the best legacies which could be left to future generations.

Among the most difficult issues facing the task force were the differing views on the extent to which the Organization should be involved in pursuing health in development. Some wished WHO to concentrate on what it could do best, control and eradication of diseases; others argued that greater efforts should be made to engage in protecting, promoting and maintaining health and quality of life as the principal means of reducing the burden of disease. However, defence of health was indeed central to development. The symptoms of ill-health were all-pervasive in society: the cancer of violence and the mass of humanity barely able to survive. It was in refusing to accept that such conditions were inevitable and in recognizing that the enjoyment of health was paramount to a sense of well-being that the task force had felt an obligation to move beyond the question “How can we enable people to live longer?” to “How can we enable them to have a better quality of life?”. During the three years of the task force’s existence, WHO had enabled it to get to grips with the realities of health in today’s world and the intrinsic links to suffering as opposed to experiencing a sense of wellness. That had motivated the task force to seek to champion the cause of health at several major international conferences which had taken place during the group’s mandate.

Placing health at the forefront of the political agenda was, however, not enough. The test of success would be translating that agenda into the realities of ensuring the enjoyment of health security for all. Those involved in promoting health had to realize that they were working from a position of strength and cease coming to the table as mendicants. Health was a powerful unifying force which transcended all boundaries. It was essential to recognize and use its tremendous potential as a political platform. Health must not be traded against economic gains; efforts should instead focus on feasible ways of accommodating health imperatives within economic and social realities. It was not the adoption of market language, or even purely economic methods for decision-making that would gain the respect of the world community. That would come from improvement of health status, giving health its rightful place in the lives of human beings, and creation of a culture of health as a way of life for humanity.

In the past half century, WHO had shown that it could find the courage and wisdom to seize opportunities to achieve health objectives. It had done so by making use of the most up-to-date scientific and technological advancements in its fight to eradicate and control diseases. However, the Organization had missed many opportunities to uphold the cause of health. That could be seen in the resurgence of some diseases, many of
them linked to sustained poverty. It could also be observed in an increasing degree of complacency with regard to preventive measures. The temptation to restrict the health agenda was always likely to be present in a world scenario fuelled by forces urging all concerned to seek value for money. At the same time, all agreed, as individuals and as communities, that they cared about protecting health. That conviction went far deeper than mere material values.

The coming years would be the most crucial test of the Organization's ability to consolidate its leadership role and continue to work towards solutions for pressing health issues through its technical programmes, training, research and capacity-building. The Organization must also be enabled to assume its responsibility to defend the cause of health, and to promote and protect health in the development process.

WHO had incorporated many of the task force’s views into its policy documents. Member States should be encouraged to take the opportunity to reflect on the work carried out by the task force, and on the conclusions contained in document A50/15 and other task force reports, including its most recent monograph entitled “Health - the courage to care”. The progress made in associating health and development had been strong rather than swift. Complacency must not be allowed to creep in. The cause of health was not, as many would like to think, simply a humanitarian one. The health of present and future generations was a development imperative and a moral obligation.

Dr SUZUKI (Japan) welcomed the innovative ideas, including those on resource mobilization, generated by the task force (document A50/15). Its views should be fully reflected in the new health-for-all strategy and the Tenth General Programme of Work, so as to avoid duplication and take diverse views into account. The Japanese delegation endorsed the draft resolution, subject to incorporation of two minor changes. Firstly, none of the 28 members of the task force came from the Western Pacific Region, despite the size of its population and its rapid economic growth. As that Region could contribute greatly to achievement of the task force’s objectives, he suggested that paragraph 4(4) be amended to ensure that the area’s views were taken into account. Secondly, while he agreed that a novel approach to resource mobilization was needed and that a health lottery was an extremely interesting idea, the text should reflect the fact that care was needed to ensure that such new measures were not paid for by the poorer sections of society; experience had shown that the less well-off were more inclined to buy lottery tickets than the rich.

Mr ESKOLA (Finland) said that Finland, as a sponsor of the draft resolution, commended the report of the task force, which would be of great value in developing the new global health-for-all strategy. He applauded the recent progress made in renewal of that strategy, which represented a considerable challenge to the Organization and was crucial to its credibility and financial viability. His delegation fully supported WHO in its use of that process as a platform for clarifying the Organization’s role in global health. The renewed strategy should give proper emphasis to equity, social justice and respect for human dignity, address the issues of urbanization, poverty, population ageing and the environment, promote the sustainable development of health, and adopt a participatory and intersectoral approach aimed at the empowerment of governments, communities, families and individuals when it was implemented.

Renewal of the health-for-all strategy should, however, be accompanied by genuine transparency in the Organization’s work so that, when the Tenth General Programme of Work and the programme budget were drafted, priorities and resource allocation would be determined in a coherent, clear and mutually supportive way. The draft policy outlined in document EB100/2, for consideration by the forthcoming session of the Executive Board, would provide a useful basis for continuing the discussion in the Board and the Regional Committees.

Ms LAURIDSEN (Denmark) concurred with the views expressed by the delegate of Finland. Renewal of the health-for-all strategy was crucial to the overall perception of WHO and to the acknowledgement of WHO's leadership in health. In the past, the broad lines of its work had been widely accepted, although details of implementation differed according to circumstances in individual states. WHO policy-making had recognized that fact and the same division of work should be respected in renewal of the health-for-all strategy. Current progress on that renewal was generally satisfactory.

One aim of the renewed strategy would be to reaffirm WHO’s leadership in health, as had been done two decades earlier with the introduction of the concept of primary health care, now a core feature of health care. The strategy should not only be a policy statement setting out the aspirations shared by all Member States, it should also appeal to all agencies in the health and health-related sectors with which WHO needed to forge
partnerships. In addition to defining broad aims and means of achieving them, it needed to be clear and accessible, specifying a small number of practical tools to be used for tackling the major health issues of the years to come. As the task force had pointed out, the success of the strategy and WHO's position as health leader would depend on the support that could be rallied behind its policies. With regard to content, the strategy should focus on quality of health care, equity of access, and review and dissemination of information. WHO should not attempt to coordinate the work of all agencies and nongovernmental organizations active in the health field, because that would completely drain its resources and not necessarily guarantee success. Voluntary cooperation was what was required. Priorities therefore had to be set in order to ensure that the new health-for-all strategy gave WHO a credible and legitimate leadership role.

The renewed health-for-all strategy, with a probable span of some 20 years would be adopted by the Health Assembly in May 1998. However, its broad lines would already have been determined by the Executive Board session in January 1998. Her delegation would appreciate a detailed outline of the preparatory work envisaged for the period between that date and the start of implementation of the strategy in the year 2000, and expected Member States to be consulted about that preparatory phase. She urged a review of the timetable shown in the Annex to document A50/5 to ensure that those two valuable years were not lost.

Mr VAN REENEN (Netherlands) commended the report of the task force (document A50/15), which set out a number of clear guidelines for WHO in the future and placed health in a broad development framework. Referring to paragraph 4(4) of the draft resolution, he could agree to a limited extension of the task force’s mandate for one year, so that it could finalize some matters, such as consideration of health as a human right, but had reservations about the suggestion that WHO establish a partnership with national lotteries in order to mobilize resources. Careful consideration was required before any engagement in such a scheme could be contemplated.

The Netherlands continued to attach great importance to renewal of the health-for-all strategy and endorsed the thrust of resolution EB99.R16. His country was, however, disappointed with progress on drawing up a draft policy document; document A50/14 was of a purely procedural nature. Although a substantive policy paper would be submitted to the Executive Board the following week and had been made available to delegations to the Health Assembly, he greatly regretted that the Assembly had not been given the opportunity formally to discuss the substance of such a policy at the present session.

Mr PETTERSSON (Sweden) said that renewal of the health-for-all strategy was the most challenging task facing Member States; unambiguous guidance for the tasks ahead in the twenty-first century was imperative. The contribution made by the task force was of the utmost importance in such renewal.

All were aware of the many severe health problems to be tackled. However, there were also promising opportunities for worldwide progress on health resulting from pledges made by governments at a number of United Nations world conferences. Clarification of WHO's role in that more favourable context was a further challenge. The most credible approach would be a shift from health ownership to health leadership.

It was vitally important that Member States should participate in a step-by-step definition of the scope, purpose and goals of the renewed strategy in a global process leading up to agreement on its key principles. The renewed strategy should brief, understandable by all and globally relevant; it should be structured around three central considerations: broad value-based guidelines centred on the major health determinants, a core strategy for approaches and action by the health sector, and a sound basis for WHO’s future role and functions. The strategy should focus on the provision of equal health opportunities for children and young people now and in the future and also deal with reproductive health as a key factor in social and economic development. Health research likewise played a leading role nationally and globally. Time was short for completion of the task; all must contribute to building consensus on a strategy for improving health throughout the world.

The meeting rose at 12:00.
SIXTH MEETING

Friday, 9 May 1997, at 14:30

Chairman: Dr M.N. SAVEL'EV (Russian Federation)

WHO REFORM: Agenda item 26 (Resolution WHA49.23) (continued)

Renewing the health-for-all strategy, including report of the task force on health in development: Agenda item 26.1 (Resolutions EB99.R8 and EB99.R15; Documents A50/14 and A50/15) (continued)

Dr MEAD (Australia) urged that the momentum of reform of the Organization be maintained. The report of the task force on health in development would make an important contribution to the renewal of the health-for-all strategy. Australia agreed with the Netherlands that the mandate of the task force might be extended for a further year to enable it to complete its work and endorsed Japan's comments regarding representation from the Western Pacific Region.

Referring to the informal briefing on the content of the draft health-for-all policy for the twenty-first century that had been held during the lunch-break, she said that it was essential that all Member States embrace and subscribe to the health-for-all renewal process; in that connection, the Executive Board’s recommendation that there be intensive consultations deserved the closest attention. Regional consultations should be coordinated globally, and every effort should be made to secure input from the widest possible range of sources following the circulation of the draft global policy document.

Clearly, a “global health charter” would be more widely read and understood than a more detailed policy document. Ownership should therefore be very wide and the process of formulation should be as inclusive as possible. Her delegation would welcome information as to the manner in which the drafting of such an instrument was envisaged.

Mr VOIGTLÄNDER (Germany), commending the informative briefing organized by the Secretariat, submitted that notwithstanding certain complaints about the slow pace of reform, considerable progress had in fact been made during the past three years: the process must continue. Most crucially, a way of streamlining WHO’s many activities had to be found, as well as of setting priorities to match the resources available. Partnerships with international and intergovernmental organizations needed to be further developed to avoid the duplication of activities and ensure a proper sharing of tasks. In that context it was hard to understand why collaboration with the European Union merited only three lines in document A50/16.

Germany commended the contribution made by the task force on health in development to the debate on basic policy issues related, among other things, to WHO’s vision and mission, health as a bridge to peace, the Organization’s global health leadership and its role at major international conferences like those held in Cairo, Copenhagen and Beijing. The task force had also been looking at ways of mitigating the negative effects of conflict and persistent worldwide social and economic inequities, focusing on the primary aim of the Organization as set out in the Constitution: to promote the enjoyment of the highest attainable standard of health as a fundamental right of every human being. There was indeed a need for such a body, which should continue to receive support, at least until the health charter had been elaborated.

Mr SINGH (India) addressed the report by the task force entitled Reflections of the past - visions of the future (document EB99/40), singling out for particular commendation the recommendations contained in paragraph 26, on promoting a global agenda for health. Not only were those recommendations especially relevant to the health-for-all strategies which were an important component of WHO’s work; some of them could
be used as a basis for WHO to assume health leadership and act as the world’s health conscience in the twenty-first century. However, paragraphs 31 and 35 of the report contained elements that went beyond health development and health for all. Paragraph 31 mentioned preventive diplomacy, conflict prevention, mitigation and resolution, and proactive measures to avert the outbreak of conflict, which his delegation did not consider relevant to the remit of the task force. In paragraph 35 reference was made to the application of sanctions which clearly went beyond the Organization’s competence. Paragraph 35 also contained other references which India deemed unacceptable, notably in relation to health accountability at all stages and levels of development.

The report had been prepared by independent experts and contained a number of useful suggestions. Clearly, it was up to Member States to consider those aspects of the report of the task force that were relevant in planning their health development strategies. The Director-General might wish to take account of some of the recommendations during preparatory discussions for the Tenth General Programme of Work and the renewal of the health-for-all strategy. It would be appropriate for the Health Assembly to agree to a limited extension of the work of the task force, on the understanding that the process was not to be open-ended.

For the reasons already mentioned, India was unable to endorse all the recommendations of the task force, or to support the setting up of a monitoring mechanism to oversee the incorporation of its recommendations into WHO’s programmes. The Director-General and Member States should endorse only those aspects of the report that were useful and relevant. Therefore, instead of the approach outlined in paragraphs 4(5) and 4(6) of the draft resolution as amended, the Health Assembly should itself keep the work of the task force under continuous review. Additional amendments should be incorporated in the draft resolution, which should take note of, but not endorse, the recommendations of the task force and ensure that its work was monitored. The question of whether the task force should continue its work until the 1998 World Health Assembly and the situation be reviewed at that time also needed to be considered. The Indian delegation would be happy to join in consultations on those matters with a view to producing a revised text of the draft resolution.

Dr KALUMBA (Zambia) warmly commended the work of the task force and the recommendations contained in its report and endorsed the draft resolution as amended. Millions of Africans in countries such as Burundi, Ethiopia, Rwanda, Somalia and Zaire had died, not from disease, but because the international community had lacked the will to prevent violence. The World Health Assembly and Executive Board had adopted resolutions on the prevention of violence. Violence, whether physical or through trafficking in human beings, was unacceptable in civilized society. With all due respect for the reservations voiced by the previous speaker, he would submit that health-promotive and disease-preventive diplomacy were very much an aspect of health advocacy. WHO had a role to play in preserving life, not just in combating disease; together with emergency humanitarian response after the event, proactive policies were needed to prevent loss of life. And was not India itself a great democracy, founded on the principle of non-violence, whose survival had been based in great measure on diplomatic effort and negotiation? He very much hoped that the present difference of opinion concerning the recommendations of the task force could be resolved through compromise.

Stressing once again that WHO indeed had a role to play in preventing violence and the associated loss of life, he said he found it difficult to imagine that anyone of goodwill could fail to endorse the commitments called for in paragraph 2 of the amended draft resolution on the report of the task force. To his mind, unless such commitments were secured, there would be little point in continuing to talk about renewal of the health-for-all strategy, about a global health policy or about any other related matter. The time had come to break out of the prison of orthodoxy and resolutely face the challenges of the future; he would willingly participate in any consultations to that end.

Dr ALVIK (Norway) submitted that while WHO’s basic objective should remain “the attainment by all peoples of the highest possible level of health” the Organization clearly needed a new, bold strategy and a new slogan with which to enter the new century, since the previous ones had proved to have serious shortcomings. She commended the report by the task force on health in development as a valuable contribution to the rethinking of the role of WHO and as a starting-point for the discussion of new strategies rooted in equity and solidarity, to which a proper concern for sustainability, ethics and gender-related issues should be added. With the unlikelihood of achieving “health for all by the year 2000” as a cautionary lesson, care should be taken not to adopt a new strategy that was too all-embracing and too complex to serve as a guide to practical implementation.
Norway would contend that in order to bring about changes in public health in a community, four basic conditions had to be met: safe food and water; improved literacy; a climate of peace; and equal opportunities for men and women and for all ethnic groups and social classes. “Development for health” might replace “health for all” as WHO’s new slogan, since not only was health achievable through development, but a healthy population was itself a contribution to development.

WHO should collaborate much more actively with other United Nations organizations. Its most important role had always been to ensure that the quality of health care activities was as high as possible, that standards set were based on well documented experience, and that norms recommended were based on scientific research, common sense and universal consensus. Technical and other support for Member States should be the main hallmarks of the new strategy. By concentrating its resources, WHO should be able to avoid conflicts of interest with other organizations and the duplication of work which unfortunately still occurred from time to time.

Her delegation supported the draft resolution on the report of the task force, as amended.

Dr EL SHAFEI (Egypt) said that her country, a cosponsor of the amended draft resolution, would be happy to enter into further discussions with interested delegations concerning further revision of the text.

Dr WINT (Jamaica) commended the task force on health in development on its report entitled Reflections of the past - visions of the future and on the work it had done in helping to redefine a vision for health in the twenty-first century, and thanked the Secretariat for the briefing session. He urged the task force in future discussions to examine, in particular, the leadership role of ministries of health and local health sectors in country-level development planning. Jamaica supported the amended draft resolution.

Dr LOUA (Guinea), stressing the importance of its mandate, commended the task force on health in development on its new ideas for mobilizing resources, and its views on public sector-private sector partnership, a matter which should certainly be subject to agreed criteria but handled with flexibility. Guinea supported the draft resolution.

Dr DURHAM (New Zealand) joined previous speakers in stressing the need for a clear, shared vision of health. Unfortunately, the current Health Assembly had so far missed the opportunity to intensify the consultation process on renewal of the health-for-all strategy: the one-hour briefing had come a little late. The global health charter would have valuable potential to inspire and lead action for health but, as the delegate of Australia had pointed out, there must be ownership of the charter by countries and health organizations for it to be properly effective. Moreover, the process of developing the charter would be as significant as the product, and her delegation would thus welcome additional information on that process. While praising the clarity and relevance of the themes and strategies in the task force’s report, she expressed grave doubts over the desirability of the lottery option for mobilizing resources: the Organization must not be perceived as gambling with health. The report had done well to emphasize WHO’s technical excellence; the Organization should assume an explicit leadership role in disseminating information on sound practices.

Dr FUKUDA (Japan) recalled that the Board, at its ninety-ninth session, had commented on the need to expedite development of the renewed strategy and to ensure the speedy delivery of information to Member States. The relevant documentation had not, however, been made available until the opening of the current session. Moreover, compared to the extensive reflection of Board discussions in the documentation relating to the proposed programme budget, only light mention was made of its discussions in document A50/15. The entire process would need to be accelerated by the Secretariat before a new global health charter could be adopted. Reconfirming Japan’s commitment to participation in the renewal process and in the formulation of the global health charter, he drew the Committee’s attention to the fruitful work carried out by the East Asian Ministerial Meeting on Caring Societies held in December 1996 in Okinawa, Japan.

Dr LÉPES (Hungary) said that Hungary supported the draft resolution as reflecting the main principles of WHO’s tasks in health development. His delegation would be in favour of moves to ensure a proper correlation between regional and global health-for-all strategies.
Dr GALLAGHER (Council for International Organizations of Medical Sciences), speaking at the invitation of the CHAIRMAN, said that perceptions of health for all had been influenced by the growth of bioethics - the development from traditional medical ethics, concerned exclusively with the good of the individual patient, to health-care ethics, which recognized the social and population dimensions of ethics. CIOMS through its “International Dialogue on Health Policy, Ethics and Human Values” had contributed substantially to improved understanding of the bioethical and human-values aspects of health for all and of the ethical principles, including equity, that should be reflected in health systems which genuinely met the needs and aspirations of their populations. The Director-General had invited CIOMS to contribute as regards ethics and health to the health-for-all renewal process. CIOMS had convened an International Ethics Advisory Committee in September 1996 to prepare the ground for an international conference on ethics, equity and the renewal of WHO’s health-for-all strategy. Held two months previously in Geneva, hosted jointly by CIOMS and WHO, the Conference had focused on equity, or distributive justice, as a particular aspect of ethics and human rights, and had proposed an action plan for a joint CIOMS-WHO initiative on ethics, equity and health for all, which had received a positive response from the Director-General. The plan specified needs and objectives with a view to ensuring that the global health policy for the twenty-first century would be founded on equity or distributive justice.

Dr RAM (World Vision International and NGO Forum for Health), speaking at the invitation of the CHAIRMAN, described the work of the NGO Forum for Health in support of the health-for-all movement globally, in enhancing relationships between WHO and nongovernmental organizations and in improving channels of communication, as well as promoting ongoing dialogue at global, regional, national and local levels.

The NGO Forum for Health was deeply concerned that 1500 million people worldwide lacked access to basic health care services. While macroeconomic policies might stimulate economic growth, they also led to large-scale marginalization; it was therefore vital to define global health priorities and develop strategies for dealing with them.

Nongovernmental organizations had great experience in working with communities and in mobilizing community participation in the development of appropriate approaches to improving health. They had participated in the 1978 Alma-Ata Conference on Primary Health Care, and continued to make an important contribution to the vision of health for all. They were able to monitor the impact of economic and trade policies on health and also to monitor the implementation of health-for-all policies in communities. For its part, WHO could support the lobbying efforts of nongovernmental organizations and strengthen their monitoring capacity, though without compromising their independence and integrity. It could also facilitate information-sharing and thus help to extend the nongovernmental organizations’ technical skills; the partners could reinforce each other’s stance on moral and social justice issues.

He would like to see continued dialogue and consultation with nongovernmental organizations during World Health Assemblies, regional meetings, and other regular WHO events, and urged that sustainable mechanisms be developed to ensure that nongovernmental organizations were involved at all levels of policy development and implementation. Appropriate structures should be created to enable them to work with the Organization, and priority should be given to important issues such as reducing poverty and hence the effects of poverty on health. Selective representation of nongovernmental organizations in delegations to the Health Assembly as well as in decision-making bodies, task forces and working groups should be promoted, and the criteria whereby they qualified for official relations with WHO should be reviewed. Lastly, a global health-watch system should be set up to determine how well both governments and nongovernmental organizations were meeting their health-for-all targets, and a joint celebration should be held on the fiftieth anniversary of the Organization. In short, a working partnership between nongovernmental organizations and WHO would inspire a vigorous renewal of effort worldwide to achieve the goals of health for all.

Mr AITKEN (Assistant Director-General) said that the Executive Board had recently addressed the issue of participation of nongovernmental organizations, with special reference to the expanded role they might play in intersectoral collaboration. The discussions had been prompted by the moves within the United Nations to consider nongovernmental organizations on national and regional bases. The Board would be examining the issue in greater depth at its 101st session.
Ms KUNTZ (World Federation of Public Health Associations), speaking at the invitation of the CHAIRMAN, said that on 5 May 1997, the Federation had adopted a resolution concerning the role of nongovernmental organizations in the renewal of WHO's health-for-all strategy which noted that of more than 180 nongovernmental organizations currently enjoying official relations status with WHO, most were primarily concerned with medical care and specific diseases. WHO had drawn attention to the social gaps in health status within and between countries in the North and South, but many consumer, development, human rights, social welfare, and environmental groups which shared WHO's concerns regarding equity were insufficiently represented in the Organization. Nongovernmental organizations operating at local level had a proven record of flexibility, innovation and efficiency in identifying and addressing the needs of communities and could be highly effective in representing grassroots concerns before governments and intergovernmental organizations. Local, national and international nongovernmental organizations had contributed significantly to advancing global health and well-being, and could make even greater contributions in the future. WHO must therefore ensure that nongovernmental organizations representing the broad range of public health concerns at all levels could play an active role in the Organization, particularly regarding advocacy and policy development. WHO should also encourage governments to strengthen their own relations with nongovernmental organizations. In particular, she urged WHO to support the NGO Forum for Health. The World Federation was committed to strengthening its links with WHO and nongovernmental organizations around the world and looked forward to collaborating with WHO to improve the working relationship between WHO and all nongovernmental organizations contributing to health. That enhanced partnership would be a giant step towards achieving the common goal of health for all.

Dr BELMAR (Chile) said that development of health systems must be comprehensive; that meant involving the private, non-profit making sector as well as the public sector. He stressed the importance of health-related nongovernmental organizations in many parts of the world.

Dr ANTEZANA (Deputy Director-General ad interim) thanked all the delegates who had participated in the discussion and in the briefing session, thereby demonstrating their commitment to health for all in the twenty-first century.

In response to questions raised, in particular by the delegates of Australia and New Zealand, he said that the global health charter would be drafted on the basis of wide consultation with Member States and interested parties such as nongovernmental organizations and academics. The time available would, of course, be limited so that ways and means would have to be found to accelerate the process. As the 101st session of the Executive Board would not take place until January 1998, it was proposed that the draft of the charter be submitted to the special group of the Executive Board set up to review the Constitution, or to any other group that might be so empowered by the Executive Board at its coming session. It would consequently be possible for members of the Executive Board to discuss the content before the formal meeting in January. A further suggestion had been made to circulate the draft by e-mail or other electronic means to Member States and other interested parties.

In answer to the delegate of Denmark, he said that the fixing of priorities was an important matter and would be settled following the adoption of a conceptual framework; once the global priorities had been established, the regional and country ones would follow.

Regarding the comment by the delegate of the Netherlands that he would have appreciated the opportunity of discussing a draft text at the present session, he replied that owing to the wide consultation process and the need for the Executive Board to consider such a document beforehand, that had not been possible. However, additional meetings had been scheduled in which Member States would be able to provide further input.

The concerns expressed by the delegate of Sweden concerning the structure and focus of the renewed strategy had been duly noted. In general, the Secretariat had been very pleased to receive feedback and comments reflecting the concerns and wishes of Member States in regard to WHO policy for the twenty-first century. The principles established by the task force would, of course, also be incorporated. He stressed that the Director-General welcomed the report of the task force and it would now be for the Executive Board to provide the appropriate guidelines with regard to the policy document, the strategy, and the charter. He was sure that the clear sense of ownership that had been called for would be established.

He assured the delegate of Chile that WHO welcomed the contributions by nongovernmental organizations, with a number of which a very successful meeting had recently been held; he hoped that a similar exercise might be organized at the regional level.
Mr TAITT (Chairman, WHO Task Force on Health in Development) thanked the delegates for their supportive comments and assured them that it was not envisaged that the mandate of the task force in its present configuration would be extended beyond the next Health Assembly or the arrival of a new Director-General, who should have the opportunity of reviewing and taking decisions on bodies such as the task force, with the Health Assembly’s guidance.

Dr SAMBA (Regional Director for Africa), referring to the recent fruitful meeting held with nongovernmental organizations, said that he had invited all those working in Africa or wishing to work on that continent to a meeting in Brazzaville in the near future, to discuss collaboration with the Regional Office. Enquiries in that connection would be welcome.

Dr KALUMBA (Zambia) said that as a result of informal consultations and in a spirit of compromise, his delegation had conceded in some measure to the arguments advanced by the delegate of India, who would present the agreed further amendments to the draft resolution on the report of the task force.

Mr SINGH (India) confirmed that a spirit of consensus had indeed prevailed in the informal consultations and proposed the following additional amendments.

In the fourth preambular paragraph, the words “will be affected by” would be replaced by “should take into account”. Paragraphs 1 and 2 should be amended to read:

1. COMMENDS the members of the task force on health in development for their commitment and creativity;

2. APPRECIATES the task force’s vision for health leadership in the twenty-first century so that WHO can act as the world’s health conscience;

In paragraph 4(2), “to use the recommendations in the task force’s report” would be replaced by “to consider taking into account relevant recommendations of the task force”. Paragraph 4(5) would be deleted; and paragraph 4(6) would be renumbered and amended to read: “(5) to report to the 101st session of the Executive Board on the above;”. Lastly, the following new paragraph 5 should be inserted:

5. DECIDES to keep the work of the task force under continuous review and requests the Director-General to report to its fifty-first session, in order to enable the World Health Assembly to consider the renewal of the mandate of the task force.

Dr BEGUM (Bangladesh), noting that a great deal of work had gone into the preparation of the report of the task force and that the Executive Board had commended it to the Health Assembly, submitted that any amendments to the draft resolution contained in resolution EB99.R8, whether substantive or structural, should be put to the vote.

Dr KALUMBA (Zambia) urged the delegate of Bangladesh to display the spirit of consensus shown by the many sponsors of the draft that had been set before the Committee in taking the concerns of the delegation of India fully into account. He pointed out that nothing of substance had been changed in the draft resolution, and that all delegations shared a mutual interest in the pursuit of global health goals.

The draft resolution, as amended, was approved.¹

Mr ASAMOAH (Secretary) said that the Committee would not consider the resolution recommended by the Executive Board in resolution EB99.R15 as it had already been taken up by Committee A in the course of its examination of the Tenth General Programme of Work.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA50.23.
The world health report 1998 and third evaluation of progress in implementation of the global strategy for health for all by the year 2000: Item 26.2 of the Agenda (Decision EB99(4))

The CHAIRMAN said that in the absence of objections, he would take it that the Committee wished to convey the following draft decision to the plenary:

**Decision:** The Fiftieth World Health Assembly, after considering the recommendations of the Executive Board at its ninety-ninth session, decided that the global report on the third evaluation and ninth report on the world health situation should be incorporated in *The world health report 1998*, and that there should no longer be separate reports on the world health situation.

The meeting rose at 16:45.

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1 Decision EB99(4).
2 Decision WHA50(11).
SEVENTH MEETING
Monday, 12 May 1997, at 14:30

Chairman: Dr T. TAITAI (Kiribati)

1. THIRD REPORT OF COMMITTEE B (Document A50/33)

Dr AMMAR (Lebanon), Rapporteur, read out the draft third report of Committee B.

Mr ASAMOAH (Secretary) said that, in accordance with the decision of the Committee at its fifth meeting, the words "and other services" should be deleted from paragraph 3 of the resolution on arrears of payment, Bosnia and Herzegovina, approved under agenda item 22.2.

The report, as amended, was adopted.¹

2. SCALE OF ASSESSMENTS: Item 24 of the Agenda (continued)

Scale of assessments for the financial period 1998-1999: Item 24.2 of the Agenda (Document A50/13) (continued from the fifth meeting)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution contained in paragraph 6 of document A50/13. He recalled that at the Committee's second meeting an amendment to add a new operative paragraph 3 had been proposed by the delegations of the Russian Federation and the United States of America. An alternative amendment to the draft resolution had since been submitted by the delegation of the Islamic Republic of Iran, whereby the following new operative paragraphs 3 and 3.1 would be inserted:

3. REQUESTS the Director-General to adjust the WHO scale of assessments for the year 1999, to reflect any new scale of assessments for 1999 established by the United Nations General Assembly at its fifty-second session, and to provide for full consistency between the two scales of assessments in future.

3.1 FURTHER REQUESTS the Director-General to take into full account the excessive contribution of those Member States whose scale of assessment for 1998 was revised down by the fifty-second session of the United Nations General Assembly, and to credit them accordingly with the equal amount of their over-assessment for 1998 in the second year of the biennium out of casual income.

Mr AITKEN (Assistant Director-General) recalled that the debate on the scale of assessments had begun with the report by the Director-General (document A50/13). That was a standard document produced for every Health Assembly, outlining the proposed scales of assessment for the biennium under consideration. In accordance with WHO's financial regulations, the latest available United Nations scale was used to carry out the necessary calculations. A very small difference existed between the WHO and United Nations scales: the fact that WHO had more Member States gave rise to a slight adjustment.

¹ See page 240.
Identical scales had been presented for both years of the biennium 1998-1999. However, in his report the Director-General had stated that in accordance with Financial Regulation 5.3, in the first year the Health Assembly might decide to amend the scale to be applied in 1999, should subsequent changes in the United Nations scale so warrant. The Director-General's proposed resolution was the subject of two proposals for amendments, one by the Russian Federation and the United States of America, and the other by the Islamic Republic of Iran.

In the initial discussions on the first amendment at the Committee's second meeting, it had been clear that no consensus had been reached on the first amendment. That amendment focused primarily on the possible consequences of a change in the United Nations scale for 1998 and 1999. At the United Nations in New York a new scale for the three-year period 1998-2000 was currently being considered and the United Nations Committee on Contributions would report, through the Fifth Committee, to the General Assembly on the matter. However, a final decision was unlikely before December 1997 and it would be unwise to predict the outcome of the debate in progress, since the Committee on Contributions had eight possible alternative scales to consider.

Similarly, the amendment submitted by the Islamic Republic of Iran focused on the effects of a change in the United Nations scale in relation to the years 1998 and 1999. As had been stated in the debate on the appropriation resolution in Committee A, certain delegations considered that the two issues were linked. Discussions had taken place to see whether a consensus could be achieved. However, it remained to be determined whether suitable wording could be found.

Mr IVANOU (Belarus) said that the restructuring of the financial mechanisms of any organization was a key issue in the process of reform. It was to be hoped that the Health Assembly would take a logical and principled stand in that connection. He could not agree with the view expressed by Mr Aitken that it would be impossible for the Committee to take a decision on the amendment proposed by the Russian Federation and the United States of America, which his own delegation fully endorsed. Furthermore, any scale of assessments should without question be founded on the principles of objectivity and equity: Belarus would not wish to see repeated its own unhappy experience of an excessive charge of US$ 11 million in connection with the Vienna Convention and the Montreal Protocol relating to the depletion of the ozone layer.

Mrs JACOBSEN (Niue) said that as a Member of WHO in its own right as a sovereign nation but not a member of the United Nations, Niue, with a population of less than 3000, paid the minimum assessed contribution alongside such countries as Samoa and Mongolia. Adoption of the draft resolution as amended by the Russian Federation and the United States of America would be tantamount to taking Niue's fate out of its own hands, something which her delegation could not accept. For that reason, it supported the proposal put forward by Japan to retain the status quo for the financial period 1998-1999 until such time as the United Nations made available to WHO the relevant figures for that biennium. As it stood, the draft resolution was one of taxation without representation, which Niue could not support as a matter of principle.

Mr JUDIN (Russian Federation) remarked that the synchronization of the WHO and United Nations scales of assessments was not an aim in itself. Indeed it could not be denied that the Health Assembly had sovereign powers with regard to the distribution of expenditure among Member States for the purposes of financing the Organization's budget. However, the United Nations scale was applied as an instrument of such distribution because, revised every three years, it reflected the latest changes in Member States' ability to pay. The aim of the work of the United Nations Committee on Contributions and the General Assembly was to achieve maximum compatibility between the assessed contributions of different countries and their ability to pay, in other words to make the scale of assessments as equitable and realistic as possible.

Unfortunately, major changes in the world economy had taken place and in a large number of countries gross national product had fallen and continued to do so. Other countries' economies were on the verge of collapse. The periodically revised United Nations scale, which was taken as a basis by most United Nations agencies for calculating their own scales, reflected the changes to a certain extent.

It was fair to ask, therefore, why a country whose contribution was - for example - halved in accordance with the United Nations scale for 1998 should be obliged to continue paying contributions to WHO in accordance with the 1997 scale, in other words at twice the rate it was deemed by the United Nations realistically able to pay. The consequences of situations such as that which he had just evoked were well known: non-payment of contributions, increased indebtedness, the imposition of sanctions and loss of the right to vote.
Reiterating the principle that Member States should be given the opportunity to pay what they could realistically afford, he said that in respect of 1998 the most recent United Nations scale should be applied: not the scale in force at the time WHO’s budget was adopted but that which the United Nations would adopt for that year. Full synchronization between the United Nations and WHO scales had been called for: that was technically possible. The amended resolution proposed by the Russian Federation and the United States of America was, he acknowledged, only one possible solution; what was essential was to resolve the problem.

It might of course be argued that the United Nations scale for 1998 was at present unknown. That was true but, however it might be determined, the scale would be a more accurate reflection of the principle of the ability to pay of a large number of States which were currently unable to pay their contributions and many of which were consequently deprived of the right to vote. Moreover, no one contested the principle of applying the United Nations scale; what had to be resolved was the technical inconsistency resulting from the fact that if the WHO Financial Regulations were followed, the realistic United Nations scale would be set aside in favour of that known at the time the budget was adopted.

It was clear that certain countries would pay more in accordance with the 1998 United Nations scale than under the 1997 WHO scale. Unfortunately, that was a consequence of current financial reality and reflected a change in countries’ ability to pay. The adjustment was, furthermore, essential if the United Nations organizations were to be placed on a sounder financial footing. At all events, the guiding principle - he insisted - should be that the distribution of expenditure between Member countries must be based on a logical and equitable scale of assessments.

Mr XU Nanshan (China) reminded the Committee that WHO was an independent specialized agency. The scale of assessments it applied must be based on its own principles and methodology. According to the relevant regulations, the scale adopted for 1998-1999 should follow the most recent United Nations scale, which meant that the 1997 United Nations scale should be the point of reference. No scale should be applied that had not been adopted by the Health Assembly. Furthermore, as was stipulated in the Organization’s Financial Regulations, a scale of assessments must not be adjusted or amended during the first year of a biennium. China’s contention was therefore that the amendment proposed by the Russian Federation and the United States of America observed neither the principles governing the relevant scales of assessment nor the Financial Regulations, and would bring about a state of unacceptable disorder in the Organization’s financial and budgetary affairs.

Mr AKAO (Japan) expressed disagreement with the amendment proposed by the Russian Federation and the United States of America. Japan did not challenge the United Nations scale of assessments or the principle of reflecting countries’ ability to pay, but merely wondered whether it was really necessary to change a tried and tested formula of 25 years’ standing. As long as the United Nations assessments had not been reduced, no complaints had been heard, but as soon as the scale started to go down, countries had been quick to urge that it be applied to WHO as soon as possible. Comparing the situation to a game with figures, he observed that countries which stood to profit had spoken out in favour of the proposed amendment while others, including Japan, had been opposed to it. But in such games, the profits were never more than ephemeral. Japan would plead for consistency, and the need to avoid being blinded by merely short-term perspectives.

As he saw it, the United States had up to now never argued against the prevailing practice. But, having failed in its attempt to secure a 5% reduction in WHO’s budget, the Administration had to find a way of persuading Congress to foot the bill. Japan sympathized, but the problem was a domestic political one; and it would certainly be inadmissible to penalize on that account countries which had faithfully paid their dues in the past, and to ask them to pay more because they were in a position to do so.

The delegate of Belarus had mentioned an unfortunate incident involving its contribution to a small body; but what was more meaningful, perhaps, was the fact that along with WHO, many major organizations, including ILO, UNESCO, IAEA, FAO, UNIDO and others, required their Member States to pay assessed contributions, according to the same fundamental approach. Why should a time-tested methodology be changed, merely for the convenience of certain Member States?

Speaking on behalf of the Member countries of the European Union, Mr VAN REENEN (Netherlands) opposed the amendment proposed by the Russian Federation and the United States of America, whereby the Director-General would be authorized to adjust WHO’s scale of assessments immediately after a new United Nations scale had been adopted. Such a proposal would create unnecessary uncertainty for WHO Member States.
in relation to their assessed contributions. There was no apparent reason to depart from the current rules. Furthermore, the implementation of the provision in the final sentence of the amendment would be at variance with domestic budgetary procedures in a number of Member States of the European Union.

Similar comments applied to the proposal by the Islamic Republic of Iran. The use of casual income in 1999 to compensate for over-assessment in 1998 would run counter to the decision approved in Committee A on the use of such income in the framework of the proposed appropriation resolution for the 1998-1999 biennium.

Ms Sosa Márquez (Mexico) said that the decisions taken by the Health Assembly should result in a clear picture of the assessed contributions to be paid by each Member State. The proposed amendment introduced an element of uncertainty both for Member States and for the Organization. The principle of harmonization should be applied, taking into account the budgetary programme cycles at national level.

Mr Moëini (Islamic Republic of Iran) stressed that his delegation's principal concern was to identify the solution which would be in the best interest of all WHO Members in the matter of assessments. His country was the twenty-fourth largest contributor to the WHO budget and he believed that in order to encourage Member States to pay their dues punctually, it was essential to take their concerns into full consideration. He had studied carefully the proposal by the delegates of the United States of America and the Russian Federation. He was also familiar with WHO's principle of complying with the United Nations scale of assessments and had worded his own amendment accordingly.

Under the terms of paragraph 3, as proposed, the Director-General would simply be authorized to adjust the WHO scale of assessments for 1999 to reflect any new scale for 1999 established by the United Nations General Assembly. Such action would be logical, straightforward, and not in contravention of the Financial Regulations; it would not prejudge any further discussions or future decisions on the subject. Paragraph 3.1 had been inspired by the fact that, as things stood at present, and because of the timing of the different operations in the United Nations and at WHO, his country was likely, for the second time, to be over-assessed by the latter. That was hardly a stimulus to States which had done their best to fulfil their obligations. The proposal was designed to create a mechanism for redressing the balance when over-assessment occurred. Again, he saw nothing in the proposal that would contravene the Financial Regulations. With all due respect to the delegate of the Netherlands, he would recall the position his own country had taken in Committee A, which was that no decision on the subject of the appropriation resolution could prevent Committee B and the Health Assembly from continuing to consider the scale of assessments. Nor did the Iranian proposal prejudice or preempt any decision on that subject that might be taken in the United Nations.

He remained convinced that his proposal constituted a good basis for compromise and consensus between differing views and would help to encourage all Member States to fulfil their constitutional obligations.

Mr Coelho de Souza (Brazil) endorsed the point of view expressed by the delegate of Japan. With regard to the WHO scale of assessments for 1998-1999, and in view of the fact that decisions had to be taken in the United Nations with results yet unknown, his delegation was unable to support the amendment proposed by the Russian Federation and the United States of America.

Mr Boyer (United States of America) said that the United States had not come to the World Health Assembly to cause trouble for the Organization. As his delegation had earlier explained in Committee A, the aim of his country was to place WHO on a sound financial footing, so that States would be assessed at a level at which they were able to pay. The problem did not affect only the United States: some 63 countries had been unable to pay any contributions in 1996 and more than 40 countries were two years in arrears - an indication that either budgets or assessments were too high or else that the latter were improperly allocated. Yet it was essential for the Organization to have a dependable income so that it could plan the implementation of its programmes.

The delegate of Japan had suggested that the problem was a domestic one affecting the United States, which was partially true. However, more importantly, there was an immediate cash flow problem confronting WHO. It was clear that in the run-up to the twenty-first century, and in the light of a bipartisan agreement between the President of the United States and Congress, funds for payment of contributions to international organizations would not be made available at the level of assessment. The United States, like various other countries, was already in substantial arrears. Under the agreement currently being negotiated with the United
States Congress, those United States' arrears would be paid. If the level of budget and/or assessments were reduced, the United States would then be in a position to pay its dues in full and on time, and would do so most willingly because of its commitment to the cause of health worldwide.

As pointed out, a number of different proposals for assessment scales were being discussed at the United Nations in New York; whatever the outcome, there would be substantial relief for several countries, notably in the form of corrective action in regard to countries which had been incorrectly assessed.

The proposal by the Russian Federation and the United States was that the new scale to be adopted at the end of 1997 be applied immediately, as from 1998. Various countries had suggested that that would create problems. The proposers of the amendment had tried to be flexible and had suggested postponing to the next Health Assembly the implementation of the new scale of assessments; but it had not proved possible to obtain agreement on that scheme either. It was much to be regretted that no compromise had been reached and that the matter would therefore in all likelihood have to be put to a vote. He reminded the Committee that he had signified willingness to withdraw the second and third paragraphs of the proposed amendment.

Mr BAYARSAIKHAN (Mongolia) said that his delegation was unable to support the amendment proposed by the Russian Federation and the United States of America, for three reasons: the new United Nations scale of assessments had not yet been adopted; WHO was an independent agency whose membership was not identical with that of the United Nations; and Mongolia, which had always paid its dues on time, despite financial hardships, was uncertain as to how the new scale would affect its ability to pay.

Dr STAMPS (Zimbabwe) said that his delegation came from an area in Africa where the ability to predict the future was claimed by some people, although regrettably he had not brought with him one of those gifted persons, and could not claim the clairvoyance that the United States delegate seemed to be capable of exercising. There was consequently no way in which he could concur with a resolution, of which there might be eight possible different outcomes, seeking to bind his country or indeed any other to an indeterminate, flexible budget likely to further destabilize the Organization.

With regard to the proposed amendment to the draft resolution, it was difficult to establish what was meant by the ability to pay: underpayment might equally signify unwillingness to pay; he noted that in fact, one of the sponsors of the amendment paid its liabilities to PAHO punctiliously. There was also the matter of capitalizing on membership of WHO: there was clear evidence of a significant profit made by the largest contributor through payments to its nationals and to WHO collaborating centres.

There was also the suggestion of a floating budget, which was contrary to Zimbabwe's constitutional requirements - and no doubt those of many other countries - concerning the certainty and predictability of liabilities. Zimbabwe had always paid its dues on time because - like the United States of America - it believed that WHO was a most important organization for global health. His delegation would only accept the amendment if the cosponsor would agree to eliminate the contribution factor in determining the equitable geographical distribution of staff within WHO; he hoped that the largest contributor could be magnanimous enough to concede that the ability to serve should supersede the ability to buy. A further condition would be that that country abandon its claim to a veto in the Security Council, which was so prone to be used for selfish and self-serving purposes.

Professor ALI (Bangladesh) endorsed the statement made by the delegate of Japan and disagreed with the proposal put forward by the delegations of the United States of America and the Russian Federation.

Mr ASAMOAH (Secretary) said that in view of the persistent divergency of views, the Director-General wished to suggest a brief suspension to permit the delegates of the United States of America, the Russian Federation, Japan, the Islamic Republic of Iran, the Netherlands and any other interested delegation to pursue the quest for consensus.

Dr RAHIL (Libyan Arab Jamahiriya), rising to a point of order, said that the discussions on the scale of assessments at the current and earlier meetings of the Committee had been extensive. All States, with perhaps two exceptions, agreed with the draft resolution contained in document A50/13 and the time had now come to adopt the proposal. If there were background considerations, then those should have been expressed at the
outset, so that delegates would know where they stood. Or were matters simply to be left in the hands of the
large States?

The DIRECTOR-GENERAL recalled that earlier in the day he had spoken out in favour of the long-
standing tradition whereby WHO reached decisions on budgetary matters by consensus. No decision having yet
been taken by the United Nations with regard to a new scale, the Health Assembly might be said for the moment
to be concerning itself with “virtual assessments”; but the proposed programme budget for the next biennium
was very much a reality that called for unambiguous decisions.

Financial Regulations 5.3 and 5.5, which he commended to the attention of the Committee, constituted
the framework for such decisions, which included his own responsibility to Members in the event of any change
in the scale of assessments in the course of the biennium. In that connection, he pledged himself to full
consultation with interested Member States, and gave the assurance that he would take account of the current
debate and of the different views expressed, as well as of the budgeting system in different countries. With that
commitment on his own part, he very much hoped that a small group of delegates might be able to reach
consensus, even at such a late hour.

The meeting was suspended at 15:45 and resumed at 16:25.

Mr ASAMOAH (Secretary) announced that the text of a compromise resolution was being finalized. He
suggested that in the meantime the Committee might proceed with the next item on its agenda.

It was so agreed.

(For continuation, see summary record of the eighth meeting, section 3.)

3. FINANCIAL MATTERS: Item 22 of the Agenda (continued)

Status of collection of assessed contributions, including Members in arrears in the
payment of their contributions to an extent which would justify invoking Article 7 of the
Constitution: Item 22.2 of the Agenda (Document A50/10) (continued from the fifth meeting)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution on the proposal
of Cuba with the amendments introduced at the fifth meeting.

Mr AMAT FORÉS (Cuba) said that after consulting its Government regarding the proposed amendments
his delegation was in a position to accept a reduction in the period initially proposed to five years. In order to
do so, his country would certainly have to make major economic sacrifices. Cuba’s substantial achievements
in the public health field, which had led to a drop in the infant mortality rate to 7.9 per 1000 live births and an
increase in the average life span to 75 years, had entailed a considerable financial investment. Since his country
was, however, aware of the importance of financially buttressing WHO and not falling into arrears, it had
decided to make an even greater effort than that initially contemplated to settle outstanding amounts, but would
propose some modifications to the proposal, as amended. Cuba still agreed to pay, as from 1997, regular
contributions for the years in question and to liquidate its 1993-1996 arrears. In 1997, his country would
propose the amount already provided for in its budget and over a five-year period, as from 1998, it would be
able to settle the outstanding sum. Such readiness to pay indicated Cuba’s political will to meet its obligations
to the Organization and to begin to implement the amended scheme. Indeed, his country had already begun to
make payments in accordance with that scheme. In the draft proposed with respect to Bosnia and Herzegovina,
the phrase “and other services” had been deleted from paragraph 3. That should also apply to the draft resolution
now before the Committee.

Mr VAN REENEN (Netherlands) asked what amounts would actually be paid in the next few years under
the Cuban delegation’s proposal.
Dr BELMAR (Chile), Dr BIKANDOU (Congo), Mrs TINCOPA (Peru), Mr XU Nanshan (China), Mrs DHAR (India), Mr GUN (Democratic People's Republic of Korea), Mrs NTLABATHI (South Africa) and Ms KIZILDELI (Turkey) expressed appreciation of the exemplary efforts being made by the Cuban Government to pay its contributions to the Organization in the face of enormous difficulties, and endorsed the Cuban proposal.

Mrs VU BICH DUNG (Viet Nam), Dr ZAHRAN (Egypt), Mr MESSAOUI (Algeria), Dr SHANGULA (Namibia) and Mr MOEINI (Islamic Republic of Iran) endorsed that view and called for the restoration of Cuba's voting rights.

Dr DURHAM (New Zealand) advocated the strict application of all agreed regulations covering the non-payment of assessed contributions and the loss of voting rights. Her delegation would consider favourably any proposals that the World Health Assembly might explore in order to find additional ways of strengthening the disincentive scheme for late payment, provided that it were done in an equitable manner. It consequently rejected both the proposal in document A50/10 and the amended draft resolution introduced at the fifth meeting because it was worried about setting a confusing and unhelpful precedent. New Zealand would not, however, oppose any consensus which might emerge.

Mr AITKEN (Assistant Director-General) announced that the delegate of Cuba had proposed that paragraph 2 of the draft resolution be amended to the effect that Cuba would pay US$ 125,000 of arrears in 1997 and settle the remaining balance over five years, starting in 1998, at the same time as they paid their contributions for those years. That would bring the amount to approximately US$ 227,894 per annum for those five years. Should the Committee find those figures acceptable and approve the draft resolution as so amended, it would be able to review the text with the amended figures inserted when considering its next report.

On that understanding, the draft resolution, as amended, was approved.¹

4. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 27 of the Agenda (continued)

General matters: Item 27.1 of the Agenda (continued from the third meeting)

The CHAIRMAN invited the Committee to consider the following draft resolution entitled “International Decade of the World’s Indigenous People”, proposed by the delegations of Argentina, Australia, Brazil, Canada, Chile, Cook Islands, Cyprus, Denmark, Mexico, New Zealand, Nicaragua, Papua New Guinea, Peru, Philippines, South Africa and Uruguay:

The Fiftieth World Health Assembly,
Recalling the role of WHO in planning for and implementing the objectives of the International Decade of the World’s Indigenous People as recognized in resolutions WHA47.27, WHA48.24 and WHA49.26;
Further recalling United Nations General Assembly resolution 50/157, which adopted the programme of activities for the International Decade of the World’s Indigenous People, in which it is recommended that “specialized agencies of the United Nations system and other international and national agencies, as well as communities and private enterprises, should devote special attention to development activities of benefit to indigenous communities”, that the United Nations system should establish focal points for matters concerning indigenous people in all appropriate organizations, and that the governing bodies of the specialized agencies of the United Nations system should adopt programmes of action for the Decade in their own fields of competence, “in close cooperation with indigenous people”;

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA50.30.
Recognizing with satisfaction the progress made in the Initiative on the Health of Indigenous People of the Americas;
Noting the recent report by the Director-General to the Executive Board;¹
Noting with appreciation the activities of the focal point for the International Decade of the World’s Indigenous People,

REQUESTS the Director-General:
(1) to continue to facilitate the work of the focal point for the International Decade of the World’s Indigenous People;
(2) to submit to the Fifty-first World Health Assembly a report reviewing progress in finalizing a comprehensive programme of action for the Decade.

Dr DURHAM (New Zealand), introducing the draft resolution, said her country strongly endorsed it, as it had earlier Health Assembly resolutions on the subject, and believed that the formulation, implementation and review of a comprehensive plan of action for the International Decade was an essential part of the health-for-all strategy. New Zealand attached great importance to the health of indigenous people and was in favour of strengthening international cooperation to solve their common health problems. The purpose of the resolution was to ensure that the issue was always kept in the forefront of WHO’s attention. Amendments to the text, which New Zealand endorsed, would be proposed by Malaysia and Chile.

The organizers of the Third Healing Our Spirits Worldwide Indigenous Conference, which was to be held in Rotorua in February 1998, hoped that WHO and representatives from Member countries would attend the event.

Dr TAHA (Malaysia) proposed that, in order to keep the same wording as in resolution WHA49.27 and to clarify the method of work to be employed, the phrase, “developed in consultation with national governments and organizations of indigenous people” should be inserted at the end of subparagraph (2) of the operative paragraph of the draft resolution.

Dr BELMAR (Chile) proposed the addition of the following subparagraph to the operative paragraph: (3) to further encourage countries to develop health programmes for indigenous people, taking into account both the need for active participation at the local level in the whole health process, and the need for cultural sensitivity of health services and the participation of health care workers of indigenous origin.

Mrs TINCOPA (Peru) endorsed the amendments proposed by Malaysia and Chile.

The draft resolution, as amended, was approved.²

5. METHOD OF WORK OF THE HEALTH ASSEMBLY: Item 31 of the Agenda (continued from the fourth meeting)

The CHAIRMAN invited the Committee to consider the following draft resolution entitled “Respect for equality among the official languages”, proposed by the delegations of Argentina, Belgium, Canada, China, Colombia, Congo, Côte d’Ivoire, France, Mexico, Morocco, Russian Federation, Senegal, Spain, Switzerland and Tunisia:

¹ Document EB99/23.
² Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA50.31.
The Fiftieth World Health Assembly,
Mindful that the universality of the World Health Organization is based, _inter alia_, on multilingualism and on the respect for the parity and plurality of the official languages chosen by the Member States;
Mindful also that, according to resolution WHA31.13, Rule 87 of the Rules of Procedure of the Health Assembly and Rule 22 of the Rules of Procedure of the Executive Board, Arabic, Chinese, English, French, Russian and Spanish are both the official and the working languages of the World Health Assembly and the Executive Board of the World Health Organization;
Stressing the need for compliance with the resolutions and rules which establish linguistic practice in the various organs and bodies of the World Health Organization and in the Secretariat;
Stressing also the importance, for the development of a global health policy, of ensuring the widest possible access by all Member States to the information and documentation of the Organization;
Stressing also the need to ensure high-quality translation of documents into the various official languages of the Organization;
Regretting that the various official languages and the working languages of the Secretariat are used unequally within WHO;
Considering that the distribution of the documentation for the Health Assembly and the Executive Board simultaneously in the six official languages of the Organization within the required time-limits is one of the fundamental conditions for equality among Member States,
REQUESTS the Director-General to:
(1) ensure the strict application of the rules of the Organization which establish linguistic practice, both as regards the Organization's relations with Member States and as regards the use of languages within the Secretariat;
(2) ensure that the documents related to the agendas of the World Health Assembly and the Executive Board of the Organization are distributed simultaneously and in good time in the six official languages of the Organization, and that those documents are not distributed until they are available in all the official languages, in order to respect the principle of equality of treatment of Member States;
(3) take the necessary steps to ensure that the essential technical information of the Organization, whether in written, audiovisual or digital form, is disseminated in as many of the official languages as is required to meet the needs and priorities of the regions and countries and give all the Member States the widest possible access to it;
(4) submit a report on the implementation of this resolution to the Fifty-first World Health Assembly.

Dr SULAIMAN (Oman), endorsing the draft resolution, said that all documents should be published in the six official languages of the Organization on the same date and in good time.

Miss BAROUDI (Morocco) said that Morocco, like the other sponsors of the draft resolution, attached great importance to multilingualism, and to full respect for equality among the official languages of WHO.

Dr ZAHRAN (Egypt), Dr FIKRI (United Arab Emirates), Mrs TINCOPA (Peru), Mrs RAKOTONIAINA (Madagascar), Mr IVANOU (Belarus), Dr AL-JABER (Qatar), Mr GRYNNYSHYN (Ukraine) and Dr BELMAR (Chile) said they wished their delegations to be added to the list of sponsors of the draft resolution.

Ms KIZILDELI (Turkey), while supporting multilingualism and equality among official languages, said that the requirement in subparagraph (2) of the operative paragraph of the draft resolution, which read: "and that those documents are not distributed until they are available in all the official languages," placed a heavy burden on the Secretariat and was unfair to countries whose national language was not one of the official languages of the Organization. Such countries needed more time to study documents and would suffer if distribution were delayed. She proposed deletion of the phrase in question.
Dr AL-JABER (Qatar) said he was opposed to any change to the draft resolution, since documents should be distributed only when available in all official languages.

Mrs SHONGWE (Swaziland), while endorsing the draft resolution, said she also supported the amendment proposed by Turkey.

Mr CLERC (France) endorsed the draft resolution. In response to the concerns voiced by Turkey and others, it might be possible for the Secretariat to do some of the work earlier, and to reduce the amount of documents. The principle of equality should apply in all circumstances.

Dr AL-MOUSAWI (Bahrain) endorsed the draft resolution and emphasized the importance of operative subparagraph (2). Documents should be distributed simultaneously, once all translations were ready.

Professor PICO (Argentina) said that he too would stress the importance of operative subparagraph (2) to the interests of equality of treatment for all languages.

Mrs NTLABATHI (South Africa), endorsing the draft resolution, said that the spirit of equality in all aspects of life had always been central to South Africa’s struggle. Nevertheless, in the interests of smooth progress, she endorsed the proposal by Turkey.

Mr GONZÁLEZ DE LINARES (Spain) said he shared the views expressed by France and Argentina. Operative subparagraph (2) was the cornerstone of the draft resolution. Three months earlier, the United Nations Commission on Human Rights had distributed all its documents simultaneously, in six official languages. Why could WHO not do the same? What was needed was a different way of handling the burden of work. In view of the large measure of support for the text as it stood, he hoped Turkey would not press its amendment.

Dr ZAHRAN (Egypt) said that Turkey’s amendment would deprive the draft resolution of its spirit, and would maintain inequality. The Organization should reorganize its work in order to ensure that documents were translated simultaneously. That would take planning, but should be feasible.

Mr AITKEN (Assistant Director-General), having listened carefully to the concerns of Turkey and others, said that the problem lay not so much with translation or conference services as in the timing of the initial drafting of documents. In the year ahead, WHO would endeavour to ensure that documents were issued in all six languages simultaneously and sufficiently in advance to allow countries whose national language was not one of the official languages of the Organization time to translate those documents into their own languages. The Secretariat would report on progress to the Board in January 1998 and to the Health Assembly in May 1998. On that understanding, the Committee might be prepared to approve the draft resolution as it stood without change.

The draft resolution was approved.¹

6. CLONING IN HUMAN REPRODUCTION: Supplementary agenda item (Document A50/30²)

The DIRECTOR-GENERAL, introducing his report (document A50/30²) said that the successful cloning of a sheep by nuclear transfer from the cell of an adult ewe had raised serious concern by bringing closer the possibility of cloning human beings. On 11 March 1997, he had expressed his position on the issue in an official statement, annexed to his report, to the effect that the use of cloning for the replication of human individuals would be ethically unacceptable as it would violate some of the basic principles which governed WHO’s policy.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA50.32.
in the area of medically assisted procreation, *inter alia* the need to respect human dignity and to protect the security of human genetic material. He had also emphasized the need in all circumstances when carrying out research and health work to observe the principles of caution and responsibility.

The report also provided information on WHO's role and the existing mechanisms for monitoring the introduction of new biomedical technology such as cloning. It outlined some of WHO's current and planned initiatives to help clarify the different procedures involved in cloning and their potential uses in several areas of human health, including gene therapy, biologicals and organ transplantation. In such areas, cloning technology opened up new and potentially beneficial opportunities for research, diagnosis and treatment, which ought to be made available for use for the well-being of humanity, although it was necessary to remain alert to the technical and ethical problems to which they might give rise.

In order not to be caught unprepared, consultation and cooperation on such issues must start at once, for example to establish the necessary standards and safeguards for the production and uses of transgenic animals and on where to draw the line between preventive care and eugenics. The guidance and commitment of the Health Assembly on that process was sought.

It was essential that WHO Member States should reach a consensus on cloning in relation to human reproduction. It was just as important that they should cooperate to ensure that all related health practices were consistent with any declaration of principle they formulated. That required not only the adoption of common regulatory frameworks but also careful consideration and monitoring of the ways in which, in the areas concerned, research and health care services were funded, staffed and managed.

As early as November 1993, at a session of the Programme Committee of the Board, responding to the emerging controversy on the cloning of embryo cells, he had expressed concern that the rapid advances in biomedical technology should be accompanied by careful consideration of their medical, ethical and legal implications. In January 1996, in a report submitted to the Board under the title *Ethics and health, and quality in health care*, he had emphasized that the development of technology should not be promoted as an end in itself but always as a means of serving humanity, and had raised a number of fundamental questions including: how respect for human dignity was to be reconciled with the growing power of technology in determining approaches to health care and how the need for freedom in the pursuit of scientific knowledge was to be reconciled with the need for caution and accountability. Not only must agreement be reached on principles; the ways in which those principles were put into practice also had to be defined.

The CHAIRMAN invited the Committee to consider the following draft resolution entitled "Cloning in human reproduction", proposed by the delegations of Algeria, Angola, Argentina, Austria, Belarus, Brazil, Canada, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Namibia, Norway, Poland, Sweden, United Kingdom of Great Britain and Northern Ireland and Zimbabwe:

The Fiftieth World Health Assembly,
Having considered the Director-General's report on cloning, biomedical technology and WHO’s role in standard-setting;¹
Noting the statement issued by the Director-General on 11 March 1997;²
Welcoming the Convention on Human Rights and Biomedicine of the Council of Europe,³ which deals with the ethical principles of biomedicine;
Recognizing the need to respect the freedom of ethically acceptable scientific activity and to ensure access to the benefits of its applications;
Recognizing that developments in cloning and other genetic procedures have unprecedented ethical implications and considering that related research and development should therefore be carefully monitored and assessed, and the rights and dignity of patients respected,

1. AFFIRMS that the use of cloning for the replication of human individuals is ethically unacceptable;
2. REQUESTS the Director-General:
   (1) to take the lead, in appropriate consultation with other international organizations, in clarifying and assessing the ethical implications of cloning in the area of human health;
   (2) to report to the 101st Executive Board on the outcome of the assessments.

Dr PICO (Argentina) commended the Director-General for his rapid response to the request of the Government of Argentina to include human cloning on the agenda of the World Health Assembly. Given the scientific and technical nature of the subject and the ethical and moral repercussions it might have, WHO should analyse the subject in depth and with the widest possible participation. The Organization could not ignore an issue which had had such an impact on international public opinion.

A decree had been issued in Argentina prohibiting the use of cloning in human reproduction. A bill was being drafted by the Ministry of Health and Social Action after consultation with the National Committee on Biomedical Ethics and with professional scientists and health professionals. Representatives from all officially recognized religious denominations were also being consulted. The use of cloning in human reproduction was ethically unacceptable, it undermined human dignity and ran counter to the cultural and moral values of the people of Argentina. For that reason he gave his broad support to the Director-General’s March 1997 statement on cloning.

Professor WHITWORTH (Australia) said that cloning in human reproduction was arguably the most contentious ethical, scientific and legal issue of the present time. It would be the most important item to be considered by the National Health and Medical Research Council of Australia in the following three years. She proposed that a WHO committee of experts be set up to study the issues involved and to provide information to the Executive Board, the Health Assembly and other interested organizations.

Dr VARGA (Hungary) said that genetic manipulation, including cloning in human reproduction, was an important issue involving biological, social, ethical and economic questions. Those questions affected health policy as well as the broader political spectrum. Standard-setting therefore required wide consensus. She endorsed the Director-General’s view that a series of national and regional consultations were necessary in order to clarify the potential advantages and disadvantages of genetic manipulation, openings for regulation and the action needed. Temporary regulations would have to be introduced with immediate effect.

In Hungary, a bill on genetic technology was being drafted by the welfare, agriculture, environment and industry ministries under the guidance of the Academy of Sciences. A 1987 act on research in medical biology currently regulated scientific research affecting human beings. Decisions on ethical issues related to biomedical research were coordinated by a special committee, whose authorization would have to be sought for any research on the cloning of human beings, which consequently was currently unlawful.

While endorsing the draft resolution, she urged that it should also make reference to the complexity of the issue, with emphasis on the importance of the ethical, biological, social and political aspects. A wide range of bodies could be involved in a consensus-building process.

Ms KIZILDELI (Turkey) joined previous speakers in expressing her interest in and concern about a subject which raised serious ethical questions. However, she agreed with the Director-General when, in his March 1997 statement on cloning, he had said that opposition to human cloning should not lead to an indiscriminate ban on all cloning procedures and research. She supported the objectives set out in the penultimate paragraph of the Director-General’s report. WHO should also tackle the problem of standard-setting. She endorsed the suggestions by the delegates of Australia and Hungary that all aspects of the subject should be examined and considered that discussion of the matter should continue at the following session of the Executive Board.

Dr SAARINEN (Finland) welcomed the opportunity to discuss the important issue of human cloning. The Health Assembly should unambiguously reaffirm the principle set out in the Director-General’s March 1997 statement, that WHO considered the use of cloning for the replication of human individuals to be ethically unacceptable. The report (document A50/30) brought to the fore many aspects which needed further study and clarification. However, reproduction of human beings by cloning should not be confused with ethically acceptable scientific behaviour.
Recalling some of the steps already taken with respect to cloning, she noted that in November 1996, the Council of Europe had approved the Convention on Human Rights and Biomedicine. Half of its 42 Member countries had already signed the Convention, which condemned the cloning of human beings and any research related to it. Further, the World Medical Association had adopted a resolution, at a meeting held during the previous week, calling on doctors and other research workers voluntarily to abstain from participating in the cloning of human beings until the scientific, legal and ethical issues had been considered and any necessary controls put in place.

WHO was the most appropriate organization to promote a global ban on the reproduction of human beings by cloning. She feared that if cloning was prevented in one part of the world only, then it could spread to those countries where regulations did not exist. Progress in ethically acceptable research led to great benefits for humanity. However, misuse of science could well endanger the human species. She urged delegations to endorse the draft resolution.

Mr DEBRUS (Germany), welcoming the Director-General’s report, said he shared its view that application of the relevant technology should not be rejected outright. However, firm guidelines would have to be drawn up with regard to the application of cloning to human beings in order to prevent human embryos from being exposed to such practices; a worldwide ban on cloning should be imposed. His Government was prepared to cooperate closely with WHO in studying all aspects of the subject as had been urged by other delegations.

Mrs WU Jihong (China) expressed both concern at and appreciation of the breakthrough which cloning represented in the field of biomedicine; she endorsed the Director-General’s statement on cloning. The Government of China had formally declared its opposition to the application of cloning in human reproduction as that activity was unethical and would harm human dignity and endanger the security of human genetic material. However, research for cloning in human health, animal husbandry and the conservation of rare species should be permitted.

She proposed that the draft resolution should be amended to ensure that it fully reflected the views expressed during the discussion by adding the phrase “as well as the statements made by Member States” after the words “Council of Europe” in the third preambular paragraph.

Mr FUKUDA (Japan) said he joined those endorsing the Director-General’s March 1997 statement on cloning. An expert committee, recently given official status, had been formed to study technology and health in Japan. It would consider all aspects of cloning taking into account information provided by WHO, other organizations, a wide range of experts and experience in other countries. It was expected that swift action would follow its deliberations on the issue.

Mr EISS (United States of America) endorsed the draft resolution and commended the Director-General’s report.

Following the successful cloning of a sheep from an adult cell, the United States Bioethics Advisory Council had reviewed the ethical, social and legal implications of nuclear transfer cloning in human reproduction. Use of federal funds for human cloning research had been banned and a moratorium on private sector research had been requested.

In 1994, the United States National Institutes of Health had convened a panel to discuss human embryo research issues. The panel had concluded that cloning human beings was not justifiable and that it was contrary to strongly held views on the value of human individuality and diversity.

Public attention had focused initially on the more sensational aspects of the latest research. The Director-General’s report was to be commended for clarifying the distinction between the cloning of an entire human being and the type of genetic research that used nuclear transfer cloning to generate specific human cell types for potential cell-based therapy. The latter could become an important stratagem for vaccines and therapeutics.

He proposed that the draft resolution should be amended so that paragraph 2(1) should include, after the words “international organizations” a reference to “national governments and scientific and professional bodies” and that the word “cloning” in that subparagraph should be qualified by placing the words “nuclear transfer” before it.

He noted that paragraph 3 of the Director-General’s report contained references including the European Commission and the Council of Europe among international agencies. While recognizing the value of their
contributions, he would prefer the use of the recognized United Nations terminology describing those organizations as “regional intergovernmental organizations”.

Although he acknowledged the public importance of the issue, it was with some concern that he noted that the draft resolution on human cloning had been brought before the Health Assembly without having been reviewed by the Executive Board; he urged compliance with that important procedural step.

Dr ZAHRAN (Egypt) commended the Director-General’s March 1997 statement on cloning and welcomed his report. The subject was one of great importance and had been studied with great attention in Egypt, as elsewhere, by both scientific and religious communities. There was a consensus rejecting the use of cloning in human reproduction in Egypt.

He proposed the addition in paragraph 2(1) of the draft resolution of a reference not only to the ethical, but also to the legal and social implications of cloning, to reflect the comprehensive approach advocated by many Member States. He further suggested that paragraphs 1 and 2(1) should be combined as reproductive health and human health were closely allied. Provided those amendments were included, he wished his delegation to be added to the list of sponsors of the draft resolution.

The meeting rose at 18:00.
1. **CLONING IN HUMAN REPRODUCTION:** Supplementary agenda item (Document A50/30) (continued)

The CHAIRMAN invited the Committee to continue its consideration of the draft resolution on cloning in human reproduction.

Dr MALYŠEV (Russian Federation) said that research in genetic engineering and progress made on the Human Genome Project were undoubtedly linked to improvements in human health. However, the implications of such research might well cause concern among the general public, which did not have a full grasp of the issues at stake. In order to avoid such a situation, there would have to be broad cooperation between specialists and public bodies; WHO should take the lead in that connection by organizing consultations with other international organizations on the ethical and social aspects of cloning in the area of human health. The Russian Federation endorsed the draft resolution.

Dr STAMPS (Zimbabwe) said that the rapid pace of scientific progress entailed serious consequences. Apart from the ethical aspects of cloning, the fact that the patent rights for cloning methods, recently submitted to the World Intellectual Property Organization (WIPO), were held by a private organization that was backed by certain industrial interests in Germany, Denmark and the United States of America gave cause for alarm. Therefore, in operative paragraph 1 of the draft resolution, he proposed that the words “ethically unacceptable” should be deleted and replaced by “a challenge to ordre public” - the term used by WIPO to justify excluding patent rights and meaning “public morality”. He also proposed insertion of an additional operative paragraph requesting the Director-General, in collaboration with WIPO, to take steps to ensure that the patent rights in question, which included human cloning technology, should be condemned and repudiated as ethically unacceptable.

Dr FIKRI (United Arab Emirates) said that achievements in scientific research had undoubtedly improved the overall health situation in many parts of the world. His country was interested in the outcome of WHO’s programmes on research on human reproduction, which had helped in the fight against disease, especially certain genetic disorders. He commended the report (document A50/30) and endorsed the draft resolution. Cloning for the replication of human individuals was quite unacceptable on any grounds whatsoever. He therefore called for concerted action and a unified stance on research into cloning in human reproduction, as well as a review of the medical, social and moral aspects of the technique.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) agreed with the Director-General and previous speakers that the Health Assembly must send a clear message as to the ethical unacceptability of cloning for the replication of human individuals. It did not follow, however, that use of cloning procedures in other circumstances, for instance in the production of monoclonal antibodies, was also unacceptable, since it could be of benefit in diagnosis and treatment. The United Kingdom had already introduced legislation on human fertilization and embryology; issues related to cloning had recently been discussed by its Parliament. His delegation was therefore a sponsor of the draft resolution. He endorsed the proposal to hold consultations with other international bodies to clarify the ethical implications of cloning procedures. It was a subject which would certainly be taken up again by the Executive Board and the Health Assembly. However, unlike other
speakers, he took the view that the debate should cover all cloning procedures and should not be confined to those by nuclear transfer. It was impossible to foresee how such procedures might develop; for instance, other techniques that might induce two or more identical embryos would be equally unacceptable from the ethical standpoint. He would prefer the word "ethically" to remain in the first operative paragraph of the draft resolution but would accept further qualification as suggested by Zimbabwe.

Dr MOREL (Brazil) welcomed the fact that cloning in human reproduction had, in view of its urgency, been taken up directly by the Health Assembly instead of delaying debate by channelling the issue through the Executive Board. He shared the view that the scope of the draft resolution should not be restricted to cloning by nuclear transfer, which did not allow for possible development of new cloning techniques. While agreeing that all aspects of cloning should be covered in the proposed consultations, he emphasized the need for consideration of its legal implications.

Dr AL-MOUSAWI (Bahrain) expressed support for the draft resolution as currently worded, and requested that his country's name should be included among the list of sponsors. He endorsed the Director-General's March 1997 statement on cloning and joined other speakers in stressing the need to consider the social, ethical and legal implications of such practices. Research into cloning for human replication purposes should not be allowed, nor given any financial or other support. He agreed that the matter should be taken up by the Executive Board and at the next Health Assembly.

Mr JUNEAU (Canada) endorsed the draft resolution and the Director-General's statement on cloning. During the previous session of the Canadian Parliament, the Minister of Health had introduced a bill intended to ban certain reproduction techniques and had announced his intent to submit further draft legislation relating to certain other practices that would be deemed acceptable if properly regulated. The Minister had also proposed a framework for the debate on reproductive health. However, before any of that legislation could be passed a general election had been called, and, in the meantime, a voluntary moratorium had been placed on practices considered as unacceptable. It was to be hoped that the issue would be followed up by the new Canadian Parliament. Like other delegations, he was in favour of WHO taking the lead in the area.

Mrs DHAR (India) shared the moral, ethical and human concern expressed by other speakers regarding human cloning. She would be strongly opposed to such techniques where they might ultimately lead to discrimination among human beings. However, some further reflection on the matter might be necessary in view of the opportunities cloning offered for scientific discoveries that might benefit mankind. On that basis, her country would be willing to become a sponsor of the draft resolution.

Dr KIELY (Ireland) expressed support for the views expressed by the majority of delegates and for the draft resolution which his country also wished to sponsor. The remit of the proposed consultations should be very broad and embrace as many varieties of cloning as possible. However, the basic principle underlying the consultations must be that cloning for human replication purposes was impermissible in all situations.

Dr VAN ETTEN (Netherlands) said that in view of the importance of the issue his country supported the principles outlined by other speakers as well as the idea of WHO assuming responsibility in the consultative process. He asked for his country's name to be added to the list of sponsors of the draft resolution.

Mrs SHONGWE (Swaziland), commending the report, said she shared the concern expressed by previous speakers. Cloning for human reproduction was totally unacceptable on ethical and human grounds and its possible implications gave cause for anxiety. The funds used for research into cloning could be put to better use to improve human health worldwide. She endorsed the draft resolution.

Mrs AL-GHAZALI (Oman) said the issue of cloning was of great importance; appropriate standards were needed to ensure that scientific progress was in keeping with the principle of human dignity. She endorsed the draft resolution subject to the amendment proposed by the delegate of Egypt to paragraph 2(1).
Professor GIRARD (France) welcomed the fact that the Health Assembly had been enabled to debate what was a very serious issue at the earliest opportunity after the successful cloning of a sheep. From what had been said by a number of speakers, the conclusion on cloning for human replication purposes appeared clear-cut: it was universally unacceptable and should be banned. Nevertheless, it was important to situate cloning in the context of the thoughts, fantasies and fears surrounding it. The National Advisory Committee on Ethics in France had considered the matter recently and, while acknowledging the intense emotion aroused, had warned against drawing hasty conclusions and putting regulations in place without taking the time to examine in depth the philosophical and moral aspects involved. Considered reflection was essential since, if cloning was to be banned by law, and if the ban was to be implemented effectively at both international and national levels, it would have to be supported by watertight ethical arguments. Rigorous assessment of potential attitudes and arguments could not be postponed on the grounds that human replication was not yet feasible: the history of biomedical research illustrated the importance of examining the ethics of potential research before it was carried out. Although the fantasies generated in the public imagination by the possibility of human cloning could be considered to be within the realm of science fiction, the practice touched upon fundamental issues of human dignity and its ethical issues thus merited serious reflection.

In France, cloning for human replication purposes had been prohibited by law since 1994. France would, however, remain active in international debate in order to ensure that all countries adopted a common stance on the issue.

He endorsed the draft resolution, without the amendment put forward by the delegate of Zimbabwe: the reference to ordre public was imprecise and merited further debate before being enshrined in a Health Assembly resolution.

Mr MOEINI (Islamic Republic of Iran) said that to talk of cloning being “ethically unacceptable” might be taken to imply that it was acceptable in other ways - scientifically for instance - and suggested that to omit “ethically” would adequately address the concern expressed by some delegates.

Dr SHANGULA (Namibia) commended the Director-General’s report. He endorsed in particular the views expressed in its paragraphs 11 and 12; cloning was ethically unacceptable in human reproduction. He requested the Director-General to provide Member States with regular reports on developments related to cloning. He welcomed the proposal by the delegate of Zimbabwe to add a further operative paragraph to the draft resolution but wished to leave paragraph 1 unchanged.

Professor SISSOURAS (Greece) said that cloning for human replication purposes had serious ethical implications, which was why his delegation was a sponsor of the draft resolution. However, the freedom to carry out ethically acceptable scientific research had to be respected and the benefits of such research made available. He asked the Director-General and Member States to make every effort to ensure that the general public was properly informed about the issue, rather than misled into fear by sensationalist media reports.

Mr KALIMA (Malawi) said it was generally accepted that the use of cloning in human reproduction should be banned for ethical reasons. He endorsed the draft resolution as amended by Zimbabwe.

Mr UEDA (Palau) commended the Director-General’s report and endorsed his statement on cloning. The role of WHO was to set standards for biomedical technology that took into account the risks it posed to health as well as its potential benefits. He agreed that the use of cloning for replication of human beings was ethically unacceptable, and announced that his delegation wished to become a sponsor of the draft resolution.

Dr KALUMBA (Zambia) said he shared the concern expressed by the delegate of Zimbabwe. Faith in God and in the common fate of humanity was important to people in southern Africa; scientific discoveries were not accepted blindly. He endorsed the draft resolution with the amendments proposed by Zimbabwe and the addition of the words “and contrary to human integrity and morality” at the end of paragraph 1, and wished his delegation to be included among its sponsors.

Dr MAJORI (Italy) paid tribute to the work of the Special Programme of Research, Development and Research Training in Human Reproduction on the subject of cloning, and endorsed the draft resolution. Cloning
for human replication purposes was ethically unacceptable, but the biomedical technology involved could have
benefits for human health; he therefore urged WHO to retain its leadership in the field and to provide guidelines
on the use of that technology.

Dr DURHAM (New Zealand), noting that her Parliament was currently considering a bill on cloning,
edorsed the amendments to paragraph 2(1) proposed by Egypt. She further proposed that the words “and
through the Board to the World Health Assembly and other interested organizations” should be added to
paragraph 2(2) after “Executive Board”. A new subparagraph should be added to paragraph 2 to read:

(3) to give consideration to the establishment of a committee expert in scientific, legal, ethical and
social matters to assist with these assessments.

Mr ROKOVADA (Fiji), while welcoming progress in biotechnology and genetic engineering that
benefited humanity, said that cloning for the purpose of human reproduction was ethically, socially and morally
unacceptable. His delegation wished to become a sponsor of the draft resolution as amended by the delegate
of Zimbabwe.

Dr BERLIN (European Commission) said that the Commission, at the request of the European Parliament,
was examining the ethical implications of cloning as a matter of urgency. Its Group of Advisers on the Ethical
Implications of Biotechnologies was expected to issue an opinion shortly on possible further action in the area
by the Commission, which would be forwarded to WHO. European Union funding for research into the human
genetic heritage and human cloning had been explicitly forbidden by a decision of the Council of Ministers in
1994. A round table on the ethical implications of cloning had recently been organized by the Group of
Advisers, to which WHO had made a valuable contribution. The references to the work of the European Union
in the Director-General’s report were thus welcomed. The Commission was fully prepared to continue to engage
in consultation with WHO and other international organizations as enjoined in the draft resolution.

He drew the Committee’s attention to the fact that it was incorrect to refer to the European Commission
as a regional intergovernmental organization, in view of the worldwide commitments and responsibilities of the
European Union, of which it was an institution.

Dr GALLAGHER (Council for International Organizations of Medical Sciences), speaking at the
invitation of the CHAIRMAN, said CIOMS was strongly committed to the support of WHO and of its other
partners in considering the ethical, human-rights and human-values aspects of mammalian cloning. Since its
inception, it had devoted much attention to the ethical, human-rights and related issues raised by advances in
the biomedical sciences and in medical and health technology. CIOMS had a solid record of achieving
consensus on standard-setting in relation to ethics, not least in the field of biomedical research. It had always
sought to include in the process representatives of different disciplines and different cultural, religious, social
and political traditions. CIOMS was ready to respond positively to any invitation to be associated with WHO
in efforts to achieve international consensus on the ethical and human-rights issues raised by the technological
biomedical advances typified by the cloning of animals and the potential cloning of humans.

The DIRECTOR-GENERAL welcomed the positive comments of delegates on his report, especially with
regard to the Organization’s rapid response to a major development. He would, as requested by several
delegates, set up an expert committee and make due budgetary provision for it. He further noted Members’ wish
that the debate on cloning should not be limited to nuclear transfer methods.

Dr TÜRMENT (Family and Reproductive Health) said that the possible uses, abuses and ethical
implications of any new biomedical technology required careful scrutiny, as did the corresponding rights and
responsibilities of individuals, society and future generations. As human cloning was undoubtedly the most
contentious ethical, scientific and legal issue facing the Organization on the threshold of the twenty-first century,
It was important that any guidelines should be based on as broad a consensus as possible. The Organization had
already started a consultative process to evaluate all aspects of the issue from a wide range of cultural and
religious viewpoints. It would seek to reach consensus by continuing to work with all the international
organizations concerned and by taking into account the outcomes of national debates, and would submit a
progress report at the 101st session of the Executive Board.
Mr ASAMOAH (Secretary) said that the amendments to the draft resolution proposed in the course of the debate had been incorporated by a drafting group into the draft resolution as follows. At the end of the second preambular paragraph, the words “as well as the statements made by Member States at the fiftieth session of the Health Assembly” would be added. In paragraph 1, “and contrary to human integrity and morality” would be added after “ethically unacceptable”. Paragraph 2(1) would read:

to take the lead in clarifying and assessing the ethical, scientific and social implications of cloning in the area of human health, in appropriate consultation with other international organizations, national governments and professional and scientific bodies; and, with the relevant international bodies, to consider related legal aspects.

A new paragraph 2(2) would read:

to inform the Member States in order to foster a public debate on these issues.

The existing paragraph 2(2) would become paragraph 2(3) and would be amended to read:

to report to the 101st session of the Executive Board, to the Fifty-first World Health Assembly and to other interested organizations on the outcome of the assessments.

Dr STAMPS (Zimbabwe) said that in view of the fact that his delegation’s submission had not been acceptable to the drafting group, and since his delegation had not been invited to attend the group’s deliberations, he wished to withdraw Zimbabwe’s sponsorship of the draft resolution, not because it did not share the view that human cloning was unethical, but because it considered the resolution inadequate and not sufficiently expeditious in dealing with the problems of proprietary control of cloning rights in private hands.

Dr ZAHRAN (Egypt) said that in the light of the amendments that had now been made to the draft resolution, he was pleased to request that his delegation be added to the list of sponsors.

The draft resolution, as amended, was approved.¹

2. FOURTH REPORT OF COMMITTEE B

Dr AMMAR (Lebanon), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.²

3. SCALE OF ASSESSMENTS: Item 24 of the Agenda (continued)

Scale of assessments for the financial period 1998-1999: Item 24.2 of the Agenda (Document A50/13) (continued from the seventh meeting)

Mr McALISTER (Canada) said that following prolonged informal negotiations, agreement had finally been reached on a formulation for the resolution contained in paragraph 6 of document A50/13 which he believed would serve the interests of all Members. It was proposed to add the following two additional operative paragraphs to the draft resolution:

3. REQUESTS the Director-General to report to the Fifty-first World Health Assembly on changes, if any, to the scale of assessments adopted by the United Nations General Assembly at its fifty-second session, and on all the implications for WHO, including its earliest comparable application, taking into account the deliberations of the Fiftieth World Health Assembly and in accordance with the Constitution

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA50.37.
² See page 241.
and financial regulations of the World Health Organization and relevant World Health Assembly resolutions.

4. REAFFIRMS the principle that the WHO scale of assessments should be based upon the latest available scale of assessments adopted by the United Nations General Assembly.

Mr AKAO (Japan), welcoming the compromise proposal, said that while his delegation’s basic position on the issue remained the same, it fully understood the difficulties facing some delegations and had therefore endeavoured to be as flexible as possible in the course of the consultations. He hoped that now agreement had been reached, the next biennial budget would be adopted without a vote in the plenary.

Mr BOYER (United States of America) said he too welcomed the agreement reached. One of his country’s main concerns had been that the Organization’s budget should be matched to the level of contributions that could be expected from Member States; its position on the budget was therefore related to its position on the scale of assessments.

The agreement reached would make it possible for the United States to avoid calling for a vote on the budget in the plenary, and should also result in improved financial credibility for WHO. However, his delegation would still be seeking to achieve a further agreement at a later stage. The United States had departed significantly from its initial position on that question in the interest of achieving a compromise. The text just read out, which had been designed to satisfy the concerns of various delegations, was open to different interpretations, but as interpreted by the United States it should make it possible for the Health Assembly the following year to decide to apply any new United Nations scale of assessments to the WHO budget for the next biennium.

Mr MOEINI (Islamic Republic of Iran), joining in the appreciation expressed for arrival at a consensus proposal, said that the revised amount that his country would have to pay as a result of its over-assessment under the United Nations scale was eight times more than the contributions of certain Member States, which showed the extent of the problem it had to face. In a spirit of compromise, his delegation was prepared to withdraw its own proposal, but could not guarantee that it would show the same flexibility when the subject was taken up again at the next Health Assembly.

Mr JUDIN (Russian Federation), applauding the fact that a solution acceptable to all had been found, said that although his own delegation had had some difficulty in accepting the agreed text, and could not support some aspects of it, he believed its main merit lay in the fact that it had succeeded in identifying the problem and had taken a first step towards solving it. He hoped that a final solution would be reached in the future.

The draft resolution, as amended, was approved.¹

The DIRECTOR-GENERAL expressed his satisfaction that a consensus had been reached on the issue, since it was customary for the Organization to decide on its budget by consensus. He was most gratified at the agreement reached, which he saw as the most important gift he could have received before leaving the Organization, and also as a sign of unity and solidarity among Member States. For his own part, he undertook to report to the Fifty-first World Health Assembly any changes in the United Nations scale of assessments, taking into consideration the resolution just approved.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA50.33.
4. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 28 of the Agenda (Documents A50/19, A50/INF.DOC./5, A50/INF.DOC./6 and A50/INF.DOC./7)

The CHAIRMAN drew attention to the following draft resolution on the item, proposed by the delegations of Bahrain, China, Egypt, India, Indonesia, Jordan, Morocco, Oman, Qatar, Saudi Arabia, Syrian Arab Republic and Tunisia:

The Fiftieth World Health Assembly,
Mindful of the basic principle established in the WHO Constitution, which affirms that the health of all peoples is fundamental to the attainment of peace and security;
Expressing the hope that the peace talks between the parties concerned in the Middle East will lead to a just and comprehensive peace in the area;
Noting the signing in Washington D.C. on 13 September 1993 of the Declaration of Principles on Interim Self-Government Arrangements between the Government of Israel and the Palestine Liberation Organization (PLO), the commencement of the implementation of the Declaration of Principles following the signing of the Cairo Accord on 4 May 1994, the transfer of health services to the Palestinian Authority, and the launching of the final stage of negotiations between Israel and PLO on 5 May 1996;
Emphasizing the need to accelerate the implementation of the Declaration of Principles and the subsequent Accord;
Noting with deep concern the current obstacles facing the peace process, in particular the Israeli resuming of settlement policies in the Palestinian territory, and especially in Jabal Abou Ghneim in occupied Arab Jerusalem;
Also noting with deep concern the adverse consequences of the continuous closure of the Palestinian territory on its socioeconomic development, including the health sector;
Recognizing the need for increased support and health assistance to the Palestinian population in the areas under the responsibility of the Palestinian Authority and to the Arab populations in the occupied Arab territories, including the Palestinians as well as the Syrian Arab population;
Recognizing that the Palestinian people will have to make strenuous efforts to improve their health infrastructure, and expressing satisfaction at the initiation of cooperation between the Israeli Ministry of Health and the Ministry of Health of the Palestinian Authority, which emphasizes that health development is best enhanced under conditions of peace and stability;
Reaffirming the right of the Palestinian patients to be able to benefit from health facilities available in the Palestinian health institutions of occupied Arab Jerusalem;
Recognizing the need for support and health assistance to the Arab populations in the areas under the responsibility of the Palestinian Authority and in the occupied territories, including the occupied Golan;
Bearing in mind United Nations General Assembly resolutions 51/26 and 51/27 of 4 December 1996;
Having considered the report of the Director-General,

1. EXPRESSES the hope that the peace talks will lead to the establishment of a just, lasting and comprehensive peace in the Middle East;

2. CALLS UPON Israel not to hamper the Palestinian health authorities in carrying out their full responsibility for the Palestinian people, including in occupied Arab Jerusalem, and to lift the closure imposed on the Palestinian territory;
3. EXPRESSES the hope that the Palestinian people, having assumed responsibility for their health services, will be able themselves to carry out health plans and projects in order to participate with the peoples of the world in achievement of WHO's objective of health for all by the year 2000;

4. AFFIRMS the need to support the efforts of the Palestinian Authority in the field of health in order to enable it to develop its own health system so as to meet the needs of the Palestinian people in administering their own affairs and supervising their own health services;

5. URGES Member States, intergovernmental organizations, nongovernmental organizations and regional organizations to provide speedy and generous assistance in the achievement of health development for the Palestinian people;

6. THANKS the Director-General for his efforts and requests him:
   (1) to take urgent steps in cooperation with Member States to support the Ministry of Health of the Palestinian Authority in its efforts to overcome the current difficulties, and in particular so as to guarantee free circulation of patients, of health workers and of emergency services, and the normal provision of medical goods to the Palestinian medical premises, including those in Jerusalem;
   (2) to continue to provide the necessary technical assistance to support health programmes and projects for the Palestinian people in the transitional period;
   (3) to take the necessary steps and make the contacts needed to obtain funding from various sources including extrabudgetary sources, to meet the urgent health needs of the Palestinian people during the transitional period;
   (4) to continue his efforts to implement the special health assistance programme and adapt it to the health needs of the Palestinian people, taking into account the health plan of the Palestinian people;
   (5) to activate the organizational unit at WHO headquarters concerned with the health of the Palestinian people, and continue to provide health assistance so as to improve the health conditions of the Palestinian people;
   (6) to report on implementation of this resolution to the Fifty-first World Health Assembly;

7. EXPRESSES gratitude to all Member States, intergovernmental organizations and nongovernmental organizations and calls upon them to provide assistance to meet the health needs of the Palestinian people.

Dr SEVER (Israel) said that arriving at the Health Assembly from the Middle East, where he had long been professionally and personally involved in fruitful cooperation between the Ministries of Health of Israel and the Palestinian Authority, he had been surprised to find himself again confronted with the politicization of health issues. Since the transfer of responsibilities in the field of health from Israel to the Palestinian Authority, joint Israeli/Palestinian committees had been continuously working together in such areas as preventive and curative medicine, food control, pharmaceutical inspection and training programmes for health personnel. All of a sudden, that cooperation had been converted into a political confrontation. Quoting the Israeli Minister of Health, he said that the Palestinians could not have it both ways: they could not seek support from Israel in the field of health both bilaterally and at international level, while at the same time using WHO to conduct political battles against Israel. Cooperation was the only way ahead.

Whereas in previous years the Israeli and Palestinian delegations had presented an agreed draft resolution on the agenda item, unfortunately, that was not the case at the present Health Assembly. Political debate, which could contribute nothing to improving the health conditions of the Palestinian population, should be reserved for the appropriate forums, such as the United Nations General Assembly and the Security Council.

As a physician, he could only regret that the draft resolution before the Committee was purely political in nature; he called on all who were truly concerned with the success of the peace process in the Middle East to vote against it. Over the years, Israel had worked with WHO and wished to continue to do so. However, if political resolutions were adopted by the Health Assembly, future cooperation would have to be reassessed.
Dr ZAHRAN (Egypt) noted that certain past developments had augured well for a start to meaningful negotiations between the parties concerned. They included the agreement reached at the first International Peace Conference in Madrid in October 1991; the signing in Washington D.C. in September 1993 of the Declaration of Principles on Interim Self-Government Arrangements between the Government of Israel and the Palestine Liberation Organization (PLO); the commencement of its implementation following the signing of the Cairo Accord in May 1994; the Interim Agreement signed in Washington D.C. in September 1995; the transfer of health services to the Palestinian Authority; and the launching of the final stage of negotiations between Israel and PLO in May 1996.

Following the Madrid conference and the commencement of peace negotiations based on the principle of land for peace, and the subsequent bilateral negotiations, it had been hoped that visible progress could be made without further obstacles being placed in the way of the peace process.

The health status of the Palestinians was deteriorating as a result of enforcement of the status quo and violence arising out of the building of new settlements. Closures and a state of siege had also led to the non-availability of health services.

Cooperation between the Israeli and Palestinian authorities should naturally be encouraged with a view to implementing the Declaration of Principles. It had been hoped that during the Fiftieth World Health Assembly a draft resolution could be agreed upon that would be adopted by consensus.

The state of health and of health care provision for the Palestinian people in the occupied Arab territories came within the ambit of the Universal Declaration on Human Rights and had been the subject of numerous United Nations and WHO resolutions. The deteriorating situation was therefore deplorable and should be remedied as a matter of priority through the adoption of the draft resolution before the Committee, which Egypt was pleased to present on behalf of the sponsors.

The draft resolution differed somewhat from resolution WHA49.24, which had been adopted by consensus. The principle of land for peace, referred to in the second preambular paragraph, had been the fundamental premise of the Madrid Peace Conference. The sixth and seventh preambular paragraphs had been inserted as a consequence of the obstacles placed in the way of the peace process, and more especially the Israeli resumption of settlement policies, most notably in Jabal Abou Ghneim in occupied Arab Jerusalem, as well as the closure of the Palestinian territory which had adversely affected the health sector. Paragraph 2 called upon Israel not to hamper the Palestinian health authorities in carrying out their full responsibility for the Palestinian people, including in occupied Arab Jerusalem, and to lift the closure imposed upon the Palestinian territory. He submitted that those departures from the previous year's text went in the right direction and took account of developments since the Forty-ninth World Health Assembly. They were also compatible with the recent United Nations General Assembly resolution, which had been unanimously adopted.

Voicing the hope that the draft resolution would be viewed positively by Member States, he called attention to some last-minute amendments. In the fourth preambular paragraph, the words “the Interim Agreement signed in Washington on 28 September 1995”, should be inserted after “Cairo Accord on 4 May”. In the sixth and tenth preambular paragraphs, and in the paragraph 2, “occupied Arab Jerusalem” should read “occupied East Jerusalem”.

Mrs AZHAR (Pakistan) asked that her country be considered as a sponsor of the draft resolution.

Dr ARAFAT (Palestine) expressed gratitude for the assistance and cooperation Palestine had received in building its health infrastructure in the face of the numerous difficulties and obstructions that were adversely affecting the health of Palestinian people. It was evident that there was a will to achieve peace within the international community. The peace agreements signed in Madrid, Cairo and Oslo had led to cooperation between the Palestinian Ministry of Health and its counterpart in other countries, including Israel. However, recent decisions taken by the Israeli Government regarding settlements and closures had erected new obstacles in the way of the peace process, placed an extra burden on the health services and impeded development of health infrastructures.

The draft resolution before the Committee would help to put an end to such practices and enable the peace process to be resumed, which would have positive consequences for both the Israeli and Palestinian people. The Director-General had said in his statement that Members of WHO were firmly convinced that permanent peace would only be guaranteed when people learned to coexist and cooperate. Only then could the principle of health
for all become a reality. Such an end could only be achieved with the cooperation and support of WHO Member States.

Mr LOFTIS (United States of America) said that his delegation could not support the draft resolution and regretted that it could not be adopted without a vote as resolutions on the same issue had been for the past three years. The reintroduction of political elements that could more appropriately be dealt with elsewhere was also regrettable; the Health Assembly's sole concern should be with the delivery of health care to the Palestinian people.

Professor ALI (Bangladesh) remarked that the issue was humanitarian rather than political. There was a need for change in the region, and his country therefore wished to be included in the list of cosponsors.

Dr FIKRI (United Arab Emirates) endorsed the draft resolution as amended. The United Arab Emirates also wished to be included in the list of sponsors.

Dr RAHIL (Libyan Arab Jamahiriya) questioned whether the peace process was really genuine. With regard to the health of the Palestinian people, there did not appear to have been any improvement during the past 10 years; indeed, Palestine continued to be afflicted by violence and loss of life. The Libyan Arab Jamahiriya endorsed the draft resolution, and wished to be included as a sponsor. The resolution held out the hope of a better future, with talks leading to the establishment of a just, lasting and comprehensive peace in the Middle East. It also affirmed the continuing efforts to be made for health; and it was to be hoped that the Palestinians would be able to implement their health policy in order to achieve the objective of health for all. Above all, the resolution was an expression of hope that the Palestinian people, who were dying from famine and disease, would be spared the burden of foreign occupation. The draft resolution, as amended, should be approved by consensus.

Mr KARA-MOSTEPHA (Algeria) endorsed the draft resolution and asked for his country to be included in the list of cosponsors.

Mrs WU Jihong (China) recalled that the issue had been the subject of discussion in WHO for many years; that was a measure of the concern felt by Member States over the situation in the Middle East, which was adversely affecting the health status, not only of the Palestinian people in the occupied Arab territories, but of all the peoples of the region, including the Israelis. China's serious concern was reflected in its decision to sponsor the draft resolution.

With powerful encouragement from the international community, significant progress had nevertheless been made towards achieving peace in the Middle East. Regional economic cooperation had already begun. Peace and development were common aspirations for everyone in the region. The principle of land for peace had won widespread international support; it was to be hoped that the countries directly concerned would adhere to that principle and pursue the peace negotiations.

Recently, however, the Israeli Government's intransigent policy of establishing settlements in East Jerusalem had created tension between Arabs and Israelis which had led to violence and brought the peace process to an impasse.

China maintained that the nations concerned must, on the basis of the relevant United Nations resolutions, seek to resolve the issue through political negotiations and achieve stability and development in the region. The international community should also do its utmost to ensure an early solution. China would do its best to cooperate with the Organization in improving the health situation in the occupied Arab territories.

Dr TAHA (Malaysia) said his country wished to be considered as a cosponsor of the amended draft resolution.

Mrs ARIAS-JOHNER (Colombia) stressed the paramount importance of the item under discussion. The draft resolution with its amendments reflected developments in the Middle East since the Forty-ninth World Health Assembly. Meeting in April 1997 in New Delhi, the Ministers of Foreign Affairs of the Movement of Non-Aligned Countries had made a declaration in firm support of the peace process, voicing at the same time
their deep concern about the obstacles to peace. Colombia thanked the cosponsors for producing a balanced
draft resolution and urged the Committee to approve it by consensus.

Dr RUIZ ARMAS (Cuba) endorsed the draft resolution as amended, agreeing with the previous speaker
that it constituted a balanced reflection of the state of affairs in the area. Cuba also wished to be considered as
a cosponsor.

The CHAIRMAN said that in the absence of any further requests for the floor, he would put the draft
resolution to the vote.

Dr ZAHRAN (Egypt), rising to a point of order, said that Egypt would prefer the draft resolution to be
approved without recourse to a vote; but were a vote to be called for - and that seemed to be the case - he in turn
would request a roll-call.

Dr AL-JABER (Qatar), rising to a point of order, said that the Committee should first determine whether
there was a need for a vote. Had there not been a call from many delegations for adoption by consensus?

Dr SEVER (Israel) reminded the Committee that he had indeed called on Member States to vote against
the draft resolution. There was no consensus.

Mr TOPPING (Legal Counsel), at the request of the CHAIRMAN, explained that as things stood, and by
virtue of Rule 74 of the Rules of Procedure, there must be a formal vote, concerning which a roll-call had been
requested.

A vote was taken by roll-call, the names of the Member States being called in the English
alphabetical order, starting with Uganda, the letter U having been determined by lot.

The result of the vote was as follows:

In favour: Algeria, Andorra, Argentina, Australia, Austria, Bahrain, Bangladesh, Barbados, Belgium, Belize,
Benin, Bhutan, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Canada, Chile, China, Colombia,
Congo, Cook Islands, Costa Rica, Cyprus, Czech Republic, Democratic People's Republic of Korea, Denmark,
Ecuador, Egypt, Fiji, Finland, France, Germany, Greece, Guatemala, Hungary, Iceland, India, Indonesia, Islamic
Republic of Iran, Ireland, Italy, Jamaica, Japan, Jordan, Kenya, Kiribati, Kuwait, Lesotho, Libyan Arab
Jamahiriya, Luxembourg, Malaysia, Maldives, Malta, Mexico, Morocco, Namibia, Netherlands, New Zealand,
Niue, Norway, Oman, Pakistan, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian
Federation, Saint Kitts and Nevis, Samoa, San Marino, Saudi Arabia, Senegal, Seychelles, Singapore, Slovakia,
South Africa, Spain, Sweden, Switzerland, Syrian Arab Republic, Tonga, Tunisia, Turkey, United Arab
Emirates, United Kingdom of Great Britain and Northern Ireland, Vanuatu, Viet Nam, Yemen.

Against: Israel, Palau, Papua New Guinea, United States of America.

Abstaining: Haiti, Mongolia, Swaziland, Uruguay.

Absent: Afghanistan, Albania, Angola, Bahamas, Belarus, Bolivia, Burundi, Cambodia, Cameroon,
Cape Verde, Central African Republic, Côte d'Ivoire, Croatia, Djibouti, Dominica, El Salvador, Eritrea, Estonia,
Ethiopia, Gabon, Gambia, Ghana, Grenada, Guinea, Honduras, Lao People's Democratic Republic, Lebanon,
Lithuania, Madagascar, Malawi, Mali, Mauritius, Federated States of Micronesia, Monaco, Mozambique,
Myanmar, Nepal, Nicaragua, Nigeria, Panama, Paraguay, Rwanda, Saint Vincent and the Grenadines, Sao Tome
and Principe, Sierra Leone, Slovenia, Solomon Islands, Sri Lanka, Sudan, Suriname, Thailand, The Former
Yugoslav Republic of Macedonia, Togo, Trinidad and Tobago, Tuvalu, Uganda, United Republic of Tanzania,
Uzbekistan, Zaire, Zambia, Zimbabwe.
The draft resolution, as amended, was therefore approved by 93 votes to 4, with 4 abstentions.¹

Mr McALISTER (Canada), speaking on behalf of Australia, New Zealand and Canada, said that those countries shared a concern for the health of all the peoples of the world and that included the Palestinians. It was in order to further global health that the Health Assembly was convened each year; such was WHO's mandate. The promotion and protection of global health represented a daunting challenge as it was, without WHO straying into areas more properly the concern of other bodies. Although they had voted in favour of the draft resolution, Australia, New Zealand and Canada questioned the appropriateness of certain elements therein which were not directly related to health promotion.

Mr MOEINI (Islamic Republic of Iran) said that although his delegation had voted in favour of the draft resolution, it had certain reservations.

The meeting rose at 12:45.

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA50.38.
NINTH MEETING

Tuesday, 13 May 1997, at 15:30

Chairman: Dr T. TAITAI (Kiribati)

FIFTH REPORT OF COMMITTEE B (Document A50/40)

The CHAIRMAN read out the draft fifth report of Committee B.

The report was adopted.¹

The meeting rose at 15:40.

¹ See page 241.
1. SIXTH REPORT OF COMMITTEE B (Document A50/41)

Dr AMMAR (Lebanon), Rapporteur, read out the draft sixth report of Committee B.

The report was adopted.¹

Dr SEVER (Israel) reminded the Committee that the resolution on agenda item 28 had not been approved by consensus; his delegation had voted against the resolution and would explain its position more fully at the tenth plenary meeting.²

Mr MOEINI (Islamic Republic of Iran) said his delegation’s positive vote on the resolution on health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine, should not be construed as recognition of the occupying regime or of the so-called peace process. In his country’s view, that process would not provide a durable solution to long decades of conflict in the Middle East or the fair and just peace which would guarantee the restoration of the rights of the Palestinian people, including their right to return to the whole of their homeland.

2. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 9:50.

¹ See page 241.
² See document WHA50/1997/REC/2.
REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly have been replaced by the serial number (in square brackets) under which they appear in document WHA50/1997/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA50/1997/REC/2. Summary records of the meetings of the General Committee, Committee A and Committee B appear in this volume.

COMMITTEE ON CREDENTIALS

First report

[A50/28 - 7 May 1997]

1. The Committee on Credentials met on 6 May 1997. Delegates of the following Member States were present: Bhutan, Congo, Ghana, Iran (Islamic Republic of), Luxembourg, Pakistan, Romania, Uruguay, Uzbekistan and Vanuatu.

2. The Committee elected the following officers: Dr J.D. Otoo (Ghana) - Chairman; Dr G. Bikandou (Congo) - Vice-Chairman; Dr J. Singay (Bhutan) - Rapporteur.

3. The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly.

4. The credentials of the delegates of the Member States shown in the list at the end of this report were found to be in conformity with the Rules of Procedure; the Committee therefore proposes that the World Health Assembly should recognize their validity.

5. The Committee examined notifications from the Member States listed below, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee recommends to the World Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Assembly pending the arrival of their formal credentials: Cambodia, Congo, Costa Rica, Denmark, Djibouti, Greece, India, Mali, Nicaragua, Palau, Portugal, Republic of Moldova, Saint Vincent and the Grenadines, Sierra Leone, Tonga and Venezuela.

6. The delegate of the Islamic Republic of Iran expressed his Government's reservation regarding the inclusion of Israel in the list of formal credentials.

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1 Approved by the Health Assembly at its sixth plenary meeting.
States whose credential it was recommended should be recognized as valid (see paragraph 4 above)

Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Cook Islands; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Germany; Ghana; Grenada; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Niger; Nigeria; Niue; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Qatar; Republic of Korea; Romania; Russian Federation; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Singapore; Slovakia; Slovenia; Solomon Islands; South Africa; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; The Former Yugoslav Republic of Macedonia; Togo; Trinidad and Tobago; 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; Viet Nam; Yemen; Zaire; Zambia; Zimbabwe.

Second report¹

[A50/34 - 10 May 1997]

1. The Committee on Credentials met on 9 May 1997, under the Chairmanship of Dr J.D. Otoo (Ghana). Dr G. Bikandou (Congo) was Vice-Chairman, and Dr J. Singay (Bhutan) was Rapporteur.

2. The Committee examined the formal credentials of the delegates of Cambodia, Congo, Costa Rica, Denmark, Djibouti, India, Mali, Nicaragua, Palau, Portugal, Tonga and Venezuela, who had been seated provisionally in the World Health Assembly, pending the arrival of their formal credentials. These credentials were found to be in conformity with the Rules of Procedure, and the Committee therefore proposes that the World Health Assembly recognize their validity.

3. The Committee noted that Denmark had submitted its formal credentials before the Committee's first meeting. However, these credentials had unfortunately not been made available to the Committee for examination.

4. The Committee also examined the formal credentials of Equatorial Guinea, Georgia, Micronesia (Federated States of), Rwanda and St Kitts and Nevis, which were found to be in conformity with the Rules of Procedure, and the Committee therefore proposes that the Health Assembly recognize their validity, thereby enabling these delegations to participate with full rights in the Assembly.

5. The Committee also examined the notification from Burundi, which, while indicating the name of the delegate concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the World Health Assembly that the

¹ Approved by the Health Assembly at its eighth plenary meeting.
delegate of Burundi be provisionally seated with all rights in the Assembly pending the arrival of his formal credentials.

COMMITTEE ON NOMINATIONS

First report

The Committee on Nominations, consisting of delegates of the following Member States: Antigua and Barbuda, Belgium, Brazil, Cambodia, Central African Republic, China, Colombia, France, Gambia, Indonesia, Kiribati, Lesotho, Madagascar, Malawi, Maldives, Mali, Mexico, Oman, Paraguay, Qatar, Russian Federation, The former Yugoslav Republic of Macedonia, Turkey, United Kingdom of Great Britain and Northern Ireland and Yemen met on 5 May 1997. Dr W.B. Mukiwa (Malawi) was elected Chairman.

In accordance with Rule 25 of the Rules of Procedure of the Health Assembly and respecting the practice of regional rotation that the Assembly has followed for many years in this regard, the Committee decided to propose to the Assembly the nomination of Mr Saleem I. Shervani (India) for the Office of President of the Fiftieth World Health Assembly.

Second report

At its first meeting held on 5 May 1997, the Committee on Nominations decided to propose to the Assembly, in accordance with Rule 25 of the Rules of Procedure of the Assembly, the following nominations:

Vice-Presidents of the Assembly: Dr A. M’Hatef (Algeria), Dr J.F. Oletta (Venezuela), Mr S. Eleghmary (Libyan Arab Jamahiriya), Mrs M. de B. Roseira (Portugal), Dr Zhang Wenkang (China);

Committee A: Chairman - Dr R. Campos (Belize);

Committee B: Chairman - Dr T. Taitai (Kiribati).

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the Assembly, the Committee decided to nominate the delegates of the following 17 countries: Argentina, Bulgaria, Côte d’Ivoire, Cuba, Eritrea, France, Japan, Morocco, Mozambique, Myanmar, Russian Federation, Seychelles, South Africa, Sweden, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland and United States of America.

1 Approved by the Health Assembly at its second plenary meeting.
Third report¹

[A50/27 - 6 May 1997]

At its first meeting held on 5 May 1997, the Committee on Nominations decided to propose to each of the main committees, in accordance with Rule 25 of the Rules of Procedure of the Assembly, the following nominations for the Offices of Vice-Chairmen and Rapporteur:

Committee A: Vice-Chairmen: Professor H. Achour (Tunisia) and Mr K.R.C. Pillay (Mauritius); Rapporteur: Dr S. Zobrist (Switzerland);

Committee B: Vice-Chairmen: Dr M. Savel'ev (Russian Federation) and Dr S.R. Simkhada (Nepal); Rapporteur: Dr W. Ammar (Lebanon).

GENERAL COMMITTEE

Report²

[A50/35 - 10 May 1997]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting held on 9 May 1997, the General Committee, in accordance with Rule 102 of the Rules of Procedure of the Health Assembly, drew up the following list of 10 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 10 Members to be entitled to designate a person to serve on the Executive Board: Burundi, Canada, Cook Islands, Cyprus, Germany, Netherlands, Norway, Oman, Peru, Sri Lanka.

In the General Committee's opinion these 10 Members would provide, if elected, a balanced distribution on the Board as a whole.

¹ See summary records of the first meetings of Committees A and B (pp. 5 and 149).
² See document WHA50/1997/REC/2, verbatim record of the eighth meeting, section 6.


COMMITTEE A

First report

[A50/36 - 10 May 1997]

On the proposal of the Committee on Nominations, Professor H. Achour (Tunisia) and Mr K.R.C. Pillay (Mauritius) were elected Vice-Chairmen, and Dr S. Zobrist (Switzerland) Rapporteur.

Committee A held its first two meetings on 6 and 7 May 1997 under the chairmanship of Dr R. Campos (Belize), its third meeting on 7 May 1997 under the chairmanship of Mr K.R.C. Pillay (Mauritius), its fourth and fifth meetings on 8 May 1997 under the chairmanship of Professor H. Achour (Tunisia) and Dr R. Campos (Belize) respectively, its sixth and seventh meetings on 9 May 1997 under the chairmanship of Mr K.R.C. Pillay (Mauritius) and Dr R. Campos (Belize) respectively.

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda items:

17. Proposed programme budget for the financial period 1998-1999
   17.1 General review
       Reimbursement of travel expenses for attendance at the Health Assembly [WHA50.1]
       WHO collaborating centres [WHA50.2]
   19. Implementation of resolutions and decisions (progress reports by the Director-General)
       Guidelines on the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce [WHA50.3]
       Cross-border advertising, promotion and sale of medical products using the Internet [WHA50.4].

Second report

[A50/37 - 12 May 1997]

Committee A held its eighth meeting on 10 May 1997 under the chairmanship of Professor H. Achour (Tunisia).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda item:

19. Implementation of resolutions and decisions (progress reports by the Director-General)
       Prevention of violence [WHA50.19]
       Quality of biological products moving in international commerce [WHA50.20]
       World Tuberculosis Day [WHA50.21].

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1 Approved by the Health Assembly at its eighth plenary meeting.
2 See the third report of the Committee on Nominations, above.
3 Approved by the Health Assembly at its ninth plenary meeting.
Committee A held its ninth and tenth meetings on 12 May 1997 under the chairmanship of Dr R. Campos (Belize) and Professor H. Achour (Tunisia).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda items:

17. Proposed programme budget for the financial period 1998-1999
   17.1 General review
       Strengthening health systems in developing countries [WHA50.27]
   17.2 Financial review
       Financing of the WHO worldwide management information system through the use of casual income [WHA50.24]
       Appropriation resolution for the financial period 1998-1999 [WHA50.25]
       Programme budget for the 1998-1999 biennium: reallocation to priority health programmes of amounts resulting from measures to increase efficiency [WHA50.26]

18. Preparation of the Tenth General Programme of Work
    WHO reform: linking the renewed health-for-all strategy with the Tenth General Programme of Work, programme budgeting and evaluation [WHA50.28]

20. Control of tropical diseases
    Elimination of lymphatic filariasis as a public health problem [WHA50.29].

Committee A held its eleventh meeting on 13 May 1997 under the chairmanship of Dr R. Campos (Belize).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda item:

20. Control of tropical diseases
    Malaria prevention and control [WHA50.34]
    Eradication of dracunculiasis [WHA50.35]
    African trypanosomiasis [WHA50.36].
Committee B held its first meeting on 6 May 1997 and its second meeting on 7 May 1997 under the chairmanship of Dr T. Taitai (Kiribati). On the proposal of the Committee on Nominations, Dr M. Savel’ev (Russian Federation) and Dr S.R. Simkhada (Nepal) were elected Vice-Chairmen and Dr W. Ammar (Lebanon) Rapporteur.

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda items:

22. Financial matters
   22.1 Interim financial report on the accounts of WHO for 1996 and comments thereon of the Administration, Budget and Finance Committee (Article 18(f); Financial Regulations 11.3 and 12.9); External Auditor’s report on his work
       Interim financial report for the year 1996 [WHA50.5]
       Transfer of funds from the Executive Board Special Fund to the Special Account for Disasters and Natural Catastrophes in the Voluntary Fund for Health Promotion [WHA50.6]
   22.2 Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution
       Status of collection of assessed contributions [WHA50.7]
       Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA50.8]

24. Scale of assessments
   24.1 Assessment of new Members and Associate Members
       Assessment of Andorra for 1997 [WHA50.9]

25. Real Estate Fund
   Real Estate Fund [WHA50.10]
   Relocation of the Regional Office for the Eastern Mediterranean from Alexandria to Cairo [WHA50.11]

27. Collaboration within the United Nations system and with other intergovernmental organizations
   27.1 General matters
       Establishment of the International Vaccine Institute [WHA50.12].

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1 Approved by the Health Assembly at its eighth plenary meeting.
2 See above, p. 236.
Second report¹

Committee B held its third and fourth meetings on 8 May 1997 under the chairmanship of Dr S.R. Simkhada (Nepal).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions and a decision relating to the following agenda items:

27. Collaboration within the United Nations system and with other intergovernmental organizations
   27.2 Environmental matters
       Promotion of chemical safety, with special attention to persistent organic pollutants [WHA50.13]
       Protection of the marine environment [WHA50.14]

29. Personnel matters
   29.1 Recruitment of international staff in WHO
       Recruitment of international staff in WHO: geographical representation [WHA50.15]
       Employment and participation of women in the work of WHO [WHA50.16]

   29.2 Confirmation of amendments to the Staff Rules: salaries for ungraded posts and the Director-General [WHA50.17]

31. Method of work of the Health Assembly [WHA50.18]

Third report²

Committee B held its fifth and sixth meetings on 9 May 1997 under the chairmanship of Dr S.R. Simkhada (Nepal).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions and a decision relating to the following agenda items:

22. Financial matters
   22.2 Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA50.22]

26. WHO reform
   26.1 Renewing the health-for-all strategy, including report of the task force on health in development [WHA50.23]
   26.2 The world health report 1998 and third evaluation of progress in implementation of the global strategy for health for all by the year 2000 [WHA50(8)].

¹ Approved by the Health Assembly at its eighth plenary meeting.
² Approved by the Health Assembly at its ninth plenary meeting.
Fourth report

[450/39 - 13 May 1997]

Committee B held its seventh meeting on 12 May 1997 under the chairmanship of Dr T. Taitai (Kiribati).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda items:

22. Financial matters
   22.2 Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA50.30]
27. Collaboration within the United Nations system and with other intergovernmental organizations
   27.1 General matters [WHA50.31]
31. Method of work of the Health Assembly [WHA50.32].

Fifth report

[450/40 - 13 May 1997]

Committee B held its eighth meeting on 13 May 1997 under the chairmanship of Dr T. Taitai (Kiribati).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of a resolution relating to the following agenda item:

24. Scale of assessments
   24.2 Scale of assessments for the financial period 1998-1999 [WHA50.33].

Sixth report

[450/41 - 14 May 1997]

Committee B held its ninth meeting on 13 May 1997 under the chairmanship of Dr T. Taitai (Kiribati).

It was decided to recommend to the Fiftieth World Health Assembly the adoption of resolutions relating to the following agenda items:

Supplementary agenda item: Cloning in human reproduction [WHA50.37]
28. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine [WHA50.38].

1 Approved by the Health Assembly at its ninth plenary meeting.
2 Approved by the Health Assembly at its tenth plenary meeting.
REPORT OF COMMITTEE B TO COMMITTEE A

[A50/32 - 9 May 1997]

During the course of its first meeting held on 6 May 1997, Committee B noted the Director-General's proposal to appropriate the available balance of casual income of US$ 12 617 000 to help finance the 1998-1999 regular budget.
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