WORLD HEALTH ORGANIZATION

FORTY-NINTH
WORLD HEALTH ASSEMBLY

GENEVA, 20-25 MAY 1996

SUMMARY RECORDS AND REPORTS OF COMMITTEES

GENEVA
1996
**ABBREVIATIONS**

Abbreviations used in WHO documentation include the following:

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<td>ACC</td>
<td>Administrative Committee on Coordination</td>
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<tr>
<td>ACHR</td>
<td>Advisory Committee on Health Research</td>
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<tr>
<td>AGFUND</td>
<td>Arab Gulf Programme for United Nations Development Organizations</td>
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<tr>
<td>ASEAN</td>
<td>Association of South-East Asian Nations</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>CIOMS</td>
<td>Council for International Organizations of Medical Sciences</td>
</tr>
<tr>
<td>DANIDA</td>
<td>Danish International Development Agency</td>
</tr>
<tr>
<td>ECA</td>
<td>Economic Commission for Africa</td>
</tr>
<tr>
<td>ECE</td>
<td>Economic Commission for Europe</td>
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<tr>
<td>ECLAC</td>
<td>Economic Commission for Latin America and the Caribbean</td>
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<tr>
<td>ESCAP</td>
<td>Economic and Social Commission for Asia and the Pacific</td>
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<tr>
<td>ESCWA</td>
<td>Economic and Social Commission for Western Asia</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
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<tr>
<td>FINNIDA</td>
<td>Finnish International Development Agency</td>
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<tr>
<td>IAEA</td>
<td>International Atomic Energy Agency</td>
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<tr>
<td>IARC</td>
<td>International Agency for Research on Cancer</td>
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<tr>
<td>ICAO</td>
<td>International Civil Aviation Organization</td>
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<tr>
<td>IFAD</td>
<td>International Fund for Agricultural Development</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization (Office)</td>
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<td>IMO</td>
<td>International Maritime Organization</td>
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<tr>
<td>ITU</td>
<td>International Telecommunication Union</td>
</tr>
<tr>
<td>NORAD</td>
<td>Norwegian Agency for International Development</td>
</tr>
<tr>
<td>OAU</td>
<td>Organization of African Unity</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>SAREC</td>
<td>Swedish Agency for Research Cooperation with Developing Countries</td>
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<tr>
<td>SIDA</td>
<td>Swedish International Development Authority</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<td>UNCTAD</td>
<td>United Nations Conference on Trade and Development</td>
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<td>UNDCP</td>
<td>United Nations International Drug Control Programme</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNHCR</td>
<td>Office of the United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNIDO</td>
<td>United Nations Industrial Development Organization</td>
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<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
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<td>UNSCEAR</td>
<td>United Nations Scientific Committee on the Effects of Atomic Radiation</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WIPO</td>
<td>World Intellectual Property Organization</td>
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<tr>
<td>WMO</td>
<td>World Meteorological Organization</td>
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<td>WTO</td>
<td>World Trade Organization</td>
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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 Forty-ninth World Health Assembly was held at the Palais des Nations, Geneva, from 20 to 25 May 1996, in accordance with the decision of the Executive Board at its ninety-sixth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, annexes and list of participants - document WHA49/1996/REC/1

Verbatim records of plenary meetings - document WHA49/1996/REC/2

Summary records and reports of committees - document WHA49/1996/REC/3

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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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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP
OF ITS COMMITTEES

President
Dr A. J. MAZZA (Argentina)

Vice-Presidents
Dr S. MBA BEKALE (Gabon)
Mr A. B. S. AL-KHAYAREEN (Qatar)
Dr M. VITKOVA (Bulgaria)
Mr A. H. M. FOWZIE (Sri Lanka)
Mrs S. H. TIY (Fiji)

Secretary
Dr H. NAKAJIMA, Director-General

Committee on Credentials
The Committee on Credentials was composed of delegates of the following Member States: Austria, Botswana, Cape Verde, Estonia, Federated States of Micronesia, Iran (Islamic Republic of), Jamaica, Kenya, Malta, Myanmar, Syrian Arab Republic and Venezuela.

Chairman: Dr P. ABELA-HYZLER (Malta)
Vice-Chairman: Mrs W. G. MANYENENG (Botswana)
Rapporteur: Dr OHN KYAW (Myanmar)
Secretary: Mr T. S. R. TOPPING, Legal Counsel

Committee on Nominations
The Committee on Nominations was composed of delegates of the following Member States: Albania, Algeria, Bahrain, Benin, Bolivia, China, Cyprus, Democratic People's Republic of Korea, Djibouti, Ethiopia, Finland, France, Lesotho, Mauritius, Mexico, Nepal, Panama, Republic of Korea, Russian Federation, Saint Lucia, Samoa, Senegal, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, and Uruguay.

Chairman: Mr K. LEE (Republic of Korea)
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: Australia, Canada, China, Croatia, Cuba, Ecuador, France, Lebanon, Mali, Nigeria, Oman, Russian Federation, Thailand, United Kingdom of Great Britain and Northern Ireland, United States of America, Zaire, and Zambia.

Chairman: Dr A. J. MAZZA (Argentina)
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: Professor B. SANGSTER (Netherlands)
Vice-Chairmen: Dr A. M. ALFARO DE GAMERO (El Salvador) and Dr M. M. DAYRIT (Philippines)
Rapporteur: Dr J. SINGAY (Bhutan)
Secretary: Dr B.-I. THYLEFORS, Director, Programme for the Prevention of Blindness and Deafness

Committee B

Chairman: Dr O. SHISANA (South Africa)
Vice-Chairmen: Dr A. Y. AL-SAIF (Kuwait) and Professor A. K. SHAMSUDDIN SIDDIQUEY (Bangladesh)
Rapporteur: Dr M. KÖKÉNY (Hungary)
Secretary: Mr A. K. ASAMOAH, Chief, Administration and Staff Support Service
AGENDA¹

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1. Opening of the session
2. Appointment of the Committee on Credentials
3. Election of the Committee on Nominations
4. Election of the President and the five Vice-Presidents
5. Election of the Chairman of Committee A
6. Election of the Chairman of Committee B
7. Establishment of the General Committee
8. Adoption of the agenda and allocation of items to the main committees
9. Review and approval of the reports of the Executive Board on its ninety-sixth and ninety-seventh sessions
10. Review of The world health report 1996 (introduction by the Director-General)
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12. Election of Members entitled to designate a person to serve on the Executive Board
13. Awards
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   13.2 Sasakawa Health Prize
   13.3 United Arab Emirates Health Foundation Prize
14. Approval of reports of main committees
15. Closure of the Forty-ninth World Health Assembly

¹ The agenda was adopted at the third plenary meeting.
COMMITTEE A

16. Election of Vice-Chairmen and Rapporteur

10. Review of The world health report 1996 (discussion)

17. Implementation of resolutions (progress reports by the Director-General)
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   - Strengthening nursing and midwifery (resolutions WHA45.5 and WHA48.8)
   - Revised drug strategy (resolution WHA47.13)
   - Reproductive health (resolution WHA48.10)
   - Occupational health (resolution WHA33.31)
   - Tobacco or health (resolution WHA48.11)
   - Prevention and control of iodine deficiency disorders (resolution WHA43.2)
   - Infant and young child nutrition (resolution WHA33.32)
   - Global strategy for the prevention and control of AIDS (resolution WHA42.33)

18. Communicable disease prevention and control
   18.1 Smallpox eradication: destruction of variola virus stocks
   18.2 New, emerging and re-emerging infectious diseases, and revision of the International Health Regulations

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   20.2 Status of collection of assessed contributions

1 Item transferred to Committee B.
AGENDA

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20.5 [deleted]

21. WHO reform and response to global change
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   21.3 Review of the Constitution of the World Health Organization
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22. Budgetary reform

23. [deleted]

24. [deleted]

25. Real Estate Fund

26. Personnel matters: employment and participation of women in the work of WHO

27. United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

28. Amendments to Articles 24 and 25 of the Constitution

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

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1 Issued in Arabic, Chinese, English, French, Russian and Spanish.

2 See page xi.

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A49/15 WHO reform and response to global change: report of the ad hoc group. Report by the Director-General
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A49/21 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine. Report by the Director-General
A49/22 Collaboration within the United Nations system and with other intergovernmental organizations. General matters. Report by the Director-General
A49/22 Add.1 Collaboration within the United Nations system and with other intergovernmental organizations. United Nations System-wide Special Initiative on Africa. Report by the Director-General
A49/23 Collaboration within the United Nations system and with other intergovernmental organizations. Coordinated follow-up and implementation of plans of action of international conferences. Report by the Director-General
A49/24 Collaboration within the United Nations system and with other intergovernmental organizations. International Decade of the World's Indigenous People. Report by the Director-General
A49/26 Collaboration within the United Nations system and with other intergovernmental organizations. Health assistance to specific countries. Report by the Director-General
A49/27 Collaboration within the United Nations system and with other intergovernmental organizations. Strengthening of the coordination of emergency humanitarian assistance. Report by the Director-General

1 See document WHA49/1996/REC/1, Annex 1.
2 See document WHA49/1996/REC/1, Annex 3.
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¹ Issued in English and French.
² Also available in Arabic.
1. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Document A49/1)

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 A49/1.

Deletion of agenda items

The CHAIRMAN indicated that, if there was no objection, four items on the provisional agenda should be deleted, namely, item 11 (Admission of new Members and Associate Members), item 20.5 (Amendments to the Financial Regulations), item 23 (Supplementary budget for 1996-1997), and item 24 (Scale of assessments: assessment of new Members and Associate Members).

It was so agreed.

Allocation of remaining items

Referring to the limited duration of the Health Assembly, the CHAIRMAN observed that, in case any items had to be postponed until the following session, priority would be given at the current session to those items that had to be dealt with by virtue of a Health Assembly resolution. In particular, Committee A might wish to set a specific time to take up item 18.1 (Smallpox eradication: destruction of variola virus stocks). Further, proposals for new draft resolutions should be submitted by the evening of Tuesday, 21 May, to allow for due consideration by the Assembly.

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

The Executive Board had allocated the items on the provisional agenda to Committee A and Committee B according to the terms of reference of those committees. The Board had proposed that under item 17 (Implementation of resolutions (progress reports by the Director-General)) the subitem on Global strategy for the prevention and control of AIDS should be taken together with item 30.4 (Joint United Nations Programme on HIV/AIDS) in Committee B, and that the subitem on Tobacco or health should also be taken in Committee B.
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 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.

Lastly, the CHAIRMAN drew attention to the Executive Board’s recommendation to the Health Assembly that holidays falling during the period of the Assembly should be considered as working days, unless the Board decided otherwise.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The CHAIRMAN reminded the Committee that the Executive Board, in decision EB97(16), had decided that the Forty-ninth World Health Assembly should close no later than Saturday, 25 May, and drew attention to the preliminary timetable prepared by the Board.¹ In the absence of any objections to the timetable, he concluded that the Committee approved it.

It was so agreed.

The General Committee then drew up the programme of work of the Health Assembly for Tuesday, 21 May, and Wednesday, 22 May. It decided to meet next on Wednesday, 22 May at 17:10 in order to draw up the list for the annual election of Members entitled to designate a person to serve on the Executive Board, and to review the programme for the remainder of the week.

Referring to the list of speakers for the debate on agenda item 10 (Review of The world health report 1996), the CHAIRMAN suggested that, in accordance with established procedure for that debate, usually held in plenary, the order of speakers on the list, which already contained 68 names, 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. The list of speakers would appear in the Journal. If the Committee had no objection, he would inform the Health Assembly of those arrangements at the plenary meeting that afternoon.

It was so agreed.

The delegate of the UNITED STATES OF AMERICA agreed that a time limit should be set for the receipt of new resolutions. He suggested that the Chairman should remind the Assembly of the provisions of resolution WHA47.14 on Health Assembly resolutions. No new resolutions on technical subjects should be introduced at the Assembly; they should be submitted first to the Executive Board for examination at its January session.

The delegate of CANADA endorsed the suggestion of the previous speaker. In view of the efforts to ensure that resources were spent according to priorities, tasks should not be added to the existing work plan of the Organization without an examination of their structural, programme, and financial implications. Without discouraging Members from drawing attention to new issues, he considered that it was important for the Health Assembly to know what was involved before action was taken.

The delegate of ZAMBIA, while supporting the views of the previous speakers, requested definition of a "technical resolution".

¹ Document A49/GC/1.
The DIRECTOR, CABINET OF THE DIRECTOR-GENERAL, read out certain operative paragraphs of resolution WHA47.14.

The CHAIRMAN requested the Legal Counsel to prepare a summary of the operative paragraphs of resolution WHA47.14 for the Health Assembly.

The delegate of AUSTRALIA expressed concern that important items referred to the Health Assembly from the Executive Board might have to be postponed until the following Assembly. He welcomed efforts to streamline the work of the Assembly, and felt that the proceedings of the first day could possibly be dealt with in preparatory meetings in the regions in order to start earlier the examination of substantive matters.

The delegate of CUBA asked when the list of speakers on item 10 would be closed.

The DIRECTOR, CABINET OF THE DIRECTOR-GENERAL, replied that Committee A decided when the list would be closed.

The meeting rose at 14:15.

SECOND MEETING

Wednesday, 22 May 1996, at 17:25

Chairman: Dr A.J. MAZZA (Argentina)
President of the Health Assembly

1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD

The CHAIRMAN reminded members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Rules of Procedure of the Health Assembly. To help the General Committee in its task, three documents were before it: a table, by region, of Members of the Organization which were or had been entitled to designate persons to serve on the Executive Board; 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 Forty-ninth World Health Assembly and which had to be replaced, namely: for the African Region, Togo, Uganda, United Republic of Tanzania, Zaire; for the Region of the Americas, Costa Rica; for the South-East Asia Region, Nepal; for the European Region, Israel, Turkey; for the Eastern Mediterranean Region, Morocco; and for the Western Pacific Region, Viet Nam; and 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, the Chairman 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 since the list apparently met with its approval.

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: Angola, Benin, Botswana, Burkina Faso, Honduras, Indonesia, Japan, Poland, United Arab Emirates,
United Kingdom of Great Britain and Northern Ireland. The list would be transmitted to the Health Assembly before it was due to meet to elect the Members.

It was so agreed.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee heard reports from Professor SANGSTER (Netherlands), Chairman of Committee A, and Dr SHISANA (South Africa), Chairman of Committee B, on the progress of work in their committees.

The delegate of AUSTRALIA, referring to the debate in Committee A on agenda item 10 (Review of The world health report 1996), noted that speakers had set a good example by respecting the five-minute time limit on interventions. He suggested that that limit should similarly be applied to country statements delivered in plenary when the general debate was again held there.

The General Committee then drew up the programme of meetings for the remainder of the Health Assembly. It agreed that its own next meeting would be held on Thursday, 23 May at 12:40.

The meeting rose at 17:40.

THIRD MEETING

Thursday, 23 May 1996, at 18:10

Chairman: Dr A.J. MAZZA (Argentina)
President of the Health Assembly

1. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

After the Committee had heard the reports of Professor SANGSTER (Netherlands), Chairman of Committee A, and Dr SHISANA (South Africa), Chairman of Committee B, on the progress of the work of those committees, the CHAIRMAN proposed that item 17 (Implementation of resolutions (progress reports by the Director-General), subitem on Infant and young child nutrition) should be transferred from Committee A to Committee B.

It was so agreed.

2. CONSIDERATION OF DRAFT RESOLUTIONS

The CHAIRMAN noted that, in accordance with the provisions of resolution WHA47.14, paragraph 5(2), two draft resolutions had been referred to the General Committee. The Committee was requested to make a recommendation as to whether those resolutions should be considered by the Health Assembly. The resolutions would be considered in turn.
Prevention of violence: a public health priority

The delegate of CANADA, observing that paragraph 4 of the draft resolution requested the Director-General to provide relevant technical material to the Executive Board, suggested that the draft resolution should be considered in Committee B as a resolution, rather than as an item for debate. Substantive discussion should be reserved until the next Health Assembly, when the guidance of the Board and the additional information would be available.

The delegate of SOUTH AFRICA similarly noted that the amendment to the draft resolution requested the Director-General to present to the Executive Board at its ninety-ninth session a plan of action for a science-based public health approach to violence prevention. Bearing in mind the broad-based support for the draft resolution, he affirmed that it should be considered by Committee B, to be elaborated upon subsequently by the Executive Board.

The delegate of the UNITED STATES OF AMERICA added that consideration of the draft resolution by the Health Assembly did not require specific technical back-up. The Assembly would focus on paragraphs 1, 2, and 4, acknowledging the public health importance of the issue and requesting submission of technical material to the Board.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that he had no objection to the draft resolution being considered in Committee B and examined by the Board in due course.

The General Committee agreed that the amended draft resolution should be considered by Committee B.

International Decade of the World's Indigenous People

The delegate of AUSTRALIA queried whether the draft resolution should fall under the provisions of resolution WHA47.14 as the matter had already been considered by the Executive Board. The draft resolution differed little from the text of resolution EB97.R18, which had requested that a programme of action should be submitted to the Health Assembly. As the relevant report by the Director-General (document A49/24) did not cover the full scope of the considerations reflected in resolution EB97.R18, an iterative operative paragraph had been inserted in what was originally an Executive Board resolution. It would seem unnecessary to return the draft resolution to the Board for further consideration.

The General Committee agreed that the draft resolution should be considered by Committee B.

3. CLOSURE

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

The meeting rose at 18:35.
COMMITTEE A

FIRST MEETING

Tuesday, 21 May 1996, at 9:00

Chairman: Professor B. SANGSTER (Netherlands)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 16 of the Agenda (Document A49/37)

The CHAIRMAN expressed gratitude for his election and welcomed those present. He then drew attention to the third report of the Committee on Nominations (document A49/37),¹ in which Dr A.M. Alfaro de Gamero (El Salvador) and Dr M.M. Dayrit (Philippines) were nominated for the offices of Vice-Chairmen of Committee A and Dr J. Singay (Bhutan) for that of Rapporteur.

Decision: Committee A elected Dr A.M. Alfaro de Gamero (El Salvador) and Dr M.M. Dayrit (Philippines) as Vice-Chairmen and Dr J. Singay (Bhutan) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN 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.


Dr MAZZA (Argentina) noted that The world health report 1996 covered the salient aspects of health of populations and the role of the Organization in the face of global change. It defined the current situation with regard to communicable diseases, their spread, the difficulty of controlling them, and the burden they represented; it indicated how combating disease fostered development. New social and demographic realities, including urbanization and easier communications and international travel, affected epidemiological profiles. Emerging and re-emerging diseases, such as AIDS and tuberculosis (which was an example of the constant microbial adaptation that raised new challenges in the control of communicable diseases), would oblige health systems to adapt to new morbidity patterns and to the rising costs of medical care. Eradication or elimination before the year 2000 of nine target diseases - leprosy, dracunculiasis, Chagas disease, onchocerciasis, poliomyelitis, measles, neonatal tetanus, brucellosis and urban rabies - would constitute a triumph for humanity. The situation with regard to those diseases should be examined within each region, subregion and

¹ See page 207.
² Decision WHA49(4).
country in order to take account of local differences; for instance, in his country there was no dracunculiasis or onchocerciasis, poliomyelitis and urban rabies had been eradicated, and the other target diseases were at different stages of control, which he outlined.

With firm political resolve, the set goals could be met by using the available technological means. The programmes of the Organization should be restructured centrally, regionally and at the country level in order to achieve health for all as soon as possible; horizontal cooperation between countries would be of fundamental importance. If communicable diseases were not controlled, they might re-emerge, as had tuberculosis, vitiating previous efforts. "Old" diseases such as malaria and tuberculosis were also priorities for new research activities, epidemiological surveillance, early diagnosis and proper treatment. Short- and medium-term activities against all emerging and re-emerging diseases should be systematized, and early-warning systems should be developed to control epidemic outbreaks.

Mr BALDOCCI (Italy), speaking on behalf of the Minister of Health of the country that held the presidency of the European Union, noted that the Health Council of the Union had discussed some of the problems raised by the Director-General in The world health report 1996. The ministers of health of the European Union considered that bovine transmissible spongiform encephalopathy was a public health problem; it would be necessary to extend surveillance to all countries of the Union, to ensure continuous review of scientific information on the causes and transmission of Creutzfeldt-Jakob disease and to conduct further studies on the two diseases.

Close collaboration between countries was needed for the control of communicable diseases. A joint task force of the European Union and the United States of America had been set up to establish an effective global early-warning system and response network for communicable diseases, which would collaborate with WHO in stressing the needs and policies of developing countries and would encourage scientists from those countries to work in European Union and United States research programmes.

The European Union assisted developing countries both bilaterally and multilaterally. Reorganization of health services, pharmaceutical policy, disease prevention and health promotion were included in its PHARE and TACIS programmes for the countries of central and eastern Europe and the newly independent States of the former Union of Soviet Socialist Republics. Programmes on cancer, on AIDS and on other communicable diseases were designed specifically for the countries of central and eastern Europe. Disease prevention and health protection were integrated into humanitarian operations carried out within the programme of the European Community Humanitarian Office (ECHO).

He supported the principles on which WHO's reforms were based - equity, solidarity, efficiency and accountability - and the priorities selected to meet the most pressing health needs: health emergencies, the poorest countries and most vulnerable groups, major causes of death, suffering and disability, and major impediments to social and economic development. Careful analysis and planning were necessary in order to avoid fragmentation or duplication of efforts at the country level. It was also essential that the technical expertise of WHO should remain of the highest quality, despite the de facto reduction approved in the programme budget for 1996-1997. The countries of the European Union had continued to pay their assessed contributions regularly, despite tight budgetary constraints, and had encouraged international agencies to make savings, set priorities carefully, undertake transparent budgeting, and ensure cost-effectiveness.

The dramatic worldwide escalation of communicable diseases called for increased surveillance and control. Adequate health infrastructures, health promotion, primary health care, the availability of essential drugs and a sound environment were still of importance, however, and it might be that communicable diseases were emerging or re-emerging because those needs had not been tackled vigorously enough.

The eradication of smallpox had been a great achievement. At least three other goals could be reached by the year 2000: the eradication of poliomyelitis, the elimination of leprosy as a public health problem, and the eradication of dracunculiasis.

Dr AL-MUHAILAN (Kuwait) said that new modalities would be necessary in order for WHO to fulfil its responsibilities materially and morally. Many emerging global problems could be combated only by WHO. Although the cost of drugs had become prohibitively high, the Organization should ensure that all people received the necessary treatment. His country had implemented legislation against smoking in public places and advertising of tobacco products, and was combating endemic diseases and causes of death linked to behaviour, such as cancer, drugs of abuse, obesity, cardiovascular diseases and traffic accidents. A long-term
strategy, to be completed by the year 2010, aimed at the provision of treatment for all citizens and residents of Kuwait. Modern hospitals, new technology and telemedicine were already available.

Dr SANGSINGKEO (Thailand) said that an important seminar held very recently in Thailand to discuss national plans up to the year 2020 had concluded that policies aimed at stimulating economic growth should be designed in such a way as to ensure sustainable human development through respect for the balance of nature, the health of the people and their quality of life. With regard to health development, a conference entitled "Health Science and Health Care for the Twenty-first Century: Problem, Challenge and Opportunity", cosponsored by the Ministry of Public Health and WHO, would take place in Bangkok in February 1997.

As a contribution to the effort to create a healthy planet through international cooperation, WHO's goal should be the eradication of certain diseases from all regions of the world. Emerging and re-emerging diseases such as bovine spongiform encephalopathy, plague, Ebola haemorrhagic fever, tuberculosis and malaria, as well as HIV/AIDS, were adversely affecting the global community. WHO had a vital role to play in promoting health development that corresponded to its own definition of health as not just the absence of disease but a state of complete physical, mental and social well-being.

The time had also come for governments to encourage greater participation in the provision of health care by the private sector, which was often more efficient than the government sector.

Dr ONO (Japan) commended The world health report 1996 on the concrete measures it proposed for dealing with three types of communicable diseases: those, like poliomyelitis, that would be eradicated or eliminated in the near future; those that exhibited resistance to antimicrobials, such as tuberculosis and malaria; and those, like Ebola haemorrhagic fever, that were newly emerging.

In view of the volume of people and goods crossing national boundaries, Japan was collaborating fully in WHO's preparations for revising the International Health Regulations.

With regard to the Organization's immunization programmes, he was pleased to note that poliomyelitis was on the verge of eradication from the Western Pacific Region. Within the policy coordination framework of the Japan-US Common Agenda, Japan had contributed significantly to international measures relating to HIV/AIDS, population, and children's health. In respect of HIV/AIDS, Japan would continue to support the measures carried out jointly by WHO and UNAIDS and would expand training programmes for those responsible for HIV/AIDS policies in Asia.

The WHO Centre for Health Development, established in Kobe in March, placed its major emphasis on urbanization and health and should contribute significantly to the control of infectious diseases linked to rapid and uncontrolled urbanization. In addition to its vital role in coordinating international health work, WHO should also be strengthening its normative function, particularly in relation to standards for pharmaceuticals and food safety.

In addition to its assessed budget contribution Japan would make a voluntary contribution, despite its own stringent financial situation, in order to demonstrate its commitment to WHO's health-for-all strategy.

Under the Director-General's leadership WHO had made a genuine effort to counterbalance the conflicting demands of increased health care needs and a dwindling budget and its endeavours should be supported in the future.

Dr SHALALA (United States of America) expressed concern over the difficulties of meeting the challenges presented by the emergence and re-emergence of infectious diseases with ever-diminishing resources, both nationally and internationally. For WHO to survive as an effective instrument for promoting and protecting global health in the twenty-first century, it must concentrate on the global community's most urgent health problems and deepen its commitment to reform, including greater budgetary transparency and restraint. The United States of America was deeply committed to the success of WHO, and President Clinton and she herself had fought hard and successfully for agreement for payments to international organizations. Without genuine reform, however, that substantial support for WHO would not be sustainable.

WHO must focus on what it did best: exerting global leadership in health; mobilizing global resources to respond to health emergencies and prevent their recurrence; setting standards, and providing countries with the information and tools to promote health and development.

Women's health would be a major challenge in the next century. The commitments made - with the help of effective WHO leadership - at the Fourth World Conference on Women in Beijing in September 1995
to promoting and safeguarding women's rights had to be put into practice. The time had come to show in the clearest possible way that violence against women and girls was unacceptable, and that an end must be put to the inhuman practice of female genital mutilation. Women should be provided with proper nutrition, education and prenatal and reproductive health care to enable them to reach their full potential and to protect both themselves and their families from environmental toxins, from drugs and tobacco and from potentially deadly diseases.

In spite of many important accomplishments in the control of communicable diseases - not least the eradication of smallpox and the possible elimination of poliomyelitis - increased international cooperation was still needed. In that respect the creation by WHO of the Division of Emerging and other Communicable Diseases Surveillance and Control was a welcome step. She also expressed strong support for the Joint United Nations Programme on HIV/AIDS (UNAIDS) and for WHO's continued coordination with that programme.

Mr DINGWALL (Canada) said that the information in The world health report 1996 was a cause for concern: one-third of all deaths in the world were due to infectious diseases, yet most such deaths were preventable. Greater international cooperation and a more dynamic WHO could contribute to reducing that burden.

Canada, maintaining its tradition of supporting international action for health, would be hosting the XI International Conference on AIDS in July in order to advance a common understanding of HIV/AIDS.

The preparation of WHO's imminent new global health policy provided an opportunity for redefining the Organization's role. Canada considered that WHO should seek common solutions to the collective problems of its Member States, that its normative functions should be clarified and perhaps expanded in strategically-focused areas, and that it should provide countries with specialized technical cooperation in a limited range of priority areas where its capacity to deliver was recognized. Its role in national health development, however, needed clarifying.

Despite WHO's success in eradicating smallpox and virtually eliminating poliomyelitis, it had lost its momentum and was no longer the primary reference point for international health matters. The Organization therefore needed effective programming, focused on priority areas to meet the real needs of Member States; it needed strengthened and fully transparent management, which was vital for public institutions; it needed to eliminate overlap and duplication within the international system; and it needed to respect fiscal realities.

Mr GAYMARD (France) said that the serious health consequences of international events in the past year had profound implications for the work and the future of the Organization. Communicable diseases were once again becoming a major priority, as the report showed so clearly. Health indicators gave cause for alarm throughout the world, and in the European Region the economic crisis was affecting immunization programmes in the newly independent States, resulting in the maintenance of poliomyelitis incidence and the outbreak of the recent diphtheria epidemic. The re-emergence of such diseases demonstrated the need for a collaborative effort, coordinated by WHO, to combat them.

Reforms were needed to check the rise in expenditure on social services, but not to the detriment of the most vulnerable sectors of society. It was the duty of both WHO and the wealthier countries to ensure that the necessary resources were made available to those most in need in order to improve the health situation throughout the world. WHO's ability to do so would depend on its ability to concentrate its human and financial resources on the areas where the need was greatest.

The very serious global threat posed by HIV/AIDS warranted concerted action by the United Nations and its programmes and agencies; for that purpose UNAIDS had started operating in January. He hoped that WHO would continue to play a leading role in its work.

The European Union had recently instituted a policy for the development of "orphan" drugs. In addition, some drugs for the treatment of parasitic diseases were no longer effective, and the European Union was seeking ways to remedy that situation. The Union also favoured a more widespread use of generic drugs in order to reduce costs and France was encouraging their development.

The process of reform initiated by WHO should enable the Organization to deal with emerging diseases such as bovine spongiform encephalopathy and to frame policies based on equity and solidarity. In view of budget constraints, it was important to meet such challenges through synergy and cooperation within the United Nations system and with such entities as the European Union.
Mr YEO Yong-Boon (Singapore) said that East Asia was going through an economic and social transformation on a scale never seen before. Overall poverty levels had come down drastically, and in the twenty-first century large parts of East Asia would be definitely middle class. The rapid growth that had started in Japan was now gradually encompassing all South-East Asia and China, causing a fundamental change in the structure of the health care sector in various countries. While the problems of communicable diseases and malnutrition would still be present for many years, they would increasingly give way to new problems of providing for the more complex health care needs of middle-class societies.

Thus a rapidly growing health-care industry was emerging in East Asia to serve the new middle classes. Public health care systems set up to meet the basic needs of fundamentally rural societies were no longer adequate. Many national systems were being reformed to meet new needs and to provide a better balance between the public and private sectors. In fact, the health care industry in East Asia would be one of the fastest-growing industries in the world. Private capital would become more important, widening the disparities in the quality and range of health care facilities available to the rich and to the not-so-rich, which in turn would create political tensions.

Contrasting with the rapidly growing health care industry in East Asia was the mature health care industry in North America and Western Europe. In the United States of America it accounted for 14% of the gross national product, a burden no society could bear for long. Thus there was an excess of health care resources in North America and Western Europe and an under-supply in East Asia, providing a great opportunity for mutually beneficial transoceanic transfers. In East Asia, whatever role the State played, responsibility for health care and healthy living should remain firmly anchored in individuals and their families. The Government at both municipal and national levels should bear part of the burden, but never most or all of it. To anticipate the growing problems of urbanization and aging, governments should avoid excessive subsidization when populations were young, because it was never easy to reduce the level of subsidy in any society. There must always be a circumspect view of third party payment. Holistic medicine, which was an important part of the East Asian heritage, should be harnessed. If the systems were well designed, they would be politically sustainable over a long period and would enable the economic growth of East Asia to continue well into the next century, in turn creating enormous opportunities for the health care industries in North America and Western Europe.

Singapore tried to strike a balance between individual, familial and group responsibility. It required every individual to build up his own medical savings for himself and his family; the employer shared some of the burden. Singapore was also facilitating the scientific development of traditional Chinese medicine and was encouraging the private sector to expand, both to meet the needs of Singaporeans and to service the region. It was also working with WHO with a view to cooperating and exchanging experience with other countries.

Mr NARASINGHA (Nepal) said that in the current times of severe financial constraints it was necessary to impress upon countries and the international community the need to maintain health and human beings at the centre of development goals and to recognize the crucial contribution that improved health made to fostering development and economic growth by reducing production losses due to worker illness, by permitting the use of natural resources that had been inaccessible because of disease, by improving school attendance and children's learning ability, and by freeing resources that would otherwise have to be spent on treating illness. The South-East Asia Region could be proud of the steady improvement in the health status of its people, particularly with regard to life expectancy, infant morbidity and mortality, and immunization coverage. Furthermore, it was expected that poliomyelitis and neonatal tetanus would soon be eradicated. In that connection, Nepal would be holding national immunization days for poliomyelitis during December 1996.

However, despite the progress achieved, infant and maternal mortality rates remained unacceptably high. The incidence of old and new communicable diseases was on the rise, the advent of resistant strains of the causal agents of diseases such as malaria and tuberculosis was creating additional difficulties, and despite widespread health infrastructure development and increased training of health workers, there were significant gaps in health services coverage, especially for the poor and the most vulnerable groups. To continue to foster development and economic growth and to ensure that all segments of the population enjoyed the benefits of development, political commitment and financial support were essential. Consequently, while appreciating the financial constraints facing Member States, he hoped that the Health Assembly's deliberations
would not be guided simply by economic concerns but that financial rigour would be tempered by an appreciation of health care needs, particularly the need to bridge the gap between those who enjoyed the benefits of the health care system and those whose health needs were often not met. As the Health Assembly sought to devise effective strategies to fight disease and foster development, it should not abandon or diminish its commitment to health-for-all principles and should ensure that the poor and the most vulnerable groups were not neglected.

Dr BAATH (Syrian Arab Republic) said that his country gave high priority to preventive medicine and to human resources development in the areas of health care, nutrition and environmental protection. An immunization programme incorporating seven vaccines had attained 93% coverage of Syrian children in 1995. The number of clinics, hospitals and hospital beds had increased dramatically over the previous 25 years and many hospitals were using information technology. Local drug factories met 83% of the country's needs and their products were carefully monitored. Average life expectancy had increased from 53 years of age in the early 1970s to over 67 in 1995. Infant mortality had declined to 30 per 1000 live births.

In view of the importance of a reliable water supply for the health of the individual and society, it was incumbent on international organizations to work towards the equitable distribution of safe water according to appropriate international criteria.

WHO had an important role to play in narrowing the gap between the developed and developing countries through the transfer of health technology and in creating the requisite infrastructure for attainment of the goal of health for all.

He condemned the recent brutal attack on Lebanon and its people by Israel, culminating in the deliberate massacre of over 100 civilians who had sought refuge at Qana with the United Nations Interim Force in Lebanon (UNIFIL). The Syrian Arab Republic condemned all forms of terrorism, whether perpetrated by individuals or States. It supported the right of peoples to resist occupation and was committed to a just and comprehensive peace based on the principles established at the Madrid Peace Conference on the Middle East and on United Nations resolutions.

Dr MARTÍNEZ (Cuba) said that the application of adjustment measures resulting from neoliberal policies had made life much more difficult for the world's poor, especially with regard to the effects of ill health. Indeed, in many countries health systems had collapsed or had not yet even been created. The under-developed countries must make an effort to advance their own development, but the huge social debt owed to them by the developed countries could not be simply ignored. For equity, solidarity, ethics, health care development and social justice to be made effective, a real flow of international cooperation from the developed to the developing countries was required.

At present, Cuba was endeavouring to readjust its economy to a crisis resulting from the loss of its traditional economic ties and the strengthening of the blockade, in such a way as to safeguard the country's public health achievements. It would maintain the principle of a fully State-funded health system and the free provision of services for all. In the field of communicable diseases, the country was free of 12 vaccine-preventable children's diseases, poliomyelitis had been eradicated in 1962, diphtheria in 1979, and neonatal tetanus and tuberculous meningitis in 1972. Since no case of measles had been reported for the past three years, Cuba wished to be declared free of that disease too. Malaria had been eradicated in 1967, and dengue in 1981.

The country's present strategy was based on reorienting the health system towards primary health care and the family doctor and nurse. Approximately 96% of the population had access to the programme. In Cuba there was one doctor for every 194 inhabitants, and the Government continued to emphasize family medicine without neglecting hospital care and advanced technology for the people. It was grateful to WHO and to peoples, governments, organizations and individuals for their support in the present difficult times. For the past 33 years Cuba had provided technical cooperation to 61 countries and was willing to continue with that task.

Mr CHAUHAN (India) said that for a country of its size, India had progressed significantly in health matters. Indeed, one of its component states - Kerala - had achieved birth, death and infant mortality rates which compared extremely well with those of countries that had much more favourable economic indices. One of the country's most notable gains had been the immunization against poliomyelitis of 87 million
children in a single day, followed shortly afterwards by that of another 93 million. The same exercise would be repeated annually until poliomyelitis was eradicated. Furthermore, a massive AIDS control programme had been launched; a leprosy-control project had succeeded in reducing the number of leprosy patients from 4 million in 1981 to 500 000 in 1996, showing that the target of eliminating the disease by the year 2000 could be achieved; a project for conducting 21 million sight-restoring cataract operations in seven years had been approved, and a tuberculosis control project was at an advanced stage of appraisal by the World Bank. In a new malaria-control project that was being formulated consideration was given, for the first time, to the application of bio-environmental methods through the use of medicated bednets, biocides and larvivorous fish, with the full involvement of local village bodies. An important district health system project seeking to strengthen the organizational structure of the health services by integrating primary health care with first-referral hospitals was currently being implemented in four states. In addition, a major thrust was being given to the programme for the control of iodine deficiency disorders.

Since India relied heavily on its systems of traditional medicine and on homeopathy, more than 50 institutions had been financed to develop the production of medicinal herbs and to improve cultivation techniques.

WHO had rightly encouraged the adoption of a global programme to combat hepatitis B, but it must also take up the issues of vaccine availability, production possibilities, cost reduction and the organization of efficient operational systems. The Organization's move to step up consultation on the renewal of the health-for-all strategy to meet national and sub-national needs was welcome, and its documentation had been circulated in India to all state governments and key officials in the Ministry of Health and Family Welfare. The time had come when health had to be seen in conjunction with the work of other departments, agencies and organizations that unwittingly or unwittingly created unhealthy situations which subsequently became the responsibility of the health sector. Health risk assessments ought to be made an integral part of the formulation and implementation of all development projects and programmes. In that connection WHO should prepare, for adoption by the Health Assembly, a mandate which health departments in every country could insist upon.

Mr BUTALE (Botswana), speaking also on behalf of the 11 Member States of the Southern African Development Community, said that although steady improvements continued to be made in health, many problems persisted and the incidence of diseases such as HIV/AIDS and other sexually transmitted infections, malaria and tuberculosis was increasing, as was microbial resistance. Many of those problems were preventable, while some, such as tobacco-related diseases and diseases associated with environmental degradation and increasing violence, were man-made. Nevertheless, the battle against disease could still be won and development fostered if effective and successful approaches could be found that were protective of human rights, well managed, adequately resourced and founded on active community commitment.

Most of the cost of combating HIV/AIDS was being borne by governments, whose main constraints included a shortage of skilled manpower. It was therefore to be hoped that technical expertise in that area would be made available.

As family members fell sick and died, the family became poorer because of lost opportunities and increased costs. In most cases the health problems concerned affected people who were at the most productive stage of their lives; many of them had benefited from years of investment in training, and their death resulted in a disruption of production. However, with a renewed commitment to the health-for-all strategy victory was possible. The countries of the Southern African Development Community had recorded tremendous successes in the fight against vaccine-preventable diseases such as poliomyelitis, neonatal tetanus and measles and through strategies such as the safe motherhood initiative, the integrated programme on the sick child, and the Joint United Nations Programme on HIV/AIDS, as well as through the integration of information, education and communication into all relevant programmes.

It would be appreciated if special funding could be found in the regular budget to assist with various programmes in Africa that were in danger of collapsing because of lack of resources. The US$ 25 billion allocated to the Special Initiative on Africa gave no promise of new resources, and the attitude of the countries in the north and of WHO's headquarters to Africa was a cause for concern. Greater transparency and accountability were required, particularly in regard to budget allocations, contributions, and the employment of Africans from southern Africa in the Organization. Sexual inequality was a matter of
particular concern, since the number of women experts from Africa employed by WHO left much to be desired.

Mr WU Jianmin (China) said that the Chinese Government made considerable efforts to control infectious diseases by measures such as its Infectious Diseases Control Law and the vigorous prosecution of the Expanded Programme on Immunization. In a three-year campaign, 400 million children under four years of age had received supplementary vaccination against poliomyelitis, and no new cases of infection with wild polioviruses had been reported in 1995. The average coverage rate for vaccination of the newborn against hepatitis B had reached 85% in urban areas; it was hoped that the rate in rural areas would reach 60% by the year 2000. However, with a population of 1.2 billion, and about 70 million people living in poverty, China faced many problems in the development and financing of its health services. He hoped that WHO would urge the developed countries to support poorer countries in their efforts to improve health conditions.

The communicable diseases which caused concern were not only new ones such as AIDS and Ebola haemorrhagic fever, but also familiar diseases such as tuberculosis which had previously been considered to be under control. China endorsed the three priorities for international action set by WHO for the coming five years (The world health report 1996, p. 110) and would play its part in international activities to promote health throughout the world.

Dr AKTUNA (Turkey) welcomed the report's emphasis on controlling disease in order to promote development. Most countries now sought to prevent ill-health and enhance the quality of life, rather than merely to reduce mortality. Turkey had made significant progress in the control of specific diseases, and it was hoped that poliomyelitis would soon be eradicated following the success of the first national immunization day in Turkey and neighbouring countries in 1995. However, many people of all ages were still suffering and dying because they lacked access to safe water, sanitation and basic drugs. Turkey was also concerned about the rising incidence of communicable diseases such as tuberculosis, malaria, hepatitis B, diphtheria and sexually transmitted diseases.

International action had successfully reduced infant mortality rates throughout the world. It was now time to give higher priority to women's health, an area in which WHO could play a unique normative role by providing cost-effective and innovative technical tools such as the mother-baby package.

Increasing urbanization had made the campaign to create healthy cities even more important. The forthcoming Second United Nations Conference on Human Settlements (Habitat II), to be held in Istanbul, would explore all aspects of urbanization and its effects on health within the context of sustainable development.

Since the 1980s, Turkey had been working on a programme of health reforms, covering quality of care, health financing and the reorganization of the Ministry of Health. The reform programme was intended to ensure equity and quality of care and improve the efficiency of family practitioners as well as instituting universal health insurance coverage.

Dr SEIXAS (Brazil) said that, despite the advances achieved in certain areas, there was increasing inequity in health throughout the world. If health for all was to be achieved, it would require a real commitment from all countries and a thorough reassessment of the way that WHO interacted with Member States. The health-for-all strategy should become a unifying force, integrating health promotion and sector reform as the basis for healthier communities in an environmentally conscious world.

Governments had an ethical duty to work towards the control of diseases such as cholera, malaria, leprosy, tuberculosis, Chagas disease, filariasis and dengue. The Brazilian Government had recently approved a wide-ranging programme for the eradication of the disease-carrying mosquito *Aedes aegypti*, which had already been endorsed by 10 countries of the Region of the Americas.

The Brazilian Government believed that it would be possible to find the additional resources so desperately needed to promote health. It was introducing a new tax on financial transactions which would substantially increase the public funds allocated to the health sector. A similar tax on international financial transactions, coupled with reform of health systems and their financing mechanisms, would be an ethical means of promoting equity in health services, throughout the world.

The structure, role and functions of WHO itself were in need of thorough review. WHO needed a more catalytic role, which would reinforce its technical, normative and information functions and encourage
national leadership and self-reliance. Application of recent advances in computer and communication technology could replace the current practice of sending technical experts around the world, thus increasing WHO’s efficiency and helping to relieve the financial crisis.

Mrs WAZIR ALI (Pakistan) said that WHO’s celebrated successes in the fight against communicable diseases were under threat. A new global strategy was needed, which would focus on surveillance and control of infectious diseases and the development of new and effective drugs. That would require real decentralization of power and responsibility to the regional and country levels to ensure a prompt response to epidemics and more reliable data about disease patterns. Another problem which concerned her Government was the increasing worldwide marginalization of the poor, millions of whom died of diseases that were preventable and curable. WHO and other international agencies could play a pivotal role in redressing the situation.

Pakistan’s health problems were, in many respects, the problems of poverty and under-development, caused by illiteracy, malnutrition and lack of human and financial resources. The Government had now introduced a comprehensive programme to provide better health care and increased access to education, with emphasis on environmental issues and population planning. In the past two years the health budget had quadrupled, with 75% of it devoted to primary health care. The nationwide network of health facilities was being strengthened, and the basic minimum needs approach had been adopted in two provinces. A total of 32 000 village-based women health workers had been trained to deliver primary preventive and promotive health services, and their number was expected to increase to 100 000 by 1999. The number of cases of poliomyelitis had fallen to below 450 in 1995, and dracunculiasis had been eradicated. Programmes of salt iodization and the provision of other nutritional supplements were being implemented. Medical education was being adapted to a more community-based approach.

As a result of those policies, infant and maternal mortality rates had declined, and life expectancy in Pakistan had risen from 59 to 62 years. Much however, remained to be done.

Pakistan greatly valued WHO’s cooperation and support, but felt that it was time to review the Constitution and functions of the Organization and enhance its ability to respond to new challenges and responsibilities. Pakistan strongly endorsed the 30% target for women’s representation at senior levels in WHO and measures to ensure equitable geographical representation in the Organization’s staff.

Mrs WALLSTRÖM (Sweden) said that her country was a firm believer in the United Nations system, but it saw the need to strengthen and realign global health cooperation. As a newcomer to the Health Assembly, she had been surprised to see so many agenda items referring to internal WHO affairs, rather than the substantive work of the Organization. There was a strong contrast between the bleak picture painted in The world health report 1996 and the lack of action proposals on the agenda. The Secretariat had done much to reform the structure of the Organization, at the request of the Executive Board and the Health Assembly, but it had mainly addressed managerial issues; the future mission, mandate and functions of WHO remained to be defined. The fact had to be faced that at present WHO lacked a common vision to meet present and future challenges.

To take the example of reproductive health, The world health report 1996 mentioned the occurrence of some 333 million new cases of sexually transmitted diseases in 1995. However, it made no mention of other crucial factors, such as unsafe abortions, teenage pregnancies, maternal mortality and morbidity, and the quality of contraceptive services. WHO should use its traditional biomedical expertise in a productive partnership with other international players in order to overcome the obstacles raised by cultural, religious and social differences.

Sweden and other countries were conducting a study on ways of strengthening international cooperation in health. WHO must not face criticism by retreating into defensiveness. It was essential to restore its pride and enthusiasm for further improvements in health in the years to come. The responsibility for doing so rested entirely with its Member States, though strong support from the Secretariat would be needed. She besought other Member States, from North and South alike, to join in framing a reform of WHO that could be adopted by consensus in 1998, on the occasion of the Organization’s fiftieth anniversary.

Mr SNEH (Israel) said that The world health report 1996 described the emergence and re-emergence of new and old communicable diseases, whose effects were aggravated by poverty, economic and social crisis,
migration and environmental degradation. It was very difficult to decide which sectors should receive priority, even discounting the current budgetary constraints.

Despite the persistent political and security problems in his country, cooperation in the field of health between Israel and the Palestinian health authorities had continued, covering educational activities and joint committees dealing with such matters as immunization, communicable diseases, and quality control of pharmaceutical products. A joint Palestinian-Israeli medical centre was planned for the area between the Gaza Strip and Israel, to care for the Palestinian population of Gaza as well as other patients from all over the Middle East. He hoped that other Member States of WHO would support that endeavour.

On the previous day, the Ministers of Health of Cyprus, Egypt, Israel, Jordan and the Palestinian Authority had signed an agreement establishing a Middle East cancer consortium; Turkey was also to sign it soon. The parties to the agreement would collaborate on cancer research, epidemiology and treatment. The consortium, initiated by the National Cancer Institute in the United States of America as part of that country’s efforts to promote peace in the Middle East, was an outstanding example of regional cooperation in a spirit of peace and reconciliation.

Although Israel was a developed nation, its population came from highly diverse backgrounds. In 1995-1996, Israel had shared its experience with 25 States on four continents, providing training, technical assistance, establishment of medical facilities and capacity-building. His country was willing to collaborate with WHO and Member States to advance the health of people throughout the world. The leadership role of WHO in bringing people together through collaborative effort could not be overestimated.

Mr DEMBA (Mauritania) said that his country attached great importance to health and especially to the health problems resulting from the population explosion, declining rates of growth in the developing world, and lack of food and safe drinking-water. Mauritania had emphasized basic health needs, notably maternal and child care. There were immunization programmes to eradicate poliomyelitis and measles and to combat diarrhoeal diseases. Efforts had been made to provide mothers with proper health care and encourage them to space their births. Health education programmes had been incorporated in school curricula, and a charter had been adopted on the health implications of the environment and urbanization. There was a plan for the purchase of pharmaceuticals and the strengthening of their local production, as well as for ensuring coverage with essential drugs for the whole country. Mauritania tried to focus on the vulnerable sectors of the population, in cooperation with WHO, governmental and nongovernmental organizations and other partners. Nevertheless, health problems persisted and required greater efforts, notably to combat tuberculosis, malaria and diarrhoeal diseases. Greater efforts must also be made to implement national and international strategies; Mauritania’s cooperation with WHO was becoming stronger, and it was certain that the Organization would do everything possible to provide it with the resources it needed. Meeting the goal of health for all presented a difficult challenge which depended on equitable action and an international environment of peace and stability. It was important to ensure that WHO was an organization for all who suffered from diseases due to wars and conflicts so that health for all could really be achieved by the year 2000.

Mr LEE (Republic of Korea) said that, despite past and expected achievements in disease control and eradication, the picture presented by The world health report 1996 was not an optimistic one. Preventable and even curable infectious diseases were not being properly treated for reasons of poverty and were causing many deaths in the less developed countries, which found themselves in a vicious cycle where poverty led to poor disease control which in turn reduced productivity and further hampered economic development. Even in the developed countries infectious diseases such as tuberculosis, cholera and malaria, once thought to have been mastered, were again on the increase and becoming more difficult to control. The case of bovine spongiform encephalopathy, which had caused a severe trade conflict, had demonstrated how a disease could lead to world panic. Epidemiological findings on the causes of diseases and the development of medical technologies to control them did not of themselves lead to their conquest; the need for many socioeconomic improvements, including the alleviation of poverty, better education and better nutrition, had to be taken into account, and it was in that context that he wished to suggest potential reforms and directions for WHO.

WHO should, firstly, integrate its efforts in dealing with human health problems with the United Nations, its specialized agencies and related international organizations, and should enhance its leadership role
in its relations with all of them. Secondly, WHO’s ability to respond promptly to outbreaks of unexpected or new diseases should be greatly strengthened, and updated information based on epidemiological investigations should be distributed without delay to Member States through an established international surveillance network linking WHO with designated focal points in Member States. Thirdly, since infectious diseases were directly related to poverty, WHO and its Member States must make greater efforts to aid the less developed countries regardless of ideology, race and social standing.

Mr THAN NYUNT (Myanmar) said that for the eradication of poliomyelitis his Government had established national immunization days on which children under the age of 5 years were vaccinated on a community basis with the participation of national and international nongovernmental organizations. The programme would be continued until the year 2000, by which time it was expected that eradication would have been achieved. With improving security in many border areas, health facilities were being extended so that previously deprived segments of the population would enjoy standards of health care similar to those obtaining elsewhere in Myanmar. A community cost-sharing system for health care expenditure would provide the community with readily available and effective essential drugs at an affordable cost; the community involvement in that mechanism would reduce the burden on the State and increase community self-determination and self-reliance. The backbone of primary health care in Myanmar was midwifery, and in that area there were many training opportunities. Three medical schools had been upgraded to institutes, and a fourth establishment, responsible for training basic health workers, would be similarly upgraded in the near future. Communicable diseases were still a major problem in his country: malaria was the prime cause of both morbidity and mortality, and basic health workers were trained in microscopy to assist in its early diagnosis. Pulmonary tuberculosis, another leading cause of mortality, was posing the greatest threat to the community since the emergence of HIV/AIDS infection. In the fight against HIV/AIDS emphasis was placed on public education, control of drug abuse, rehabilitation centres for drug addicts and the control of sexually transmitted diseases. Condoms had been distributed to high-risk groups, which had also been given counselling. Health workers and both national and international nongovernmental organizations were actively involved in HIV/AIDS prevention in a multisectoral effort.

Professor TSAREGORODTSEV (Russian Federation) said that The world health report 1996 rightly emphasized the fight against diseases, especially infectious and parasitic diseases. Serious problems were being caused for many countries by diseases such as tuberculosis and malaria which had seemingly been conquered but were now re-emerging and affecting wide sectors of the population. There was the separate problem of newly emerging infectious diseases such as HIV/AIDS, Ebola haemorrhagic fever and diseases caused by hantaviruses. Socioeconomic factors were slowing progress against such diseases; it was therefore important to strengthen WHO’s coordinating role so that the entire world could be involved in the work. The Organization had done an enormous amount to coordinate efforts to solve global problems and to provide technical assistance to Member States. The Russian Federation was particularly grateful for WHO’s participation in its efforts to combat diphtheria, poliomyelitis and tuberculosis. He also emphasized the importance of WHO’s work in controlling diarrhoeal diseases, respiratory diseases and viral infections in infants and young children. It had done much to promote health education among adolescents and health care among the working population, the elderly and women. Its cooperation with UNDP, the World Bank and UNICEF on environmental matters was greatly appreciated, notably in developing ways of involving people in overcoming problems relating to the supply of safe drinking-water and sanitation, the extension of the Healthy Cities Network and the plan to promote health and health education. The organization and management of health care, health reforms and the legislative framework should remain within the purview of WHO, and standardization should continue to be given priority attention.

Health care reform in the Russian Federation was being undertaken on the basis of specific legislation, decrees and government decisions, and was focused on the demarcation of competence between federal, territorial and local levels; decentralization of management and the transfer of the management, financing, procurement and training functions to the territorial level; and identification of mechanisms for financing health services from federal, territorial and local budgetary sources, federal and territorial compulsory insurance funds, enterprise and company resources, charitable and social funds, private institutions and the personal resources of citizens themselves. The reforms brought together State, municipal, social, charitable and private health care institutions into a single health service system, providing free access to primary health
care, emergency medical care and specialized hospital treatment within a framework of compulsory medical insurance, and a basic prevention and treatment programme. The achievement of a high-quality medical service was an inalienable principle for the Russian Federation, which defined its priorities by reference to WHO’s strategy for achieving health for all. Undergraduate and postgraduate training for professional medical staff was being improved, and much was being done to support medical science, research and training, and to ensure that generally accepted ethical standards for medical service were observed.

In spite of its difficult economic situation, the Russian Federation was continuing to pay off its arrears of assessed contributions to WHO, and during the current year had transferred US$ 10 million to the Organization; by the end of the year it planned to transfer a similar sum.

Dr Sandoval Morón (Bolivia) said that a country such as his, with a 75% poverty rate, was a fertile breeding ground for infectious diseases, particularly tuberculosis, malaria and Chagas disease. Rapid urbanization forced millions of people to live in overcrowded and unhygienic conditions.

In view of the heavy toll of human life taken by infectious diseases and the emergence of 29 new diseases in the last 20 years, his delegation viewed with concern the evident lack of political will and resources, both nationally and internationally, to establish and maintain systems for the detection and containment of such diseases. WHO and its regional offices must therefore take resolute action in the areas of prevention, information and promotion of new technologies for disease control and must alert governments and international organizations to the importance of economic development and higher living standards for the eradication of infectious diseases.

While recognizing the vital importance of international cooperation and input of economic resources and technology, Bolivia had opted for a decentralized approach to the analysis and solution of health problems, with community participation and shared responsibilities, especially in combating malaria, Chagas disease and tuberculosis.

Dr Marandi (Islamic Republic of Iran) said that with the emergence of such diseases as AIDS and Ebola haemorrhagic fever and the re-emergence of others such as tuberculosis, disease control demanded the cooperation of all countries in a global mission. Comprehensive disease surveillance systems should be established and expanded through national, regional and global networks, disseminating data and information; the present International Health Regulations should also be revised. An important approach to enhancing disease control and surveillance was community-oriented medicine; medical students should be trained not only in hospitals but throughout the health care system and in the community. In his country medical education and the health care system had been integrated for the past 10 years, and medical education was the responsibility of the Ministry of Health; his country was prepared to share its extensive experience in that regard with others. It was also expected of the World Health Organization that it should encourage and facilitate collaboration in applied research as a vital instrument for effective disease surveillance and control. WHO should benefit from the support of all Member States, in particular the developed countries, which should take on more responsibilities for the provision of its financial needs. All WHO Member States should ensure that the Organization remained a technical and specialized entity. Social equity, including equity between the sexes, should always be at the forefront in all decisions and in the implementation of health-related programmes. Many countries were rapidly privatizing their health sectors, and that phenomenon could be more beneficial when it was in line with the development of national health insurance schemes and social security systems aimed at achieving and securing social equity.

Mr Moreno Rojas (Colombia) said that his country in reforming its social security system, was endeavouring to consolidate a new model based on health promotion and disease prevention. It was also undergoing a process of social transformations, many of which conditioned the health situation. For example, the proportion of males in the population had been declining since 1985 as a result of the violent deaths of adolescents and young men. Since 1950 rapid urbanization had taken place. The population growth rate was falling, despite the increase in life expectancy, which was 69.2 years. The population over 65 years of age would increase to 12.8% of the total by 2025, from 5.6% in 1980, resulting in a higher incidence of chronic noncommunicable diseases and injuries. Violent death was the foremost cause of mortality in the country, with a murder rate of 80 per 100 000 inhabitants. There was an increase in chronic and degenerative diseases, and in communicable diseases such as tuberculosis, leprosy and leishmaniasis, while malaria was
still a health problem. In addition, diseases such as Venezuelan equine encephalitis, cholera, dengue and yellow fever had reappeared, and new diseases, including some associated with HIV, had emerged. The increasing difficulties experienced in the control of communicable diseases, especially tuberculosis, were necessitating multilateral plans with specific goals and effective assistance for those lacking sufficient means.

The control of communicable diseases required a strong political commitment, but Colombians could testify that it could be done. In the past 30 years infant mortality had been reduced from 100 to 24 per 1000 live births; poliomyelitis had recently been eradicated and in a few years' time it would be possible to say the same of measles, leprosy, neonatal tetanus and onchocerciasis.

Technology was a major factor in the campaign against communicable diseases. The world required treatments and vaccines of low cost and broad application. Research must therefore be supported and diversified, especially in areas where it was still inadequate. Malaria and tuberculosis were obvious examples of diseases against which, owing to the development of resistance, existing drugs were ceasing to be effective and new ones were not yet available.

The high cost of drugs was becoming an insurmountable obstacle for many people. Governments should therefore try to ensure that drugs were made available to all and to prevent their misuse. Information campaigns targeted on women in poor countries would be very effective and would cost only a small percentage of the sums spent on defence. If health and environmental conditions were improved, if malnutrition and poverty were reduced and if new technological and scientific knowledge was developed, accompanied by judicious epidemiological surveillance, the road to well-being, development and a better level of health for everyone would be open.

Mr HERNES (Norway) said that the frustrations of modern medicine, and of the World Health Organization as well, were generated by the increasing divergence between what was within reach and what could actually be grasped. The possibilities of medicine had never been greater, yet The world health report 1996 made it clear that the state of the world's health was a cause for grave concern. There was an increasing mismatch even in the richest countries between rapidly advancing medical knowledge and what health systems could afford. There were growing demands for access, efficiency and quality, but the capacity to deliver was undermined by unemployment, uncertainty and dire financial straits. Despite what was known about the links between disease, poverty, lifestyles and the environment, health care systems remained tailored to dealing with medical specialities and not intersectoral complexities. Never before had there been such a divergence between ambitions and accomplishments.

Adding to that frustration was the mismatch between the importance of WHO's mission and the feebleness of its actions. Norway had frequently expressed its concern about the lack of direction of WHO in recent years, and was now repeating with even stronger urgency its call for clearer leadership, a more explicit strategy and a keener sense of mission. The Organization could not afford to lose time and waste resources on vague goals and nebulous priorities. Instead of responding in fundamental ways to those problems, the WHO reform process had been issue-oriented and piecemeal. It had been fragmented rather than focused. It had serious problems in establishing real priorities, and did not have good enough mechanisms to link regular and extrabudgetary funds in strategic discussions and operational planning. Progress was still slow and fumbling on those critical issues.

Only by sharpening the focus of WHO's mission could measures to reform the Organization from within be tested according to whether they contributed to results where results mattered. The time had come for clear guidance on priority functions, and for WHO to make explicit the normative tasks that lay at the core of its mission. The Organization could not do everything everywhere. The task called for intellectual leadership, for authority that was based on medical knowledge fused with conceptual skills and humane commitment. The independent study that was being conducted of WHO programmes at country level should contribute constructively to the debate on the Organization's decentralized functions and partnerships with other agencies. Unless duplication and waste between agencies at national and international levels were reduced, global health would not be improved. Unless WHO became more efficient in its own operations, specialized in key functions and utilized its network more strategically, it would not serve as the instrument that was now needed. That called for organizational leadership which generated loyalty based on skills in coping with diverse needs without losing focus and credibility among the many actors jointly facing rapid change. WHO could not expect its budget to grow while social budgets in the Member States themselves were cut. The best way of generating support for further allocations - even increased allocations - was for
the intellectual and organizational leadership to be matched by creative economic leadership that convinced Member States that they could not make any better use of the funds allocated than to spend them at WHO.

There were hopeful signs and new opportunities in world health. The eradication of smallpox was a classic example, and another was the poliomyelitis eradication campaign. During the first quarter of 1996 Europe had been free from poliomyelitis for the first time in its history, and similar efforts in Asia and Africa were promising: that showed WHO at its best.

The officers of an organization were there to promote its goals; an organization was not there to promote the ambitions of its officers. If Norway was impatient, that was because it did not see in the documents presented to the Health Assembly the kind of creative thinking that alleviated frustrations, took up opportunities, and kindled hopes. It was a time for accomplishment, not for complacency; for initiative, not for inaction; for leadership, not for laggardness. It was the common challenge and obligation to the many millions who had put their faith and hopes in WHO.

Professor SHBOKSHI (Saudi Arabia) said that international cooperation to control communicable diseases should focus on the following activities: dissemination of up-to-date information on the epidemiology of emerging diseases; improvement of the capacity to respond to medical emergencies and epidemics; enhancement of awareness to promote healthier lifestyles; technical cooperation and pooling of experience among all States.

Primary health care services in Saudi Arabia were available to 98% of the population. There were special projects on noncommunicable diseases, mother and child care, and psychological and social health. A child immunization programme covering nine diseases, including hepatitis B, had led to a sharp decline in the morbidity rate.

During the Pilgrimage which brought over 2 million pilgrims to Saudi Arabia every year, the Kingdom had shown its ability to respond effectively to various kinds of health emergencies.

He proposed that the Organization should play a prominent role in developing a comprehensive strategy for the control of re-emerging communicable diseases on the lines of the anti-tobacco, HIV/AIDS and environmental health strategies. It should continue to develop the International Health Regulations and promote cooperation among Member States in the dissemination of epidemiological and other information and in lowering the costs of health services while preserving their quality. It should provide more effective support to Member States for the training of national health professionals and should give high priority to occupational health and prevention of accidents in the workplace.

Mr COLLA (Belgium) said that vulnerability to disease was heightened by social and urban exclusion and the associated phenomena of poverty, unemployment and homelessness. He therefore welcomed the Organization's more realistic approach to its tasks in the years ahead, as reflected for instance in the updating of the International Health Regulations.

WHO should maintain its principal role as the reference point for advice, expertise and recommendations in public health - for example, establishing international standards for foodstuffs and biological and pharmaceutical products.

Most of the Organization's human and financial resources should continue to be directed to the assistance of the poorest countries, focusing on the reorganization of basic health structures. WHO should convince its partners in other sectors and institutions that health was a prerequisite for sustainable development and that the health dimension should be integrated into all planning and decision-making. In that connection, he praised the Organization's chemical safety and health legislation programmes.

Comprehensive health data were an essential tool for the formulation of health policies and the history of AIDS had shown the importance of a sound epidemiological surveillance system for health planning. In Belgium, a network of physicians collected basic data for surveillance of communicable diseases with the voluntary collaboration of private laboratories. His country was more than willing to share its experience in tropical diseases with the international community. In that connection, an international conference on the Ebola virus would be held in Antwerp, Belgium, in September 1996.

WHO should be more active in promoting the delegation of responsibility to grassroots communities in the area of health.
Health policy should be geared to new urban environments, particularly in terms of action against pollution, noise and other nuisances. He advocated an in-depth evaluation of experience gained from the Healthy Cities network.

Priority should be given to the containment of violence and of trafficking in human beings, particularly women and children.

Dr WILLIAMS (Cook Islands), also speaking on behalf of Fiji, Kiribati, Federated States of Micronesia, Nauru, Palau, Papua New Guinea, Samoa, Tonga, Tuvalu and Vanuatu, said that the signing by France and the United States of America of the treaty of Rarotonga banning nuclear testing in the Pacific had been welcomed by the governments and peoples of the region. The small island nations of the Pacific commended the President of France for taking the initiative and the High Commissioner of French Polynesia for his assistance.

In his part of the world, communicable diseases were no longer the leading causes of death. Improved overall socioeconomic status and changing lifestyles had led to increased prevalence of such noncommunicable diseases as diabetes, hypertension, coronary heart disease and cancer. Control and eradication efforts had focused on case-detection and case-holding and on surveillance. Health education programmes were aimed at all sectors of the community and in particular at high-risk populations.

Stressing the pivotal role that immunization programmes played in the prevention and eradication of infectious diseases, he expressed concern at the suggestion that organizations should redirect their immunization funding and leave governments to meet the cost. He supported the continued provision of free vaccines.

He welcomed the Director-General’s call for a strategy to improve surveillance systems, strengthen laboratory services and respond rapidly to public health problems. Laboratory services in the island nations were inadequate and more sophisticated technologies were needed.

He suggested that the WHONET information system should be expanded to make all information relating to WHO activities available to the small island nations of the Pacific. Diseases such as poliomyelitis, leprosy and tuberculosis had almost been eradicated in some of those nations but newly emerging diseases such as HIV/AIDS and dengue fever would undoubtedly cause havoc.

If scientists’ predictions were to be believed, the fate of many Pacific islands would be determined not by disease but by global warming, for they were doomed to disappear beneath the ocean. He asked the Health Assembly, the United Nations and its agencies, and the global scientific community, what was being done to avert such a disaster.

The meeting rose at 12:50.
SECOND MEETING
Tuesday, 21 May 1996, at 14:30

Chairman: Professor B. SANGSTER (Netherlands)

REVIEW OF THE WORLD HEALTH REPORT 1996: Item 10 of the Agenda (The world health report 1996; Document A49/3) (continued)

Dr MUBARAK (Iraq) said that despite the existence of national health plans in his country and constant efforts to enhance awareness of the importance of health, especially through the prevention of childhood diseases, care for newborn children and administration of oral rehydration salts for diarrhoeal diseases, implementation of those plans had been made impossible by the continuing boycott of Iraq over the past five years. The result had been a general deterioration in child health, a dramatic increase in child mortality, and the increasing spread of communicable diseases, such as cholera, poliomyelitis, malaria, typhoid and hepatitis. Lack of sufficient medication had also led to increases in cardiovascular diseases, hypertension, diabetes, cancer, thyroid disorders, and night blindness in children owing to vitamin A deficiency. Despite the efforts made by Member countries of the Eastern Mediterranean Region, the boycott had continued without justification. Iraq had made every effort to cooperate with humanitarian organizations and had just signed a Memorandum of Understanding with the United Nations on the basis of "oil for food". He hoped that the resolutions of the Health Assembly would have a positive influence in achieving a radical solution to the problem.

Dr VOLJČ (Slovenia) stressing the close links between disease and individual and social behavioural patterns, said that the development of a society and its political, demographic and sociological characteristics determined the prevalence of the most frequent diseases and their phenomenology. Despite worldwide debates about peace, human rights and responsibility, the gap between rich and poor was widening and feelings of responsibility were decreasing. In affluent societies, violence, homicide and dependency diseases were increasing alongside an attitude of indifference to poverty and disease elsewhere. The spread and dynamics of various diseases were influenced by all those factors.

In the fight against disease, the greatest social progress was represented by the protection of young lives, since only the productive work of the young could ensure the continuing development of a country. Yet, in the Third World, millions of children and young people died, while in developed regions the lives of the sick and the elderly were being prolonged at high cost. Much more could be done, without major expense, to overcome those disparities. With its growing financial difficulties, WHO's role would be increasingly to appeal to the conscience of mankind rather than effectively alleviating the burden of disease; it was important to heighten awareness in individual countries, at government level, of the essential importance of health care for social development.

Slovenia strongly supported the activities of the WHO Regional Office for Europe, which had to deal not only with the current health problems but also with questions of political transition. The epidemiological and social situation in Europe had led to a further spread of both communicable and noncommunicable diseases. With a view to promoting solidarity in the Region, it had been decided to organize in Lubljana in June 1996 a ministerial conference on health care systems which were either in transition or in the process of establishment. The situation also demanded reform and consolidation in the Regional Office.

Mr HAMADE (Lebanon) said that not only was there a marked contrast between developed and developing countries, but some political authorities gave less priority to health than, for example, to military matters: it was essential to mobilize all forces in order to fight disease. The world health report 1996 listed among the obstacles to the achievement of health for all such factors as financial crises and migration.
movements, both of which Lebanon had witnessed only too often in recent years. Despite its successful efforts to combat leprosy and poliomyelitis, his country had experienced a severe setback as a result of Israeli aggression which had culminated in the massacre of Cana. An immunization programme had been partially carried out with the help of WHO, UNICEF and the World Bank, but further regional and international assistance was essential. In that context he referred to resolution WHA48.2 and thanked all countries which had provided recent assistance. All Member countries must exert their collective responsibility in order to improve the financial situation of WHO and to resist centralization at the expense of the regional offices.

Mr AL-KHAYAREEN (Qatar) said that although Qatar was small, its health services had always maintained a high level of care, which had improved in recent years. Health centres, now 23 in number and distributed equally throughout the country, were the cornerstone of the health services, along with specialized and general hospitals. All types of cancer could now be treated, and emphasis was given to early detection. Other services included the provision of safe local blood supplies; country-wide supply of high-quality drugs through an efficient system of distribution, pricing and control; and a high immunization coverage, all elementary schoolchildren being currently required to have a certificate of immunization against the six childhood diseases. Together, those activities had stemmed or halted the spread of communicable diseases: mortality rates had fallen sharply and there had been a marked increase in life expectancy. Medication and medical care were free of charge in Qatar and a high level of qualification prevailed among medical personnel.

Professor REINER (Croatia) observed that The world health report 1996 reflected the major efforts which had been made to improve the health situation throughout the world but also pinpointed the new, emerging and re-emerging diseases, which called for a more efficient, flexible and future-oriented WHO, backed by appropriate policies within each of its Member countries. It was important that national health policies should be accompanied by a corresponding implementation document, such as the Croatian Master Plan on country health development, which was integrated with a policy document on health for all by the year 2005. Health systems, not only globally but in each country, should also undergo continuous reforms in order to adapt to the drastic changes in the health situation. However, care should be taken to avoid any negative effects of such reforms on the health of the population and to ensure stable financing of the health system through rationalized legislation and increased efficiency of the health services. Ethical considerations, such as universality of access to equitable health care, should be of overriding importance.

Professor GUIDOUM (Algeria) said that the main lines of Algeria’s health policies coincided with those set out in The world health report 1996. Despite wide immunization coverage, his country had not been spared the re-emergence of communicable diseases, which still included diphtheria and measles. Water-borne diseases caused by failure to comply with elementary town-planning regulations were still prevalent, with economically disastrous consequences. Anthropozoonoses, tuberculosis and malaria, despite previous marked regression, still presented a threat on account of migratory flows from neighbouring countries, and HIV/AIDS remained a potential danger. Other disorders to be faced included diabetes, asthma, cardiovascular diseases and mental disorders. In tackling those problems, Algeria supported WHO’s approach set out in Chapter 3 of the report, entitled "Charting the future". The Expanded Programme on Immunization had been adapted to include a mandatory first dose of antipoliomyelitis vaccine for newborn infants, an antimeasles booster for children before entry into school, and revaccination against diphtheria and tetanus every 10 years after the age of 18. A specific vaccination and revaccination programme for the population in the south of the country was under way, and the campaign to eradicate poliomyelitis was continuing. Emphasis had also been placed on programmes for care of sick children, nutrition and school health and for control of water-borne diseases, and on the consolidation of epidemiological surveillance to combat resistance to drugs, lack of vector control and emergence of new diseases.

Interest in the intersectoral approach, which had been tested in connection with World Health Day activities and programmes concerning water-borne diseases, zoonoses, drug dependence and HIV/AIDS, was increasing but could be effectively sustained only through health regionalization, which was also the only way of making optimum use of available resources and treating specific health problems pertaining to a country or a region.
It was unacceptable that factors which were the direct or indirect cause of disease were being created by the international constraints imposed upon certain countries. The right to health must be included among the fundamental human rights. His comments referred specifically to the disastrous health situations in Iraq, Palestine and the Libyan Arab Jamahiriya.

In conclusion, he expressed support for the reinforcement of the health policy of the Maghreb and the sustained cooperation which existed within that African subregion.

Mr KOTSONIS (Greece) said that it was clear that health promotion and disease control could not be achieved by primary health care and preventive measures alone. While some recent political, economic and social changes had aroused expectations of a better world, WHO’s role as a directing and coordinating agency in the field of health remained as valid as ever and attainment of the target of health for all was still far off. Many major public health problems contributing to high morbidity and mortality were caused by growing industrialization and the emergence of large urban centres, in both the developed and the developing world.

Emphasis should be given to the fight against noncommunicable as well as communicable diseases, since they all endangered development. Ways must be found to deal efficiently with, for example, alcohol-related diseases and drug abuse problems. Intersectoral collaboration must include high levels of community participation. Training in the management skills needed for achieving the goals of health for all should continue to be one of the Organization’s main objectives.

In Greece, prevention was given great prominence in regard to all diseases, with emphasis on surveillance, immunization, early detection and the promotion of healthy lifestyles. A plan to make health care available to all citizens was to be submitted for parliamentary approval. Improvement of classic indicators of health standards had been a constant concern in recent years.

The Greek Government would continue its support for WHO’s efforts to promote health throughout the world by sharing its technical know-how and experience; socioeconomic development was a sine qua non for the attainment of health for all.

Professor SUJUDI (Indonesia) said that, despite some success in disease eradication or control, the threat posed by a number of emerging and re-emerging communicable diseases must be countered by constant vigilance, particularly as the situation in many developing countries was exacerbated by malnutrition. Although the scarce resources of many developing countries were greatly depleted and the health-for-all target would not be attained in those countries, or in others which had suffered political turmoil, he was happy to note the progress made since the renewal of strategies based on the primary health care approach. He advocated concerted efforts, including the stepping up of technical cooperation among developing countries and adherence to the proposed UNDP 20:20 formula in that endeavour.

Along with a number of other efforts at improving health, Indonesia was striving to reduce its unduly high maternal mortality rate. The country was also fully committed to health and education development, in view of their role in enhancing the quality of human resources and alleviating poverty.

Dr VITKOVA (Bulgaria) said that in 1995 her country had formulated a national health strategy, now to be implemented with technical assistance from the Regional Office for Europe. It was restoring cooperation in the health field with the countries of central and eastern Europe, suspended in recent years, with a view to improving health systems. Nationally, reforms had been made in the legislative and regulatory basis of the health system, notably on questions pertaining to medicinal drugs, preventive medicine and environmental and occupational health. Action had been taken through an immunization campaign to control hepatitis B, and Bulgaria had participated in the joint project for the eradication of poliomyelitis as well as in a tripartite preventive medicine project with WHO and the United Kingdom health service. National centres for public health were also being created, a national committee on HIV/AIDS had been established and new legislation had been enacted on primary health care, guaranteeing the right of patients to choose their physician and establishing criteria for assessing the work of physicians, in connection with a new system for remuneration of physicians which paved the way for the introduction of a health insurance system.

In a rapidly changing world, WHO had an important role to play in the global process of health system reforms, in the spirit of the health-for-all strategy. She trusted that the difficulties being experienced by the Organization were only financial in nature and expressed her concern at the reports she had heard regarding merging of the Regional Office for Europe with WHO headquarters.
Mr. VOIGTLÄNDER (Germany) said that for many years the health strategy of the German Federal Government in relation to multilateral and bilateral cooperation with developing countries had been based on the interdependence of health and development; it had sponsored several WHO programmes for many years, as well as engaging in bilateral action. The world health report 1996 indicated the misery infectious diseases continued to cause in the world, and he advocated the establishment of a modern epidemiological information network and early warning systems for certain diseases. WHO had an important part to play in providing cooperation and timely advice in national decision-making, particularly during emergencies.

Recent major geopolitical and socioeconomic changes had adversely affected health care systems in many States; Germany was assisting central and eastern European countries to overcome their difficulties concerning the reform of health care systems and the introduction of general health insurance. The Regional Office for Europe also offered such assistance, a very important reason for its existence, in the need for which he continued to believe. In conclusion, he proposed that future world health reports should lay more stress on the many noncommunicable diseases which were of considerable importance, particularly in the industrialized countries.

Professor SALLAM (Egypt), after stressing the increasing importance of WHO’s role, given that everyone was entitled to health protection as a basic human right, said that the developing world suffered many health problems, which jeopardized development in other fields. Furthermore, poverty and the widening gap between the poor and the rich had led to a decline in health standards in developing countries.

Two main areas needed attention: prevention and the equitable provision of health care. The necessary knowledge and means for reducing mortality from communicable diseases existed and should be used; greater efforts were needed to overcome the obstacles depriving the people of the developing countries of one of their basic rights. Egypt subscribed to the civilizing dimension of preventive medicine and effective care. In particular, it wished to see protection given to the family, the fundamental unit of society, and was ready to cooperate with the international community in that area.

Mr. ROMAY (Spain) observed that one of the chief functions of the Organization was to encourage general awareness of the importance of health, perhaps the chief instrument of national social development. While there had been a general improvement in global health indicators, there was still great disparity in health and access to health care, reflecting economic inequalities. Furthermore, the recent appearance of new threats to health, along with medical problems caused by serious political disturbances, emphasized the need for increased vigilance in emergency situations. In that connection, he supported the establishment of the new WHO Division of Emergency and Humanitarian Action. Spain had contributed US$ 510,000 the previous year towards the reconstruction of a hospital in Rwanda, in addition to its traditional contribution made to cooperation programmes with Latin America.

He expressed concern at the negative effects on health caused by the deterioration of the environment. Prosperity without equity did not result in general well-being. Since health was an essential element in the quality of life, health problems must be tackled jointly through a new collaborative effort based on international solidarity and commitment to creating a world that subsequent generations would be proud to inherit. Spain, for its part, faced that challenge by assuming fully its international commitments.

In conclusion, he stressed that Spanish was an official language of the Organization and trusted that its status would be fully respected.

Mr. CHRISTOPHIDES (Cyprus) said that for almost two decades countries had struggled to attain the ambitious target of health for all, established at Alma-Ata in 1978. If every country had to face the challenge alone, there would clearly be progress in developed countries and setbacks in the developing world. However, there had been some successes and WHO had been able to mobilize resources and develop programmes specific to the needs of individual countries. Evidence indicated that levels of health had improved in all countries. However, Africa and southern Asia were not keeping pace with the rest of the world and 40 countries in those regions would still have infant mortality rates of over 100 per 1000 at the end of the century unless further measures were taken. Perhaps efforts should be concentrated on the provision of a universal health care system for children under five years old, with particular stress on the attainment of targets relating to immunization and vitamin A provision.
The fortunate had a duty to assist the countries which could not achieve those targets by the year 2000. The challenge of providing hope, opportunities, commitment, partnerships and action involved all Member States. In particular, it was important to provide children with a "window of hope" and he proposed that a programme should be established bearing the name of the goat-nymph who, in Greek mythology, nurtured Zeus as a child: "Amaltheia’s programme - health for all children of our planet".

Mr ABDULLAH (Maldives) noted that the health situation in many countries was deteriorating owing to lack of resources and to deficiencies in the planning and operation of key public health services. Environmental degradation, mass poverty, migration, overpopulation and social disintegration had seriously undermined global health development, while AIDS, drug-resistant malaria, the re-emergence of tuberculosis and recent outbreaks of Ebola haemorrhagic fever and plague had brought humanity to the brink of disaster. WHO had been successful in eradicating smallpox and would soon eradicate poliomyelitis, but the health situation remained alarming. He therefore strongly supported the reform process which would strengthen the capacity of the Organization to tackle widening health disparities throughout the world. In that regard, mobilizing resources, pooling expertise and building strong monitoring and surveillance mechanisms were indispensable. A safe environment was also essential for good health.

Maldives attached the highest importance to health and a substantial portion of the national health budget provided for improved health services, with emphasis on primary health care. Privatization, community participation and decentralization were central to health policy. Malaria and poliomyelitis had been eradicated and life expectancy had increased. Women’s development and empowerment were seen to be a major component in solving health problems. A healthy lifestyle and individual responsibility were being promoted.

Technological advances allowed the rapid transmission of information, but they did not eliminate the need for people. WHO should therefore give priority to human resource development.

Dr BARTOS (Romania) said that The world health report 1996 indicated the concerted approach needed to respond to current health problems and highlighted the contribution made by WHO.

Romania was experiencing profound social and economic change and its health system was being restructured; some aspects of the report were of particular relevance to that reform process. WHO, through both headquarters and the Regional Office for Europe, had provided support to Romania in confronting ongoing health problems and in dealing with new and emerging diseases. Assistance had been given in consolidating the immunization programme and in establishing programmes to combat sexually transmitted diseases, tuberculosis and AIDS.

WHO played a highly important role in strengthening national systems and in facilitating international collaboration on health issues. The subtitle of the report, "Fighting disease, fostering development", underlined the social relevance of WHO’s activities and the direct contribution made to enhancing quality of life. Romania would lend its full support to the priorities for future international action set out in the report. It was hoped that participation in European health programmes would accelerate the country’s integration in modern European structures.

Dr COSTA-BAUER (Peru) considered that The world health report 1996 constituted an appeal for action and must be given immediate and priority attention. Complacency following some substantial but unsustained successes in combating disease had had serious consequences for public health. Statistics gathered in relation to infectious diseases were essential in deciding future health activities, both for redefining priorities and for allocating the necessary resources.

Important results obtained in Peru included the eradication of the wild poliomyelitis virus. It was hoped to eliminate measles by 1998. Cholera had been brought almost completely under control and significant advances had been made in the fight against tuberculosis and tetanus. Malaria and yellow fever were being tackled, while AIDS remained a future challenge. The health of infants, children, adolescents and pregnant women was given priority in Peru’s health policy for the period 1995-2000 and infant immunization coverage was currently 90%. Although the advances made in Peru were a sign of hope for the international community, past experience had shown the need to remain vigilant and prevent the recurrence of transmission. However, a disproportionate reaction to disease risks could produce panic in commodity and tourist markets:
in 1991, reports concerning a cholera epidemic had caused Peru losses of US$ 1 billion. International cooperation to offset such reactions was a priority.

Countries should respond in a coordinated and integrated manner to the challenge of new and re-emerging diseases in accordance with the priorities outlined in the report, and governments should understand that improvement of the environment and dissemination of healthy lifestyles required multisectoral coordination.

Mr FOWZIE (Sri Lanka) said that the theme of The world health report 1996, "Fighting disease, fostering development" was appropriate and timely.

The two-way approach based on the categorization of diseases and three levels of priority suggested in the report provided a pragmatic framework for a plan of action for fighting disease. However, that fight required the removal of many obstacles external to the health sector. There was an imperative need not only for more concerted actions on the part of Member countries, but also for more effective international collaboration focusing on poverty alleviation and the empowerment of people through education and awareness-building.

Sri Lanka had embarked on a programme of health development with emphasis on prevention and promotion and the provision of better services to the underprivileged. The budgetary allocation for health had been maintained at 5% of total government expenditure. The provision of universally accessible free health services, together with other social welfare measures, had enabled people to enjoy a health status that compared favourably with that of other developing and some developed countries. Sri Lanka, with support from WHO and other organizations, continued to combat communicable diseases with success. Since the adoption of the global strategy for the control of malaria in 1993 incidence of the disease had declined substantially. HIV/AIDS prevalence remained relatively low and it was hoped that a concerted effort would contain the epidemic. Incidence of the six vaccine-preventable diseases had declined and the elimination of neonatal tetanus had been achieved in 1995. Measles mortality had been reduced dramatically. National immunization days had been conducted in 1995 with the objective of eradicating poliomyelitis by the year 2000, and rubella immunization had been introduced in 1996.

Speaking as Chairman of the conference of health ministers of the South-East Asia Region, he underlined the coherent manner in which countries within that Region worked and requested that, should WHO reconsider its regional structure, the South-East Asia Region should remain intact. Strong advocacy for health at both national and international level was essential to mobilize a global response to the challenge of fighting disease and fostering development. Sri Lanka would play its part in such endeavours.

Mr PHILLIPS (Jamaica), speaking on behalf of Barbados, Jamaica, Saint Lucia and Saint Kitts and Nevis, said that The world health report 1996 highlighted the dilemma of countries such as those he was speaking for in providing adequate health services in the face of new challenges, such as lifestyle diseases resulting from abuse of drugs, including tobacco, accidents, violence and HIV/AIDS, while communicable diseases such as dengue fever, typhoid fever and diarrhoeal diseases persisted and had been exacerbated by environmental degradation, particularly as a result of unplanned and rapid urbanization. Diseases such as cholera, tuberculosis and drug-resistant gonorrhoea were also re-emerging. International travel and trade and rapid advances in communication technology made those problems truly global and of concern to all. Those growing challenges were being confronted at a time when global economic crises and the structural adjustment policies resulting from them had contributed to the devastation of social programmes, including those of the health sector, and reduced the capacity of traditional public preventive health infrastructures for disease surveillance, prevention and control.

In charting the future, Member States were being challenged to reform health systems and to ensure that investment priorities were set more carefully, that cost-effective technologies and programmes were developed, and that finite resources were used as efficiently as possible. Such action would require the maintenance of adequate research, surveillance, and response capabilities. In that regard, vulnerable island countries that were subject to hurricane, volcano and earthquake disasters would urge that an effective disaster response capability within WHO should be maintained. In addition, national public health infrastructures would need to be strengthened by allocating additional human and financial resources, restructuring institutions, reorienting health providers and, most importantly, recruiting new partners, particularly in the
community, whose involvement was essential for the achievement of long-term lifestyle and behavioural changes.

Dr ALAMI (Morocco) said the health policy initiated in his country in the 1980s was now close to achieving its objectives. Thanks to the joint efforts of the Ministry of Health, local communities, and Morocco’s international partners, there had been clear signs of improvement in the health of the population in recent years, despite difficult socioeconomic conditions, further exacerbated by recurrent droughts. By 1992, life expectancy had risen to 66.5 years, and by 1995 infant mortality had fallen to 61 per 1000. In 1995, immunization coverage had been 85%; no case of poliomyelitis had been reported since 1991, and none of diphtheria since 1992. The launching of the Vaccine Independence Initiative in 1993 was proof of Morocco’s commitment to eradicating those diseases. Control of diarrhoeal diseases, acute respiratory infections, and iodine deficiency disorders had also advanced. Further, there had been a decline in fertility and a marked increase in contraceptive use.

Unfortunately, the targets for maternal and neonatal mortality had not been attained, and demographic changes, urbanization, stress, and new behaviour patterns had combined to increase non-communicable diseases. To combat that trend, a law had now been passed banning smoking in public places and a national social development strategy had been launched which aimed to give disadvantaged groups better access to primary health care, drinking-water supplies and sanitation, education and housing. Over the next five years, Morocco’s priorities in the field of health would be in line with those of WHO’s Ninth General Programme of Work.

He thanked WHO and other organizations for their help in improving the health of the people of Morocco and of peoples worldwide. Lastly, he urged that the Regions should play a greater role in framing, implementing and evaluating health strategies.

Dr KHAN (Bangladesh) observed that The world health report 1996 provided a pointed reminder of the links between health and development. In tackling the world’s health problems, the first factor that had to be taken into account was poverty, since it was the poor who bore the brunt of the effects of ill-health. Proper management and adequate resources, including up-to-date information, were also essential. Lastly, coordination between national agencies and among donors was crucial to ensure the efficient implementation of country programmes.

Following the recent emergence or re-emergence of certain diseases on a global scale, his Government had launched a number of projects. There had been significant achievements in family planning, the Expanded Programme on Immunization, control of diarrhoeal diseases and health education and in the performance of mid-level management. Infant and maternal mortality rates had been cut by half, and the case fatality rate for diarrhoea had decreased to 0.5%. At the same time, population growth had fallen to 1.8%.

Hepatitis, cardiovascular diseases, cancer, HIV/AIDS and diabetes mellitus could pose problems in the future. As one of the world’s least developed countries, Bangladesh was handicapped in tackling those challenges. Management infrastructure for monitoring environmental quality was almost non-existent, laws on food hygiene were primitive, and surveillance mechanisms for viral diseases still at a rudimentary stage. Widespread malnutrition presented a further challenge. Bangladesh was also prone to natural disasters: he was pleased to state that a regional centre for emergency preparedness and response was currently being established in Dacca with the help of WHO.

Developmental activities must be considered from the viewpoint of sustainability, with the focus on participatory planning and a system for allocating funds adequate to meet requirements. Community leaders, politicians and health care providers must give priority to health, and a management information system remained to be established. He was confident that, with the support of WHO and other development partners, those goals could be achieved.

Dr VAN ETTEN (Netherlands) said that socioeconomic factors were not only obstacles to success in controlling communicable diseases, but also major causes of those diseases. The focus should therefore be not only on health issues, but also on development issues. WHO should be an advocate of the public health approach, and should take the initiative in fighting those diseases that were the world’s leading causes of death.
In assigning priorities to communicable diseases, the burden imposed by each disease and the cost-effectiveness of intervention (established by research) should be the criteria used. WHO should pay particular attention to the major killers such as diarrhoeal diseases, respiratory infections, tuberculosis and malaria, most of which were aggravated by malnutrition; new initiatives were needed in that regard. The voluntary contributions made by the Netherlands to a number of WHO programmes to combat communicable diseases were proof of its commitment to that cause.

He agreed that a speedy response to outbreaks of communicable diseases was needed to prevent potential epidemics; for that, an early warning system and clear guidelines for outbreak management were crucial. He hoped that WHO’s newly-established Division of Emerging and other Communicable Diseases Surveillance and Control would play a key role in that regard. Recent outbreaks of Ebola haemorrhagic fever and plague had clearly shown the need to improve current information systems. Initiatives such as the creation of a European Union/United States task force to establish a global early warning system and response network for communicable diseases were to be welcomed, and WHO should participate actively in them.

The Organization would have to prove that it was a key player in the field of communicable diseases, and would have to reaffirm its leadership in health, despite constraints on its budget and other challenges. It must therefore concentrate on the content of its work and the fulfilment of its mandate.

Mr SOSA RAMÍREZ (Guatemala) said his country was one of the poorest in Latin America: in 1989, a survey had shown that 80% of its population lived in poverty. Although the Government was doing what it could, it was hampered by lack of funding for the social sector, due in turn to the very low contribution made by tax revenue to GNP (some 8% in 1995).

A sweeping modernization programme had been launched, with a view to increasing tax revenue, controlling the fiscal deficit, and increasing social spending, so that the most vulnerable groups could have better access to basic services. New legislation was being introduced to control tax evasion, and to put public spending on a more rational basis. A coordinated national health system was being introduced, which aimed to widen coverage and improve the standard of basic health services, with emphasis on prevention and control. The system would also improve hospital management and health infrastructures, notably water supplies to rural areas. Those reforms, which were included in a recent peace agreement covering socioeconomic and agrarian aspects, should help to improve the country’s health indices, in respect of which Guatemala compared very unfavourably with other Latin American countries at the same level of development.

Although Guatemalans realized that the destiny of their country depended on their own efforts, their own resources were inadequate to the task. Guatemala stood in need of international solidarity and cooperation if it was to be successful in tackling the root causes of the armed conflict within its borders.

Mr RIXIN (Bhutan) said that over 90% of his country’s population now enjoyed basic health care coverage. With support from WHO, the goal of universal child immunization had been attained, and Bhutan was on the verge of eliminating iodine deficiency disorders and the age-old scourge of leprosy. Nevertheless, many old, familiar communicable diseases such as hepatitis, typhoid fever, malaria and worm infestations remained, while at the same time noncommunicable diseases such as cardiovascular ailments, cancers, and nutrition-related deficiencies were demanding greater attention and some diseases once thought to be controlled were re-emerging. Demographic trends were disheartening, changes in behavioural and consumption patterns were causing many new and complex health disorders, and increasing globalization was breaking down traditional barriers to disease.

Because of Bhutan’s lack of skilled manpower, the health system’s capacity to deliver was well below demand. Accordingly, plans were being made to provide equitable and efficient services, with special emphasis on groups that had not yet been reached. Research, especially on health systems, was being promoted as an important tool for managerial decision-making.

While the efforts of individual countries to stamp out communicable diseases were important, concerted efforts at the global level were vital. No one country could be made safe from disease unless all countries were made so.
Mrs MEGHJI (United Republic of Tanzania) said she had noted with concern the re-emergence of diseases which until recently had been on the decrease. In particular, tuberculosis was again becoming a major cause of morbidity and mortality, chiefly in association with the spread of HIV/AIDS.

Her country's health sector reforms targeted diseases which were still a major cause of ill health in its population, notably malaria, diarrhoeal diseases, and acute respiratory infections. The main constraint was lack of resources, which greatly affected the implementation, management and sustainability of control strategies.

She appreciated WHO's contribution to health in the United Republic of Tanzania, as described in Chapter 2 of The world health report 1996. Although some of the targets set for the year 2000 would not be attained, the setting of those targets had served as an encouragement. Thus, there had been a significant improvement in immunization coverage, and hence a significant decrease in morbidity and mortality from measles, once a leading killer of the under-fives. Progress had also been made in the control of diarrhoeal and other diseases.

Certain important issues had been omitted from Chapter 3 of the report. In the United Republic of Tanzania, health sector reforms emphasized equity of access to health services, and it was her government's intention, in view of the rapid urbanization which had led to a deterioration of health indicators in urban areas, to put equal emphasis on rural and urban health services.

For the future, priority should be given to the following: general capacity-building at country level; community involvement; implementation of targeted and integrated programmes; the development of built-in mechanisms to evaluate implementation of future strategies; the strengthening of surveillance, diagnostics and information-sharing services; and lastly, capacity-building in disease surveillance and programme management.

Professor LJUBIC (Bosnia and Herzegovina) said that the recent cessation of hostilities in his country was enabling the Ministry of Health to restore health development for all its people following the destruction or impairment of 40% of health facilities. The three and a half years of aggression had also left over 12 000 persons badly disabled, 70 000 in need of physical rehabilitation and 15% of the total population in need of treatment for mental disorders. Nevertheless, it had proved possible during that time to readjust the health care system to the realities of the war, to reassess priorities and to begin thinking about future health care needs in the light of current economic and technological trends. In dealing with the immediate impact of the war, the focus was on physical and mental rehabilitation. A plan to establish community-based and hospital-based rehabilitation programmes throughout the country was under way.

Looking to the future, a series of health care reforms had been introduced and were currently accelerating. They focused on the need to prevent disease and place health in the context and in the service of broader social development. There was recognition of the need for radical change and priority-setting: the emphasis would thus move from tertiary care to primary health care and the empowerment of local communities. The challenge of disease control and prevention in the context of major damage to water supplies and a high level of substandard and overcrowded housing was also being addressed. A federal programme for reconstruction of the health sector was in preparation, and a number of projects prepared by national experts with the assistance of WHO, the World Bank and other international partners were already being implemented.

One reason, even when the situation was at its worst, why health care challenges had been met and mortality and morbidity from communicable and noncommunicable diseases kept under control had been the high educational level of the population, which had ensured the success of preventive measures. It was essential to build on that experience and achievement and to strengthen the community-based approach. The Ministry of Health would be collaborating closely with other ministries in that work.

Dr AL-MOUSAWI (Bahrain) said that attention should be given to the future difficulties the developing world was likely to face once communicable disease mortality and morbidity had been reduced through the programmes WHO was promoting. Such a reduction was bound to increase life expectancy - which indeed, according to The world health report 1996, had already risen by three years between 1985 and 1995 - and lead to the aging of populations. Mortality from noncommunicable diseases such as cardiovascular disorders, cancer, diabetes and geriatric diseases was therefore bound to increase, inevitably bringing a great deal of pressure to bear on limited health resources. The preventive and curative measures required to deal with a
rising incidence of noncommunicable disease in the developing countries would be completely different from those in place to deal with communicable diseases, and would call for considerable investment in new facilities. WHO should initiate studies to evaluate the likely future impact on health programmes, with a view to enabling developing countries to deal with such challenges. It was essential that the problems that might lie ahead during the coming two decades should be clearly delineated and that all should work together to alleviate them.

Dr KERKER (Switzerland) said that, despite the general improvement in global health evident from the report, there was a growing gap between the health of the haves and the have-nots in all parts of the world. That gap was often masked in aggregated data; a breakdown by sex, age, income, social status, educational level and other appropriate factors would better permit inequalities to be revealed and remedial action taken. A growing scarcity of resources, in addition to deficiencies in current health approaches and models, perpetuated such gaps in both the developed and the developing world. In the former, for example, aging of the population was putting increasing economic pressure on the dwindling population at work, placing social welfare at risk and posing major problems of ethics and equity. In both the developing and the developed world, therefore, there was need for a more rational and rigorous distribution of scarce resources, not merely by the application of better tools and indicators but also by a broader approach to human health encompassing all social, economic, educational and other aspects impinging on it. Such a holistic approach was essential in order to ensure sustainable development; it would have to be based on a new form of partnership that would be more balanced, open and equitable, treating matters of ethics and human rights with the same level of commitment and funding as those more strictly related to health care as such.

In pursuit of strategies on those lines, as propounded by recent international summits, with efforts in the health field as a core activity in joint action, Geneva, which was host to many international organizations and thus offered many opportunities for mutual inspiration, appeared to have considerable advantages as a headquarters base for WHO. The foregoing considerations should guide any reform of the institutions concerned, with the aim of enabling them to make a more appropriate response to current global change. The reforms under discussion in WHO during the past four years showed promise, but the report did not make sufficiently plain the line of reasoning linking the institutional changes introduced to the new challenges perceived. Although a first step had been made towards meeting the expectations of Member States, a continuing lack of transparency was likely to jeopardize the credibility of WHO.

Dr AL-BATAYNEH (Jordan) said that, despite WHO's effort in helping Member States to combat disease, the current global health situation gave cause for considerable concern. WHO must be constantly on the alert to respond to changes in disease patterns and to emergencies. Furthermore, instability and conflict, which were currently as widespread as disease in many parts of the world, had in many cases relegated concern for health to a secondary position. The noble goal of health for all would be unattainable unless all such conflicts were resolved by the achievement of a just peace.

WHO should make every effort to ensure justice and solidarity in health matters in order to reduce inequalities in living standards among all States irrespective of differences in ideologies. Material support given by industrialized and wealthy countries to poorer countries to enable them to develop their health sector and implement national strategies was in fact an investment on their own behalf: development in one country would inevitably benefit all since disease knew no borders. There was a recognition that health could only be achieved by overcoming poverty, famine and unemployment. Furthermore, improving the quality of life was integral to economic and social development and had thus to be included in any development plan. All factors militating against health should be combated by those working in the health field, whose only concern should be to improve health.

Dr CANDUCCI (San Marino) said that the political and social upheavals of the past decade in Europe had made plain the difficulty of reaching the target of health for all by the year 2000 and had drawn attention to the need to review that strategy in the context of the global reform process. Furthermore, the economies of many countries were in recession, forcing them to take stringent measures to control social welfare costs. Any reform of the health system thus necessarily had to take a wide variety of economic and health aspects
into account, creating a need for indicators and methods designed to evaluate the impact of the reform process and ensure rational use of resources and provision of effective and high-quality services. However, the success of such reforms could not be measured by cost-effectiveness alone; respect for human dignity, equity and professional ethics all had to be taken into account.

San Marino had developed a computerized system applicable to both general and specialized medical care in an effort to achieve a more rational and cost-effective health policy. It was based on indicators relating to quality of life, disease prevention, quality of life of the elderly in the context of family policy, and equal opportunities for the disabled in education and employment. In pursuit of those aims, legal measures had been adopted to provide financial assistance where necessary and to give access to medical care free of charge. Priority was being given to preventive activities within the framework of a number of WHO programmes. Training was an essential part of any health policy, as were measures to promote improvement of services.

Emerging and re-emerging diseases were the cause of a deteriorating level of health in some countries. In dealing with the situation, humanitarian assistance would be needed from governments and international and nongovernmental organizations. Partnerships for health promotion should be established to bring together the technical expertise and financial resources required, particularly for developing countries, which were at greatest risk. The economic crisis facing many countries should not be allowed to hinder international cooperation on health development. Harmonization of WHO’s programmes with those of other international organizations through preparation of joint projects would be the most effective way of meeting the needs of all.

Dr WEINSTOCK (Costa Rica), speaking on behalf of Belize, Costa Rica, El Salvador, Honduras, Nicaragua and Panama, said that the Central American countries had been working together to introduce coordinated disease prevention programmes simultaneously, since disease respected no borders. In addition, efforts to improve health systems in the area were focusing on ensuring the provision of primary health care facilities in villages and communities so as to ensure access for all to such services. Concentration on the base of the health care pyramid before moving on to provision of advanced hospitals where complex surgery could be carried out was the best way to ensure a high level of general health. Moreover, prevention was not only better than cure, it was also cheaper. Another important aspect of health care was that it should show a sense of common purpose and mutual support. Although in Costa Rica people were free to seek private health care if they wished, all were obliged to show solidarity by paying social security contributions. It was only equitable that those who were wealthy paid more, but all should have equal access to health care. Current discussions tended to centre on the economic aspects to the neglect of social needs, but it should be remembered that social and economic aspects were merely two sides of the same coin. If efforts were directed to economic ends alone, unsatisfied social needs would end up by crippling countries. The Central American countries were endeavouring to set up a joint epidemiological information system using communication through the Internet to follow up outbreaks of disease wherever they occurred.

When he had attended the Health Assembly 20 years previously he had had occasion to remark that he considered such meetings of little use. He had not changed his view in the interim and appealed to all the countries making up the Organization to work together to reorganize its structure in such a way as to prevent further deterioration.

The meeting rose at 17:35.
THIRD MEETING

Wednesday, 22 May 1996, at 9:00

Chairman: Professor B. SANGSTER (Netherlands)

1. REVIEW OF THE WORLD HEALTH REPORT 1996: Item 10 of the Agenda (The world health report 1996; Document A49/3) (continued)

Mrs AL-GHABSHAWI (Sudan) said that economic and social reconstruction in her country had been made particularly difficult by 10 years of warfare, and international aid was needed to help rebuild and foster development. The setting up of 26 provincial health ministries in Sudan had been costly in terms of both human and material resources, at a time marked by other economic pressures and a reduction in foreign aid. In 1993 a policy of economic liberalization had been introduced and the private sector was now participating in the funding of health care. There were currently over a million immigrants in the country, which placed enormous pressure on health institutions. Diseases and epidemics were being combated even in parts of the country controlled by rebels. Health was regarded as an essential human right and charters and declarations of the United Nations organizations working in the area of health were respected, as illustrated by support for programmes on malaria - which the emergence of chloroquine resistance had re-established as a priority - tuberculosis, poliomyelitis and AIDS. The importance of women in relation to the health of the family and of children was recognized.

Dr CALMAN (United Kingdom of Great Britain and Northern Ireland) wished to emphasize four points. First, health was one of the best indicators of development. Secondly, WHO had a key leadership role, particularly in establishing partnerships. Thirdly and most important, future development should be based on a six-point framework, details of which he would supply to anyone interested; and fourthly, the importance both of resource issues and of continued reform should be stressed. If, as he for one wished, WHO was to continue to be the premier health organization in the world it would need support.

Dr KÖKÉNY (Hungary) affirmed that the theme of The world health report 1996 had particular relevance for countries in overall economic and social transition, with the associated adverse effects on health. Throughout central and eastern Europe life expectancy was continuing to decrease and infant and maternal mortality to rise. Deaths from cardiovascular disease, cancer, accidents and violence were also increasing. At the same time, there had been a breakdown in the public health system and communicable diseases such as tuberculosis were re-emerging. The Regional Office for Europe had established the EUROHEALTH programme to support health development in those countries and two-thirds of regional resources had been reallocated in their favour. Nevertheless, needs still continued to exceed diminishing resources. At its session in 1995, the Regional Committee had expressed the view that the European Region should receive a larger share of the total regular budget to reflect realities in the Region.

As part of the reform process, the examination of the WHO Constitution was a significant step forward. Priority was being given to WHO's mission and function, but there were many other topics suitable for review. In any case, important matters concerning the future of WHO, including a better balance of resources within the Organization, should be discussed in the governing bodies in an open, democratic way, rather than through press statements.

Hungary cooperated closely with WHO and others, such as the European Union and the World Bank, in formulating and implementing national health care policies and reforms aimed at disease prevention and health promotion.

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Dr ARAFAT (Palestine), speaking at the invitation of the CHAIRMAN, welcomed The world health report 1996. The twin goals of peace and health for all by the year 2000 had been generally accepted. All obstacles to peace must be removed; the long-standing blockade had adversely affected the health of the Palestinian people, especially among vulnerable groups. The Palestinian health authorities were committed to providing health services and thanked WHO and all those countries and international and nongovernmental organizations that had provided assistance. The health authorities were currently cooperating with those of Israel to develop health services for the two peoples. He welcomed the agreement signed by countries in the region and by Palestine for joint action against cancer, with support from the Government of the United States of America.

Mr TCHEUL (Democratic People's Republic of Korea) regretted that people should still be vulnerable to new, emerging and re-emerging diseases that ranged from diarrhoeal diseases to Ebola haemorrhagic fever and AIDS. It was unacceptable that those diseases were on the increase as a result of war, drug abuse and unemployment, as well as a lack of coordination and planning in the provision of health care services and cooperation in the public health sector. He therefore supported the three priorities set out in The world health report 1996 which should contribute to coordinated action by the international community. Diseases could be tackled only through international cooperation based on firm determination and reliable resources. WHO should concentrate on reforming its own internal structure to enable it to help Member States to make the necessary improvements to domestic infrastructures. An international conference on fighting common diseases might contribute towards mobilization on a global scale. The Democratic People's Republic of Korea would continue to cooperate with WHO in carrying out programmes directed to improving people's chances of survival. In conclusion, he thanked WHO and all countries which had offered emergency assistance to flood victims in the Democratic People's Republic of Korea in 1995.

Dr ADAMS (Australia), welcoming The world health report 1996, said that WHO would undoubtedly be remembered for eliminating a number of diseases, including yaws and smallpox, from the planet, but other threats, such as Ebola haemorrhagic fever, bovine spongiform encephalopathy (BSE), tuberculosis and iodine deficiency disorders, remained. WHO still had a vital role to play in a number of areas: responding to emergencies, developing early warning mechanisms for emerging and re-emerging diseases, modernizing the International Health Regulations and drawing attention to the link between communicable diseases and cancer. If progress was to be made in health development, however, WHO would have to join forces with other bilateral and multilateral organizations. In view of its restricted budget, the Organization would also have to reconsider its role and priorities, which might mean dropping some of its present programmes and concentrating on contemporary major public health issues.

Mr CHUA JUI MENG (Malaysia) said that his country's rapid development was creating new health challenges. Although good programmes were in place, action was needed in new areas of concern. Both communicable and noncommunicable disease problems were present. The diseases in the first priority area defined in The world health report 1996 were under control as a result of immunization and good cold-chain maintenance, but diseases in the second priority area, especially malaria and tuberculosis, required active WHO programmes to combat them. Diseases in the third priority area were particularly important for Malaysia, since dengue and dengue haemorrhagic fever were spreading, and appropriate research, including behavioural studies, would be important in developing effective strategies to control them.

There was a great need to improve the health information system and collaboration at country, regional and global levels. He therefore welcomed the institution of WHONET for the global surveillance of bacterial resistance to microbial agents, and hoped that such an innovative use of information technology could be extended to the surveillance of communicable diseases. In a world in which large-scale international travel spread viruses and bacteria, WHONET, the Internet and the development of "telemedicine" would change the way in which the world viewed health care delivery. However, total community involvement would be required. For that purpose Malaysia had evolved a policy providing for interaction between the public and private sectors and with nongovernmental organizations, assistance from which was particularly important for combating the new "lifestyle" diseases, as had been shown in the "healthy lifestyle" campaigns carried out since 1991, concentrating on diseases such as heart disease, AIDS and diabetes.
Malaysia looked forward to greater collaboration with WHO, to whose work it was fully committed, believing that despite the criticism levelled against the Organization and despite some of its failings it remained the best hope in the fight against diseases old and new.

Professor LE NGOC TRONG (Viet Nam) said that as the twenty-first century approached, the world was confronted by political, social and economic changes never experienced before. The gulf between the rich and the poor was widening, while rapid population growth and urbanization, the aggravation of health gaps between the developed and least developed countries, worldwide environmental destruction and the mass migration of refugees following natural or man-made disasters were all affecting the international health situation. Viet Nam was therefore looking at health and environmental problems from a somewhat different perspective, focusing on consideration of the environment as a factor in all stages of development.

The dynamic development of the western Pacific area had not always had a positive impact on health or the quality of life. Viet Nam was therefore taking a fresh look at its development priorities and was reorienting national strategies through programmes to eradicate poverty in remote mountain areas, special initiatives to ensure tangible benefits for vulnerable groups, and programmes to combat vaccine-preventable diseases and social diseases such as malaria and endemic goitre. It was endeavouring to improve living conditions, to rehabilitate schools, health clinics and roads, and to provide clean water and sanitation.

Economic development, education, poverty alleviation, environmental policy and agricultural activities were all key factors influencing the health status of individuals and the population in general. The relation between health and development proved to be stronger in the case of women and children. Development generated growth, but the fruits of growth must also be distributed equitably. His Government hoped that WHO, which it fully supported, would continue to provide the necessary leadership in achieving health for all by the year 2000.

Dr IVANOU (Belarus) said that his country shared WHO’s concern over the communicable disease problem, which had a very important impact on socioeconomic development. Communicable diseases were especially important for Belarus, which, on account of its geographical situation, received a large number of legal and illegal migrants from the Commonwealth of Independent States, the Middle East and Asia. His country was most grateful to WHO, UNICEF and the International Committee of the Red Cross for their help in controlling communicable diseases, especially through the provision of vaccines and improvements in the cold chain.

At present the Government of Belarus, with the assistance of international organizations, was engaged in a campaign to vaccinate the whole population against diphtheria. Also, a special programme had been prepared to protect the population against viral, bacterial and parasitic diseases. Belarus, which had the laboratories and services to carry out research with highly pathogenic biological agents, was willing to cooperate with other countries on problems such as microbial resistance to antibiotics and the control of poliomyelitis.

Work in such a complex field as the control of communicable diseases required the closest possible coordination in the areas of provision of information, preparation of standardized approaches to research, prevention of infection, and training. Appropriate national programmes must be formulated, and national and international coordinating centres must be designated and fitted out with up-to-date equipment. Belarus had offered to establish a WHO coordinating centre for the control of communicable diseases at its Institute for Epidemiological and Microbiological Research.

Integrated research must continue on endemic and other diseases in areas having higher radioactivity as a result of the Chernobyl disaster, the aftermath of which was continuing to affect Belarus. Unfortunately the funds available for remediying the effects of the disaster had been reduced. Belarus could not cope with all the problems on its own, and it was therefore necessary to continue the International Programme on the Health Effects of the Chernobyl Accident and the international "thryoid" project. His delegation hoped that the Health Assembly would adopt a resolution on the subject and that WHO would find funds. In turn, Belarus was willing to share its tragic but unique experience with the rest of the world.

Mr SIDIBE (Mali), speaking on behalf of Benin, Burkina Faso, Burundi, Cameroon, Chad, Congo, Côte d’Ivoire, Gabon, Guinea, Madagascar, Mali, Niger, Senegal and Togo, said that the health situation in those countries was still a source of concern and there was still a need to promote health as a sector that contributed
to economic growth and well-being. The scarcity of resources made it necessary to establish rigorous priorities that took account of endemic diseases, diseases in epidemiological transition, and emerging and re-emerging diseases. The outbreak of cerebrospinal meningitis in which 10,000 persons in the West African subregion had died had been mastered thanks to international solidarity. The economic and social costs of malaria were becoming increasingly severe, while acute respiratory infections, diarrhoeal diseases, cholera, measles, trypanosomiasis and Ebola haemorrhagic fever were endangering development and shattering fragile health systems. The spread of the HIV/AIDS pandemic would, it was hoped, be checked with the establishment of UNAIDS, whose activities should go beyond prevention and, in the name of equity, also cover the problem of AIDS patients' access to medicines. Meanwhile, the world population was constantly growing, in association with a galloping urbanization that was having harmful consequences on the health of city dwellers, particularly women and children. In order to meet those challenges, innovative strategies must be adopted and health systems strengthened by stressing the importance of integration at different levels, and of improved organization and health service management. Water supply and a clean environment also had to be taken into account, while mental disorders and infections of the oral cavity could not be overlooked. In that context the countries on whose behalf he was speaking were determined to continue the reforms undertaken, since only through a comprehensive and integrated health system sustained by vigorous community commitment would it be possible to combat disease effectively. They called upon their partners to match those reforms.

Cooperation among States, especially in emergencies, must be further developed. Many countries had established mechanisms for preventing and responding to emergencies through the constitution and pre-positioning of stocks, the creation of crisis committees and the formation of teams for emergency prevention and management, but generally those arrangements were dependent on epidemiological surveillance and early warning systems which needed to be reinforced. What was now required was a real pooling of all health resources in a regional strategy for the prevention and control of communicable disease epidemics. Furthermore, in view of the size of forced population displacements, there was a need for mechanisms to ensure good health services for all in full security. In any case, WHO was effectively supporting the health programmes and systems of the countries on whose behalf he was speaking, so its mandate must be preserved. The international community should therefore place at its disposal sufficient resources, which should, however, be managed with greater rigour and relevance.

Mr DUGASSE (Seychelles) recalled that delegates had left the Forty-eighth World Health Assembly with a clear understanding of the need for broad consultation within their respective countries in order to raise awareness of the need to place health high on the political agenda among the general public, political leaders, ministries and other partners concerned with social and economic development. A comprehensive study and a series of consultations had been launched in the Seychelles soon afterwards, with the prime objective of reviewing the country's health policy and strategies. The study had shown that, despite changing perspectives, health for all remained a valid and realizable policy, and primary health care a very effective and appropriate strategy. Decentralized primary health care services would continue to be made available to the population free of charge, based on actual needs and not on ability to pay. There was, however, a fast-growing private medical sector. The recent review had strengthened the Government's conviction that primary health care required unswerving political commitment and that governments must continue to play a central role in the planning, organization, provision and monitoring of health care services.

Following the review, health policies and strategies had been not only revitalized but also prioritized and translated into practical measures. For example, the Ministry of Health had succeeded in obtaining an increase in its share of the national budget. A commitment had been made to redressing the imbalance that existed in the allocation of resources between hospitals and primary health care. The Government had recognized that human resources development was central to sustainable development and was reviewing development of the managerial capacity required at all levels of health care. Progress had been made in building up greater awareness of health among individuals and in the community. A stronger partnership was being fostered with governmental and nongovernmental organizations through, for example, strengthening of collaboration in schools and with those involved in community level social services. The Government was also enhancing community participation and promoting the concept of individual responsibility for health. It was anxious to sustain and upgrade the quality of health care delivery and would therefore include quality assurance among the indicators for the provision of health care.
When Seychelles had gained its independence in 1976, its health budget had been tiny and its health indicators dismal. Now, 20 years later, it had recorded significant gains against all major health indicators, which were comparable to those of many developed countries. Its current aim was to sustain the gains and improve on them. There was no doubt that, throughout the process of health development, Seychelles had been inspired and guided by WHO, whose support at the country office, regional office, and headquarters levels it appreciated. It had learnt from and adapted the experience of other countries and now sought new ways of cooperating in the years ahead. In any event, Seychelles wished to renew its commitment to the cause of health for all and to WHO.

Dr MADUBUIKE (Nigeria), speaking on behalf of the Member States of the West African Health Community (Gambia, Ghana, Liberia, Nigeria and Sierra Leone), said that all the countries of the Community (WAHC) faced the same challenges in the health sector, including high maternal and infant mortality rates, the pressure of a soaring population, forced migrations resulting from natural and man-made disasters, and communicable diseases such as HIV/AIDS, tuberculosis, yellow fever, cholera, Ebola haemorrhagic fever and Lassa fever. An epidemic of cerebrospinal meningitis was currently affecting some countries of the subregion. WAHC was grateful to international donors for their assistance in combating the epidemic. Malnutrition, including micronutrient deficiencies, played a major part in premature death, disease and disability. However, it was hoped that dracunculiasis would soon be eradicated, and a programme of salt iodization had begun with the aim of eliminating iodine deficiency disorders by the year 2000.

A number of other problems were of concern to WAHC, including the rising incidence of cardiovascular diseases and accidents and the spread of tobacco smoking. Better water and sanitation services would have an immediate impact on people's health - also an area where more help was needed from the international community. Some members of WAHC had suffered civil strife which had adversely affected many sectors, including health, and it was to be hoped that matters would improve when the conflicts were over. The continuing problem of fake and substandard drugs made it more important than ever to enforce WHO's essential drugs policy.

Although many countries were undertaking health sector reforms, economic crisis and structural adjustment programmes had adversely affected people's health, and both local and foreign resources must be mobilized in order to meet the urgent health needs of the people. WAHC supported WHO's budgetary reforms, which were intended to increase allocations to country programmes and give countries more control over their country budgets.

Human resources development continued to be a major concern of WAHC. Nurses and midwives made up the majority of health personnel, and he welcomed the new focus on strengthening nursing and midwifery as an integral part of health development. More training was needed for medical and nursing staff who worked to rehabilitate disaster victims and displaced persons. Specialist medical personnel were being trained at national or regional training centres in order to improve the capacity and quality of health care at all levels, and more efforts were being made to increase training in specialist areas. The assistance of the international donor community in that endeavour would be appreciated. Management training for senior- and middle-level health personnel was also important, since management problems had been blamed for most of the failures in the implementation of policies and programmes. He welcomed the new emphasis on workplace health programmes, although few people in the WAHC countries worked in the formal sector. It was important to address the needs of all workers.

Dr VASSALLO (Malta) said that while The world health report 1996 provided a balanced view of successes and failures in the fight against the world's major health problems, it failed to mention the regrettable reduction in the number of WHO's public health specialists, including those experienced in tropical diseases. The pharmaceutical industry should consider intensifying its research in that field, which was assuming greater importance. WHO was making a great effort to raise awareness of the deteriorating communicable disease situation, and he welcomed the creation of the new Division of Emerging and other Communicable Diseases Surveillance and Control. It was essential to make the International Health Regulations, currently under review, more helpful to countries.

WHO must not lose sight of the massive burden of ill-health caused in rich and poor countries alike by noncommunicable diseases such as heart disease, diabetes and cancer. Many countries were vulnerable to unhealthy lifestyles and glamorous advertisements for harmful substances. WHO's future programmes of
work should strive for an appropriate balance between communicable and noncommunicable disease activities. However, any revision of priorities should be approached with caution.

Malta had always supported health efforts at the global, regional and subregional levels. It was currently exploring the feasibility of launching an initiative for a coordinated strategy and programme of action for Mediterranean countries, involving WHO headquarters, the European, Eastern Mediterranean and African Regions and individual countries, as a contribution to the global review of the health-for-all strategy. He supported the report’s conclusions and priorities for action and appealed for international solidarity in support of WHO initiatives.

Dr IBRAHIM (Brunei Darussalam) said that the spread of communicable diseases had become a very serious problem, exacerbated as it was by increasing drug resistance and factors such as poverty, economic and social crises and people’s increasing mobility. The changing patterns of diseases demanded a fresh approach to health planning and management on a global scale.

In general, noncommunicable diseases were more of a problem in Brunei Darussalam than communicable diseases. However, there was concern that diseases such as tuberculosis, malaria and HIV/AIDS might become more serious in the future because of changing lifestyles, an expected influx of migrant workers and increased tourism and trade.

Dr PALACIO (Ecuador) said that health problems respected no frontiers and must be tackled at the global level. Radical political change was required in order to reform the structure and financing of WHO. Despite its many achievements in the past, WHO was only now beginning its most vital task - the creation of a new world health order which would define more clearly the relation between national health systems and the various economic and cultural processes. The new order must also consider healthy human reproduction as a necessary condition for a healthy world.

The current restructuring of WHO was not enough: ideological changes were also needed in order to foster people’s links with nature and with human organizations. Important issues such as the impact of cities on people’s health and the economic potential of the health sector must not be ignored. One example of a specific problem was the fact that almost all the pharmaceuticals produced in the world were consumed by the rich minority in the north rather than the poor masses of the south.

He urged WHO to establish a global health system whose main objective would be the health of future generations and which would involve all social, economic and political sectors. The new system should incorporate health into all national cultures and provide a way of freeing the world from underdevelopment and ill-health.

Dr OPOLSKI (Poland) said that the situation of communicable diseases, with old diseases re-emerging and new ones arising, epitomized the world’s health problems as a whole. Many Member States were reforming their health care systems to balance the growing expectations of their population against the financial constraints on health expenditure. WHO, too, had begun a reform process in response to global change which had had to be accelerated in recent years because of severe financial constraints. It must consider all possible options for maintaining and improving the effectiveness of its work: the role of the regional offices in that task was particularly important.

Poland was currently reforming both its socioeconomic and its political system. It had come to realize that inappropriate utilization of available resources was the main problem in health care delivery, rather than a lack of infrastructure or human resources as had been thought in the past. The Government’s main function was one of management, even though it also acted as an employer or a producer of consumable commodities, as well as fulfilling social, educational and political functions.

Dr BARAKZAI (Afghanistan) said that, in 17 years of war, his country had lost 75% of its health infrastructure. Infant and maternal mortality rates were high, and life expectancy, at 43, was low. Tuberculosis, malaria, leishmaniasis, gastroenteritis, acute respiratory infections, other communicable diseases, and iodine and vitamin A deficiency disorders gave particular cause for concern.

Despite its economic difficulties, Afghanistan had pursued its expanded programme on immunization to achieve a coverage of 70%-80%. It hoped to receive increased funding in that area and for the planned water chlorination programme. A mass immunization campaign against poliomyelitis was also planned, and
Afghanistan acknowledged the assistance of the Regional Office for the Eastern Mediterranean, UNICEF and the Islamic Republic of Iran in poliomyelitis control activities. Many communicable diseases affected more than one country in the Region, and his Government had suggested the formation of a joint committee to coordinate their control. The fight against iodine deficiency disorders would require intersectoral cooperation between the Government, economic agents, the legislature, the media and educationists. He called upon WHO to assist in the supply of iodized salt.

Because of the effects of the war, the cities of Afghanistan were far from being "healthy cities": they did not have electricity or water supplies and their children, their most precious asset, were living in an unhealthy environment without schools or play areas, undernourished, mentally distressed, and under constant threat from the land mines left over from the war. He appealed to all participants in the Health Assembly to provide the funding, technicians and designers needed for a truly healthy city which could serve as a model for reconstruction all over the country.

Mr ANGATIA (Kenya) said that the process of reforming the health sector in his country was based on the development of a new health policy framework paper, exploration of alternative financing mechanisms, capacity-building and rationalization of personnel working in the sector, and improvement in the delivery of health care services. The main health challenge was to prevent and control communicable diseases, of which malaria remained the most significant. Kenya had recently launched a five-year programme of action on malaria control for whose implementation it would require the support of WHO and other international as well as bilateral organizations. The approaches to be adopted were multi-pronged and included vector control, environmental management, chemotherapy and the monitoring of drug resistance trends. Kenya was implementing a national drug policy but, as in other countries of the Region, problems relating to counterfeiting and to import of substandard drugs were beginning to occur, requiring the concerted attention of the pharmaceutical industry, regulatory boards and government departments, under the guidance of WHO. In addition, Kenya was dealing with the challenge of new, emerging and re-emerging diseases; WHO’s role should be strengthened to assist Member States to be in a state of readiness to contain those diseases when they occurred, with minimal suffering and loss of life. The Organization also had a crucial role to play in working out strategies to link the coordinating efforts of UNAIDS in the fight against AIDS and sexually transmitted diseases with what was being done in the prevention, control and treatment of tuberculosis. Kenya devoted special attention to child survival and development programmes; since the beginning of 1996 the country had recorded no cases of poliomyelitis and had every reason to believe it would achieve its eradication. A similar trend was recorded for dracunculiasis.

Mr KASONGO-NUMBI (Zaire) said that despite the current difficulties his Government still gave real priority to health: health expenditures ranked second in the country’s budget and Zaire had paid all its arrears of contributions to WHO. Health coverage had improved significantly, with the activities of the expanded programme on immunization, the National Bureau for Tuberculosis, the Central Bureau for Trypanosomiasis, and the National Bureau for Onchocerciasis, the action taken to control iodine deficiency disorders by banning the sale of non-iodized salts, and improvements in the quality and effectiveness of health care through the rehabilitation of infrastructure and partnership with the private sector and with local religious and other nongovernmental organizations. Nevertheless, the overall situation remained precarious, with the unprecedented socioeconomic crisis being made worse by the breakdown in structural cooperation and successive waves of refugees. He wished to draw the attention of the international community to the disastrous effect that mass population movements had on the spread of HIV; in Zaire prevalence had soared from 6% to 18% in only two years. The fight against HIV infection should take that into account. Zaire welcomed the friendly overtures being made by a number of countries regarding structural cooperation. Finally, his delegation had prepared draft resolutions on HIV and trypanosomiasis, which he hoped would meet with the support of the Health Assembly.

Dr MAKUMBI (Uganda) said his Government had increased the financing of its health sector by over 50% since 1993, and that effort had been enhanced by strategies designed to attract back those professionals who had left the country during the civil turmoil prior to 1986. The Government was restructuring the workforce and improving the working environment through health sector reforms including better remuneration for health professionals. The Ministry of Health was carrying out a study of 39 districts to give
priority to control of certain communicable diseases, formulate cost-effective interventions, and analyse in
detail the sources and expenditure of funds at each district level to enable resources to be allocated rationally
and flexibly. Alongside that, every effort had been made to promote early diagnosis and prompt case
management, improve vector control measures, and develop early warning systems and surveillance
mechanisms to prevent epidemics and the spread of new pathogens. Activities included sharing of information
and fostering of a better understanding of the constraints that hindered the effective control of epidemics and
better collaboration between neighbouring countries and districts. Uganda had drastically reduced the
incidence and prevalence of both dracunculiasis and poliomyelitis, and was stepping up its efforts to control
measles, onchocerciasis, AIDS, tuberculosis and malaria. It welcomed national and international collaboration
to combat newly emerging diseases, as well as operational research on their prevention, treatment and control.
Trypanosomiasis was on the increase in Uganda, and the Government was grateful for WHO’s efforts to
ensure that the production and delivery of melarsoprol was resumed. Uganda had hosted the Ninth
International Conference on AIDS and Sexually Transmitted Diseases in Africa in December 1995, attracting
nearly 4000 participants from all over the world.

Mr MARQUES DE LIMA (Sao Tome and Principe) said that *The world health report 1996* presented
a number of causes for concern; the means were available to solve some of the problems. For example, there
were effective vaccines for a number of communicable diseases, and malaria mortality could be reduced by
earlier diagnosis and the use of impregnated mosquito nets. Furthermore, efforts should be made to deal with
the threatened increase of emerging diseases by improving human resource training and working conditions,
pursuing research at national, regional and interregional levels and applying the results of that research with
determination. International solidarity should be ever present.

Dr DASHZEVEG (Mongolia) said that in recent years his country had conducted large-scale campaigns
to combat communicable diseases, which had long been the main cause of morbidity and mortality. The
expanded programme on immunization, including immunization against hepatitis B, was being organized with
the support and assistance of WHO and UNICEF and with the active participation of a number of donor
countries, including France and Japan. Since 1993 Mongolia had been organizing twice-yearly national
vaccination campaigns as a result of which there had been no cases of poliomyelitis or neonatal tetanus for
the past three years and no deaths from measles in children; the number of hepatitis B cases had fallen by
one-third between 1991 and 1995. Widespread vaccination and treatment had put a halt to outbreaks of
meningococcal infection and diphtheria in 1993 and 1994. However, other communicable diseases, including
plague and tuberculosis, were on the increase. The International Health Regulations should be reviewed as
part of the fight against communicable diseases; they should take account of global changes in disease
patterns and the current demands of the world community. A technical working group should be set up for
that purpose. It was essential to provide the world medical community with full information about new
diseases and about the emergence of atypical pathogens. It was also very important to establish bilateral and
multilateral cooperation within regions. Mongolia was currently undergoing a severe economic crisis and,
at the beginning of 1996, had suffered from more than 270 separate forest and steppe fires - 25 of them still
ablaze - which had affected seven provinces and 73 districts, causing much material damage and even loss
of life. He thanked all the countries and international organizations, including WHO and especially its
Regional Office for the Western Pacific, which had given the Mongolian people material and moral assistance
in overcoming their difficulties.

Mr FEKADU (Eritrea) said his was the newest nation in Africa, and was on the eve of celebrating its
fifth year of liberation. Eritrea was rapidly emerging from the crises caused by 30 years of war through rapid
relief and rehabilitation measures; the country was now fully engaged in the development process, and
cooperating with its neighbours in the Horn of Africa. It was implementing several nationwide health
programmes in spite of financial and human resource constraints and, through a national health policy based
on primary health care, was seeking to make basic health services available to the majority of its population.
Considerable progress had been made in a short space of time in the rehabilitation and construction of health
facilities. Eritrea had developed a primary health care policy and guidelines, a national AIDS control
programme, a strengthened national malaria control programme, an expanded programme of immunization
at national and regional levels, iodization of all salt supplies with the aim of eliminating iodine deficiency
disorders by the year 2000, a national drug policy and a drug quality control laboratory, a pharmaceutical production plant, a health financing scheme with the introduction of private practice, a restructured and streamlined Ministry of Health, and decentralization of health services to the regional level.

Eritrea believed that WHO should continue to play the leading role in all health matters, but for it to be able to discharge its obligations it should improve its managerial performance, with the assistance of all Member States. Eritrea regretted the steps being taken to reduce WHO's budget in certain priority areas, but at the same time believed that developing countries should try to make their programmes sustainable from their own resources. Regional or subregional cooperation played a significant role in the development of health services, and the countries of the Horn of Africa had already begun to promote the coordination of health intervention in border areas, especially for the control of communicable diseases.

Dr SOLARI (Uruguay) said that the demographic and epidemiological situation and increasing social exclusion in Uruguay compounded the problems arising from new, emerging and re-emerging communicable diseases. In addition, the prevalence of cardiovascular diseases, malignant tumours, various kinds of rheumatism and other chronic illnesses associated with an aging population placed a heavy burden on the health care services. Uruguay had responded to the challenge by focusing on high-technology therapeutic services. So far, however, it lacked properly planned and funded preventive projects aimed at risk factors such as tobacco, excess weight and lack of exercise that were conducive to chronic illness. The lack of an explicit medical training policy was another major shortcoming. Keen competition among a very large number of doctors made for over-specialization, so that only 10% of doctors were general practitioners. As a result, although Uruguay devoted 9.5% of its gross domestic product to health services, its performance in terms of health indicators was relatively poor. It would need WHO's support to change its approach in the interests of efficiency, equity and quality and to counteract the forces originating in developed countries (medical specialization, pressure from the pharmaceutical industry and the spread of advanced technology) which made it difficult for moderately developed countries such as Uruguay to strike a proper balance between, on the one hand, the adoption of costly technology and, on the other, the promotion of health and the prevention of disease.

Mr ESKOLA (Finland) said that, while the strong emphasis on communicable diseases in *The world health report 1996* was justifiable on the grounds that the least developed countries were most severely affected, it might also be viewed as a narrowing of scope and a move towards vertical methods of work. The emphasis in the 1995 report on promoting equity as a crucial means of achieving better health should remain a key principle of WHO policy in the years ahead. Demographic factors, urbanization and changing lifestyles had led to an increase in noncommunicable diseases in the developing countries. The increase in maternal mortality figures was an example of their "double burden" in terms of lack of equity. Improved and widely accessible primary health care held the key to a reversal of recent trends. More information was needed concerning social and cultural aspects of the spread of communicable diseases and their impact on the community; WHO must be actively involved in existing regional and global plans for intensifying their surveillance and control. While renewing strategies and improving management, the Organization should continue to promote the values of equity, of solidarity, and of health as a basic human right, adopting a horizontal and integrated approach.

Mr AL-MADFAA (United Arab Emirates) said that efforts to prevent the spread of new infectious diseases were impeded by such modern phenomena as a highly mobile international labour force and mass tourism and also by the failure of some countries to report outbreaks.

Basic health indicators in the United Arab Emirates had in some cases exceeded the targets set in 1981. The country's performance in terms of life expectancy, infant and child mortality rates, immunization rates and the proportion of the budget devoted to health services was comparable to that of developed countries. Technical guidance had been sought for the implementation of WHO health strategies such as the global malaria strategy and programmes such as the Expanded Programme on Immunization.

The Ministry of Health viewed primary health care, based on the principles of participation and accessibility, as the key to the entire health system. Existing services incorporated a referral system for specialist treatment.
In 1993, the Government had donated US$ 1 million to WHO to institute an annual award for outstanding achievements in the field of health by individuals or organizations. The Executive Board had subsequently approved the establishment of the United Arab Emirates Health Foundation Prize.

The DIRECTOR-GENERAL said that delegates’ comments and recommendations would be extremely useful not only for future planning and priority-setting but, more importantly, for underlining the importance of health for socioeconomic development and peace. He had been particularly gratified by the reaffirmation of WHO’s key role in world development. To fulfil that role, the Organization must combine increased cost-effectiveness with unremitting hard work.

The report had been issued on the recommendation of the Executive Board Working Group on the WHO Response to Global Change. Reform was a continuous process. The different issues dealt with from year to year in the report formed part of the continuous process of implementing WHO’s vision and basic goal. The issue of bridging the health gap between rich and poor dealt with in the 1995 report was related to the priority-setting exercise undertaken in the current report.

The Secretariat greatly appreciated the active participation of Member States and pledged to continue its work to enhance the status of health worldwide, bearing in mind the principles of solidarity, equity and full participation by all.

The CHAIRMAN took it that the Committee wished to commend the Director-General on *The world health report 1996* and express its satisfaction with the manner in which the programme of the Organization was being implemented.

It was so agreed.

2. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4)

**Improving technical cooperation among developing countries** (Resolution WHA43.9)

Dr ANTELO PÉREZ (representative of the Executive Board) said that a lively exchange of views had taken place in the Board on the document containing the Director-General’s report on the implementation of resolution WHA43.9. In the context of rapid globalization, increasing poverty and criticism of international organizations for failing to tackle development issues, technical cooperation among developing countries (TCDC) promoted solidarity for sustainable development through individual and collective self-reliance. WHO had supported many innovative TCDC initiatives, especially at the subregional and regional levels and on behalf of the neediest countries. The Non-aligned Movement had called for an international network of solidarity against poverty. Such an initiative would provide a unique opportunity to include TCDC in the human development framework, stressing the relevance of the primary health care strategy for poverty alleviation. The Executive Board had called for a critical analysis of the role of WHO and its regional offices in improving the effectiveness of TCDC, which would identify the major obstacles impeding such cooperation in the field of health.

Professor BERTAN (Turkey) noted that, where health was poor and there were social problems, TCDC was one of the most promising and perhaps most cost-effective tools for coping with specific needs. Each region could prepare documents describing the areas in which technical cooperation might be useful (such as disease prevention and control, research, management, human development and resource generation) and on how such cooperation could be brought about, including successful case studies. WHO should catalyse and disseminate the TCDC concept and monitor and report on how it was practised. Strengthened WHO collaborating centres could provide guidance on the identification of specific needs and the implementation of technical cooperation. Successful cooperation would encourage both provider and recipient countries to collaborate further.
Dr Morel (Brazil) suggested that WHO collaborating centres could play a much more active role in TCDC.

Dr Khoja (Saudi Arabia) endorsed the views of the Executive Board. An information system was needed to ensure cooperation among the countries of all regions, and not only among developing countries. WHO should undertake joint regional studies to reinforce cooperation for health development and should set up a committee in each region to serve as a catalyst. Exchanges of experience should be encouraged through cooperation among experts throughout the regions. WHO should also encourage joint activities in developing countries in order to reinforce programmes that were experiencing difficulties, such as those for health for all and for combating chronic, endemic, and infectious diseases.

Dr Daulaire (United States of America) stressed the importance of technical relationships among equal partners. However, the report had not clearly addressed the issue of improving TCDC. Electronic communication and consultation could make such cooperation more feasible, less expensive and more regular. PAHO had held a useful seminar in November 1995 on the subject "Rethinking technical cooperation in health", the results of which might be useful to the WHO Secretariat and to the regional offices.

Dr Bihari (India) noted that the recent realignment of global political and economic relationships made for greater emphasis on market-based economies and democratic reforms, stressing individual rights and individual responsibilities for basic needs such as health, food, housing and education. Those changes had, however, been accompanied by others, including environmental degradation and pollution, rapid population growth, unplanned urbanization and mass migration, which had significantly affected health status and contributed to morbidity trends such as the spread of the AIDS pandemic and the re-emergence of diseases like tuberculosis and malaria. Economic growth had not kept pace with the rising cost of health care, especially as technical advances in medicine and increasing health awareness had created higher expectations with regard to the level and quality of health care; at the same time, there was no substantial increase in national funding for the health sector in developing countries. As those problems transcended national boundaries, well-coordinated inter-country intervention was required, in the form of technical cooperation among developing countries. It would ensure not only the pooling of resources for health but also the sustainability of health programmes and would contribute to social and economic development.

With the second largest population in the world, India had the largest reservoir of trained health manpower; it also had developmental capacity and expertise. A number of joint ventures had been started to share those resources with neighbouring countries. For instance, India had evolved a joint strategy for controlling malaria and other vector-borne diseases along its borders with Bangladesh, Myanmar and Nepal; at a recent technical committee meeting of the South Asian Association for Regional Cooperation (SAARC) it had been decided to conduct a common "pulse polio immunization" day; and the ministers of health of the countries of the South-East Asia Region had identified eight areas for technical cooperation: control of diarrhoeal diseases, immunization, family planning, maternal and child health, nutrition, control of epidemics, essential drugs, and training of human resources in health.

Mrs Milen (Finland) commented that few of the examples of TCDC given in the report appeared to be supported by WHO. The usefulness of North-South cooperation for human development tended to be overestimated, often at the expense of South-South cooperation. The experience of countries with similar characteristics in analysing, solving and modelling problems should be shared more effectively. WHO should actively support such cooperation and ensure exchange among experts in developing countries; it should also provide more support to regional collaborating centres. She concurred with the United States delegate that new approaches were needed to use experience gained in developing countries.

Professor Pico (Argentina) said that WHO and its regions should promote horizontal cooperation among countries with similar histories, cultures and problems. Also important were subregional initiatives such as Mercosur, the trade group of four South American countries which had adopted WHO's requirements for good manufacturing practices for pharmaceutical products. TCDC should be coordinated by ministries of health in order to avoid duplication of efforts. Limited resources should be used as efficiently as possible.
so as to provide more and better treatment, and new strategies were needed to avoid the types of error that had been committed previously.

Mr CHAUDHRY (Pakistan) recognized the efforts of WHO in fostering TCDC. Pakistan had taken several steps to improve such cooperation in the South-East Asia Region in forums such as SAARC; it had also advocated more collaboration during the International Conference on Population and Development held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995.

Dr MARTÍNEZ (Cuba) said that technical cooperation was important not only for countries facing difficulties in developing health programmes but also for the spirit of the Organization and for the achievement of health goals for all countries. Health problems were not distributed equally throughout the world or within countries but had to be resolved by the international community. Country- and region-specific strategies should be supported at the country level, which should ensure optimum use of resources and of experiences to complement those of other countries and regions. A number of agreements with other countries in the Region, including arrangements for exchange of medical personnel and technical information, had allowed Cuba to optimize the use of its health resources and to increase its experience and efficiency, by focusing on problems of common interest.

Mr YANG (Republic of Korea) noted that the alleviation of poverty was a vital factor in controlling communicable diseases in developing countries. The experience of developed countries in incorporating health policies and programmes into social and economic systems could be used by developing countries. Mechanisms were needed for the exchange of such information once bilateral and multilateral cooperation practices had been monitored and compared by international organizations such as UNDP. WHO should expand TCDC in collaboration with other international and nongovernmental organizations. The Republic of Korea wished to strengthen technical cooperation in the field of health with the less developed countries of the Western Pacific Region.

Dr ANTELO PÉREZ (representative of the Executive Board) noted that delegates' comments had been consistent with the views expressed in the Executive Board, especially with regard to the need for new methods and new regional strategies. The comments had been most useful and would be taken into account in the report to the Executive Board by its representatives at the current World Health Assembly.

Dr KONÉ-DIABI (Assistant Director-General) noted that the comments had also been in keeping with the spirit of the recommendations of the PAHO seminar in November 1995 on the subject, "Rethinking technical cooperation in health".

The DIRECTOR-GENERAL commented that the ministers of health of the Non-aligned Movement would meet during the Health Assembly, as they had in 1995. WHO regulations existed for study and scientific groups, collaborating institutions and other mechanisms of collaboration (Basic documents, 40th ed., pp. 107-114). In view of the useful comments that had been made, he could review those regulations in order to ensure that they reflected global change and would report to the Executive Board and the World Health Assembly, if the delegates so wished.

The CHAIRMAN asked whether he might take it that the Committee wished to note the report of the Director-General and the progress made.

It was so decided.

The meeting rose at 12:30.
Implementing the Resolution (Progress Reports by the Director-General): Item 17 of the Agenda (Document A49/4) (continued)

Strengthening nursing and midwifery (Resolutions WHA45.5, WHA48.8 and EB97.R1)

Mrs HERZOG (representative of the Executive Board) said that the Board acknowledged nursing and midwifery as a crucial means to meet the priorities proposed in the WHO Ninth General Programme of Work. Implementation of many WHO programmes was primarily in the hands of nurses and midwives, who, as the one female health profession in most countries, were in a unique position to work with the most vulnerable groups and those with special needs. Furthermore, in many rural areas nurses and midwives were the only literate women and thus played a crucial role in the development process, often being the first to detect public health problems as they arose. They also played an important part in developing primary health care practices and a vital one in responding to emergencies, as well as contributing to the quality of care at all levels and encouraging healthier lifestyles.

A steep increase in the demands made on nursing personnel had been noted in all regions and the Global Advisory Group on Nursing and Midwifery had addressed some major issues in that context, such as the need to increase intersectoral collaboration and strengthen links with collaborating centres and nongovernmental organizations. The Director-General had been asked to provide for the continued work of the Global Advisory Group and the Executive Board had adopted resolution EB97.R1, recommending a text for adoption by the Health Assembly.

Mr CHIBAMBO (Malawi), supporting the draft resolution, proposed two amendments to it: the insertion of a new subparagraph 3(3) reading:

*to provide for the continued work of the Global Advisory Group on Nursing and Midwifery;*

and the addition to the existing subparagraph 3(3), renumbered 3(4), of the words: "and to report to the Fifty-fourth World Health Assembly in 2001".

Dr ABU HALIQA (United Arab Emirates) outlined the steps taken in her country to implement the relevant Health Assembly resolutions, emphasizing the establishment of a central administration to cover nursing in all the health institutions of the country and the formulation of a national nursing policy. According to the Director-General's report in section II of document A49/4, only a relatively small percentage of countries had taken such action. The level of education in the profession was also being raised, three new nursing schools having opened in the past three years, and a central computerized register of nurses and health personnel was being compiled. In conclusion, she supported the draft resolution and agreed with Malawi that a definite date should be set for submission by the Director-General of a report to the Health Assembly.

Ms OLSSON (Sweden) drew attention to the alarming drop of 40% in nursing posts in WHO since 1991. That must be offset by strengthening the nursing and midwifery components in WHO's various other programmes, which should be asked to report on such activities. If the stated aims of WHO and Member States in reproductive health, adolescent health and immunization were to be met, nurses and midwives must be empowered to make a cost-effective contribution. In Sweden, for example, where maternal and perinatal mortality rates were among the lowest in the world, the major components of maternal and child health care were based on nursing and midwifery. The Swedish midwife worked independently and was authorized to...
use instruments during delivery. Care was based on well-organized collaboration between nurses/midwives and obstetricians/neonatalists, though physicians were, of course, called in when medical intervention was needed.

In most Member States of WHO, nurses and midwives occupied too weak a position: governments should be encouraged to develop the health care aspects as well as the educational, leadership and research aspects of their work and Sweden therefore supported the proposed resolution, as amended by Malawi.

Dr VIOLAKI-PARASKEVA (Greece) said that national health strategies could not be implemented effectively without the participation of nurses and midwives. Nursing care would have to be expanded and modified to meet the needs of the ageing population and other vulnerable groups and take advantage of advances in technology. There must be commitment to the promotion of nursing and midwifery in all countries in order to develop health-for-all strategies, and to strengthening management and leadership among nurses and midwives at all levels. She supported the draft resolution, to which she proposed the following amendments: in the second preambular paragraph, the word "personnel" should be added after "nursing and midwifery" and the words "in the strategy of health for all" should be added after "quality health care"; in paragraph 2, a new subparagraph should be added, reading:

to strengthen nursing/midwifery education and practice in primary health care;
in subparagraph 3(1), the words "to support" should be replaced by "to increase support to"; finally, a new subparagraph 3(4) should be added, reading:

to promote and support the training of nursing/midwifery personnel in research methodology, in order to facilitate their participation in health research programmes.

Dr SIDHOM (Tunisia) expressed his appreciation of the report of the Director-General in section II of document A49/4 and his support for the draft resolution recommended by the Executive Board with a view to involving nurses and midwives more closely in health programmes and to providing improved training for them. Tunisia attached special importance to such health personnel, striving to provide appropriate training so that they could respond where necessary and ensuring that they participated in planning and management. The particular characteristics of each country should be taken into account in such activities.

Professor YU Zonghe (China) supported the draft resolution recommended in resolution EB97.R1. The report in document A49/4 emphasized that nursing and midwifery were crucial to the attainment of the goal of health for all. He expressed his appreciation of the efforts made by WHO to strengthen those services as detailed in the report.

China had always attached great importance to the subject and had established an improved nursing education system, strengthening in-service training for nurses, formulating regulations on nursing qualifications, providing for quality assurance and organizing training in management skills for nursing tutors. Community-based nursing services had been developed and wide scope was given to nurses in providing primary health care and care of the elderly.

Measures had been taken to improve nurses' salaries and their terms and conditions of employment. China was willing to collaborate with WHO in conducting technical cooperation with community-based nursing services.

Dr MWANZIA (Kenya) said that, while the Director-General's report indicated some positive results, much remained to be done in strengthening nursing and midwifery services. He therefore supported the draft resolution, with the amendments proposed by Malawi.

In its health policy framework paper of 1994 Kenya had acknowledged the contribution made by nurses and midwives, who comprised 35% of the total of Ministry of Health personnel and 60% of professional personnel; 52% were deployed in urban areas and 48% in rural areas. Strengthening that workforce had proved both cost-effective and productive. Management and leadership skills and the integration of primary health care had been introduced into nursing and midwifery training.

The Kenyan Government had reviewed the terms and conditions of service of all health personnel in 1994 and had introduced salary increases and allowances in order to maintain morale and motivation. Despite funding constraints, it had tried to provide the resources for effective health care, using the regular budget and funds generated by user fees.
Dr VAN ETTEN (Netherlands) was somewhat disturbed to note from the report that the proportion of WHO professional staff concerned with nursing and midwifery had decreased in recent years; he urged the Organization to carry out a proactive recruitment policy in order to increase their number.

In view of the importance attached by WHO to reproductive health, it should make efforts to strengthen the position of midwives, who in many countries did not enjoy the same status as nurses.

In the light of the survey data which indicated that only 4% of WHO fellowships had been awarded to nurses and midwives (document A49/4, section II, paragraph 9), he particularly supported paragraph 2(3) of the draft resolution, which urged Member States "to increase opportunities for nurses and midwives ... when selecting candidates".

Ms BETTS (United States of America) supported the draft resolution with the amendments introduced by Malawi.

She expressed particular interest in the excellent work of the Global Advisory Group on Nursing and Midwifery. She looked forward to the Group's achieving its essential strategic plan and in particular to the enhancement of the role of nurses and midwives in shaping public policy, to improved working relations between health authorities, higher education and professional associations in order to advance the role of nursing, and to greater recognition of the role of nurses and midwives in the working environment.

Resolution WHA48.8 had included a request to the Director-General to present to the Executive Board at its ninety-seventh session a report on the reorientation of education and practice of nurses and midwives. She expressed disappointment that the request had not been fulfilled.

An important benefit of nursing and midwifery was that it had traditionally been a vehicle for women's social advancement. The significance of the profession therefore extended beyond the provision of high-quality, cost-effective health services into the broader sphere of the well-being of women and their families. It was gratifying to see that the subject was being considered by the Health Assembly.

The number of nurses and midwives should be increased throughout WHO, in order not merely to augment the number of women employed by the Organization, but also to enhance the ability of WHO to focus on the health needs of individuals, families and communities.

Mrs TAPAKOULE (Cyprus) commended the steps taken to strengthen nursing and midwifery, most notably the development of a regional plan of action by the regional Nursing Advisory Panel with the assistance of the Regional Office for the Eastern Mediterranean and WHO headquarters. The plan promoted education, nursing leadership, health systems research capability and the effective use of available nursing resources.

She supported the draft resolution with the amendments proposed by Malawi.

Mrs ARAYA UGALDE (Costa Rica) gave her full support to the draft resolution with the amendments proposed. Nurses and midwives made an important contribution to the teams working to solve individual, family and community health problems. In Costa Rica, thanks to the organization and leadership of nursing services, very satisfactory health indices had been obtained, an example of which was the 95% immunization coverage achieved for children 0-5 years old in 1995. The training of personnel had allowed great progress to be made in modernizing the health sector.

Mrs MONTELL (Finland) said that as nurses and midwives represented the largest group of health care personnel, it was important to use the capabilities of that educated work force in the current process of health sector reform. It was essential for nursing to be included as a core component in all WHO programmes.

Finland supported the draft resolution, with the amendments proposed by Malawi.

Dr JEAN (Canada) supported the draft resolution recommended by the Executive Board, with the amendments proposed.

The world health report 1996 highlighted the need for immediate and concerted action on critical health problems. It was evident that in order to achieve the goals of WHO programmes, human resources in the health sector would have to be reinforced and deployed more effectively. Although some progress had been made, nursing and midwifery personnel were still not used to their full potential in many countries. The world health report pointed to the need to strengthen primary health care and target prevention of disease and
promotion of health: nursing and midwifery services could make a substantial, cost-effective contribution to those priorities.

The dramatic reduction of nursing and midwifery staff in WHO was a cause for serious concern. Without the resources and programme structures of WHO for the support of Member States, their modest health gains since 1992 would not be sustainable. She urged WHO to continue, and to increase where necessary, investments in nursing and midwifery and to ensure that the nursing programmes at WHO headquarters were carried out in close collaboration with the WHO representatives in Member States in order to coordinate and deploy nursing and midwifery human resources in response to health needs.

Dr SILVA (Brazil) lent her full support to the resolution recommended in resolution EB97.R1, with the amendments proposed by Malawi.

Dr MTSHALI (South Africa) also supported the draft resolution with the amendments proposed by Malawi.

Nurses and midwives were essential to the attainment of health for all by the year 2000 and she noted with concern the scant recognition accorded to them. The life of the Global Advisory Group on Nursing and Midwifery should be extended to the year 2001 so that it could continue to provide guidance to countries in developing a comprehensive strategy. That would allow for an evaluation of how curricula could be made more responsive to changing needs in terms of health care service delivery and human resource development. The utilization of nurses as equal partners in multidisciplinary teams at all levels (as clinicians, managers and policy-makers) should also be assessed.

Mr ONIŠČENKO (Russian Federation) said that the Director-General’s report showed that a great deal of work had been done by the Organization to strengthen nursing and midwifery. WHO had achieved concrete results in reinforcing the role of nurses and midwives in national health systems. Professional training for midwives and senior nurses had been improved in the Russian Federation. That important work needed to be continued and constantly reviewed in the light of the rising demand for highly qualified nursing and midwifery personnel. Some areas should be given priority in the process, such as the quality of services provided, although problems would vary depending on the state of development of the health services in different countries. His delegation supported the draft resolution recommended in resolution EB97.R1.

Ms GREW (New Zealand) supported the draft resolution and the amendments proposed by Malawi. New Zealand favoured the strengthening of nursing and midwifery as a means of improving access to health care. Countries needed to find new ways of reducing health care costs, and one way of doing so was to expand the scope of nursing practice; there was evidence that such an expansion, if carefully planned, was welcomed by consumers. The quality of the health care delivered by nurses was equal to that provided by other health personnel, and a World Bank report of 1993 had also found it to be cost-effective.

Because nursing was in general a mainly female profession and nurses tended to suffer from sexual discrimination, WHO should be seen to be offering nurses its support. That would be in line with efforts to promote the participation of women in the work of WHO, a subject which was to be dealt with under item 26 of the agenda.

Nurses must play a greater role in policy-making, and for that they must develop leadership skills, which would in turn give them greater confidence. Guidelines for the development of such skills were currently being worked on by a small group of nurses’ leaders in New Zealand, and were to be widely disseminated.

Mrs MOORES (United Kingdom of Great Britain and Northern Ireland) said nurses and midwives were crucial for the implementation of WHO’s health-for-all strategy, as well as for the delivery of its Ninth General Programme of Work; they could bring about substantial improvements in the health status of peoples throughout the world.

The United Kingdom had implemented a national plan of action for nursing and midwifery, and welcomed WHO’s support for similar plans in other countries. Since nurses were in general under-
represented in key policy positions, she would like to see more of them in such positions in the Organization itself, both at headquarters and in the regions.  

Her country strongly favoured continuation of the Global Advisory Group. The strategic plan developed by the Group, with its focus on research, legislation, human resource planning, education and leadership, would contribute to further improvements in the status of nursing and midwifery.  

The United Kingdom strongly supported adoption of the draft resolution, together with the amendments proposed by Malawi.

Dr SHAFEI (Egypt) said nurses and midwives not only made a vital contribution to primary health care, but had also proved their worth in diarrhoeal disease control and immunization programmes; it was thanks to the work of nurses that Egypt now enjoyed 94% immunization coverage. However, the country needed more resources to train nursing staff if it was to reach the goal of health for all by the year 2000. Egypt therefore supported the draft resolution and the amendments proposed by Malawi.

Mr CHAUHAN (India) said the report rightly emphasized the important role played by nurses and midwives. There was urgent need for the services they provided to be strengthened if the goal of health for all was to be achieved. With that end in view, India had decided to create senior positions for nurses at national level, and to strengthen the unit concerned in the Ministry of Health and Family Welfare so as to provide a focal point for strengthening nursing training, practice, administration and management. The nursing curriculum was being revised to make it better able to meet the country’s needs, and 10 more nursing schools were being set up in order to achieve a better nurse/patient ratio. A programme had also been launched to upgrade nurses’ knowledge and skills, and training programmes at nursing schools abroad were also being organized under the WHO fellowships programme. Despite the large number of nurses being trained, however, the nurse/doctor ratio continued to be adverse, partly because demand exceeded supply and partly because many trained nurses were emigrating to other countries.

He was therefore glad to support the draft resolution and the amendments proposed to it.

Dr WINT (Jamaica) noted that paragraph 10 of section II of document A49/4 referred to shortages of nurses and midwives. In countries such as his own the shortage, caused in part by the continued brain-drain, had reached proportions which threatened the viability of the health care system. Jamaica had adopted a three-pronged strategy. In the short term, it was continuing to seek technical assistance, for which it wished to thank the Governments of Ghana, Japan and Nigeria. In the medium term, it was intensifying training programmes and had quadrupled the number of nursing and midwife graduates, although more tutors were still needed. In the long term, it was developing a strategic plan for human resource development in the health field, with the help of WHO.

He supported the draft resolution and proposed amendments.

Mrs MANYENENG (Botswana) said that in her country the nurse was the backbone of the health care delivery system. Nurses formed the majority of health cadres and were working in every part of the country, including the most remote rural areas. The role of midwives was crucial, notably in implementing the Safe Motherhood Initiative; after retraining, they had demonstrated their ability to perform tasks previously reserved for specialists. Nurses not only played a valuable role in helping to tackle Botswana’s unacceptably high maternal mortality rates, but were also in the forefront of all other preventive programmes, notably the expanded programme on immunization. Botswana was now reorganizing its nursing education system, giving particular emphasis to managerial and leadership skills.

She too supported the draft resolution and the amendments proposed by Malawi.

Dr VASSALLO (Malta) said his country in recent years had made every effort to improve the education and training of nurses and midwives. More attractive salary scales had been offered, a media campaign had been launched to boost their image, and a new management structure, which was to be headed by a director of nursing, had been introduced. Major recruiting campaigns had also been carried out, and nurses and midwives were increasingly being involved in policy-making and decision-making.

While he supported the draft resolution, including the amendments proposed, he did not fully understand why in the third preambular paragraph three conferences were singled out for special mention in
preference to matters that were more pressing and more directly relevant to nursing and midwifery. He therefore proposed that, after the paragraph in question, a new preambular paragraph should be inserted reading:

Concerned about the emergence of new diseases and the re-emergence of old diseases, as highlighted in *The world health report 1996*.

Professor ÜLKER (Turkey) said her country considered nurses and midwives as key health personnel, particularly in regard to the implementing of health reforms which laid emphasis on primary health care. She therefore strongly supported the draft resolution and the amendments proposed by Malawi.

Dr GREEN (Israel) said his country was promoting the role of nurses as key personnel in the surveillance and control of nosocomial infections, which were increasing in importance with the rapid rise in the frequency of antibiotic-resistant organisms and the incidence of emerging infectious diseases. He strongly supported the draft resolution and the amendments proposed by Malawi.

Dr DINARVAND (Islamic Republic of Iran) said the draft resolution was consistent with the work currently being carried out in his country to strengthen the role of nurses and midwives. However, he believed that nurses and midwives also needed to be more involved in the development of health policies, which in his view should be community-oriented rather than global.

He therefore urged WHO to promote and support community-oriented nursing and midwifery, and supported the draft resolution as amended.

Ms MOLAPO (Lesotho), endorsing the draft resolution with the amendments proposed by Malawi and Greece, said that creation of new posts for nurses and midwives within WHO at headquarters, regional and country level, with equitable and fair distribution of posts among the regions, would be welcomed. The noble profession of nursing and midwifery had been placed at a disadvantage in recent years, being excluded from the decision-making process; in reality health had to be based on a team approach. In Lesotho, nurses and midwives were the spearhead of the Safe Motherhood Initiative and the Child Survival Programme; the draft resolution thus gave a timely message.

Dr CICOGNA (Italy) joined previous speakers in noting that an effective health system needed the full involvement of an efficient and competent nursing and midwifery service. That was a requirement particularly felt in Italy, where the ratio of nurses to medical practitioners was very poor.

He endorsed the draft resolution with the amendments proposed by Malawi. The Global Advisory Group on Nursing and Midwifery had proved of considerable assistance to most countries in their efforts to enhance the importance and status of nursing and midwifery in the health sector.

Mrs RINOMHOTA (Zimbabwe) said that nurses and midwives accounted for 80% of health workers in Zimbabwe; as a group they had been sadly neglected for some time. Following adoption of the concept of primary health care, they had willingly expanded their role to include provision of total health care in the absence of specialist staff. A needs assessment carried out in the context of strengthening nursing and midwifery had led to activities to enhance expertise in education, practice, research and management in the field.

With government support, nurses and midwives had been afforded the opportunity of further study leading to a degree to enable them to promote quality health care at community level. Criteria had been developed by which to monitor and evaluate nursing and midwifery standards. Curricula had been reviewed with a view to giving nurses and midwives the skills essential for provision of primary health care.

Zimbabwe endorsed the draft resolution with the amendments proposed.

Dr LEGNAIN (Libyan Arab Jamahiriya) said that an efficient health service could not be achieved unless nurses and midwives participated in the formulation of health policy. The strengthening of nursing and midwifery was both urgent and essential, especially in countries with severe shortages of such staff, where national plans to make good the deficit were needed. Increased cooperation among different sectors
was also needed. The Organization should increase the number of its posts for nurses and midwives and enhance its follow-up activities aimed at strengthening nursing and midwifery.

She endorsed the draft resolution with the amendments proposed by Malawi and Greece.

Professor PICO (Argentina) associated himself with those speakers who had stressed the importance of nursing and midwifery personnel. As part of the wide-ranging health reform at present under way in Argentina, particular attention was being paid to primary health care in order to promote universal access to health services. Participation of nurses in the health team was an essential component of the strategy. A national coordinating committee representing all areas of nursing training and employment had been established to supervise development of human resources in the nursing field, thus emphasizing the importance of nursing staff and ensuring their full democratic participation in the changes to come.

He endorsed the draft resolution

Dr VARGA (Hungary) said that policy-makers in Hungary, recognizing the key importance of nursing for improving the quality of preventive care and of health care delivery, had involved nurses' and midwives' organizations in the process of reform of the health care system, accepting them as equal partners in strategy planning and implementation.

She warmly endorsed the draft resolution with the amendments proposed.

Mrs AL-SHARRAH (Kuwait) said that a nursing administration was in charge of the provision of nurses in Kuwait. Midwives were not trained separately; nurses received specialized midwifery training following their graduation from nursing training.

She too endorsed the draft resolution.

Mrs AL-SHAIKH (Bahrain) also endorsed the draft resolution, noting the importance of nurses and midwives for improving health care. A deadline ought to be set for review of progress in its implementation and for assessment of the obstacles confronted by countries in applying it.

Dr MUÑOZ (Chile), endorsing the draft resolution, said that in all health systems the central imperative was to develop human resources, the frequent shortage of which was a cause for concern. Among the means that would help to overcome the shortages and improve the quality of health care was the provision of appropriate monetary and other incentives to foster recruitment, reward merit and experience, and encourage staff to improve their qualifications. Attention should also be paid to improving working conditions.

Nurses and midwives, whose qualities were all too often disregarded, were essential to any effort to improve a health system in view of the direct contact they had with those seeking health care. They played a vital part in ensuring the effectiveness of primary health care and hospital services.

Mrs HOMASI (Tuvalu) said that nurses and midwives formed the bulk and backbone of health care services in Tuvalu. Their role needed to be strengthened at clinical, managerial and policy-making levels. She strongly endorsed the draft resolution, with the amendments proposed by Malawi and Greece, and shared the views expressed by the delegate of New Zealand.

Dr MANGUELE (Mozambique) said that nurses and midwives continued to form the bulk of health professionals in Mozambique, ensuring the quality of promotive, preventive and often curative health care. He therefore strongly endorsed the draft resolution with the amendments proposed by Malawi.

Dr KIMAMBO (United Republic of Tanzania), endorsing the draft resolution with the amendments proposed by Malawi, said that recognition by the Health Assembly of the importance of nurses and midwives to health care delivery was gratifying. Nurses and midwives made up the largest single group of health professionals in her country. Their role in primary health care was recognized and they had been involved in the preparation of proposals for reform of the health sector. Nurses were members of regional and district health management teams. Training opportunities at undergraduate and postgraduate level had recently been increased. Despite such developments, however, there were still few nurses or midwives in high decision-
making positions. Greater support was needed to develop their managerial skills. WHO was requested to continue its support for capacity-building in the form of technical assistance and training.

Dr KIHUMURO-APULI (Uganda) endorsed the draft resolution. A number of steps had been taken in Uganda to strengthen nursing and midwifery services. In April 1996, Parliament had adopted a revised Nursing and Midwifery Act that would increase the decision-making capabilities of nurses. A university degree course in nursing had been introduced two years previously. With a view to strengthening the country's nursing services the post of Chief Nursing Officer had been raised to the Commissioner level. Vigorous steps were being taken to improve the working conditions of nurses and midwives in pursuance of civil service reform.

Mr HARALDSSON (Iceland) said that nurses and midwives in Iceland played an important part not only in health care delivery but also in management and policy-making. The incumbent Minister of Health was in fact a nurse. Iceland endorsed the draft resolution.

Ms ASHTON (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said the Confederation welcomed the attention given to the strengthening of nursing and midwifery by some countries since the adoption of resolutions WHA45.5 and WHA48.8. The support provided by the Organization through its nurses and midwives and through regional projects was opening the way for a comprehensive approach to a sustainable health care policy.

From the Director-General's report it was apparent that, although nurses and midwives formed a high percentage of the total number of health care personnel, they were often among the lowest in status, inappropriately deployed and inadequately prepared for the roles they undertook. Country reports showed inequalities in the attention paid to midwifery in relation to nursing with the result that midwifery services had declined. Raising the profile of midwives and midwifery at country level was essential to secure the health and well-being of mothers, babies and families. Research around the world had shown that good outcomes for mothers and neonates were directly related to the provision of care by personnel with midwifery skills.

Since 1987, the Confederation had worked closely with WHO to reach the Safe Motherhood Initiative's goal of reducing the maternal mortality rate by 50%. WHO and many Member States acknowledged that there was still much work to be done if that and other goals in reproductive health were to be attained. WHO had recognized the significant contribution which midwives, as key workers in communities in the field of reproductive health, could make to reaching the overall goal. The time had come to give that recognition extensive practical expression in order to raise awareness, establish appropriate legislation and improve the level of education of midwives. In addition, conditions of service must be improved to secure an efficient and flexible midwifery service capable of meeting the changing needs of women through their childbearing years.

The Confederation urged the Health Assembly to endorse the draft resolution with the amendments proposed by Malawi so that the valuable work already under way could be further developed, particularly in the field of midwifery education; it also suggested that the Organization should further strengthen midwifery in its programmes on human resources for health, especially at regional level.

Dr MADDEN STYLES (International Council of Nurses), speaking at the invitation of the CHAIRMAN, found it deeply gratifying that so many delegates had spoken in support of nursing and midwifery. The International Council of Nurses particularly appreciated the partnership approach to health which was evident at WHO headquarters and within Member States, with a view to achieving common goals despite health care reform and cost restraints. One of those shared goals was to strengthen nursing as a means to achieving health for all. Examples of collaboration between WHO and the Council included: a programme to assist nurses in acquiring leadership skills in a changing health environment, the setting of standards of nursing practice, and the establishment of regulatory mechanisms enabling nurses to perform to their greatest potential. At the Forty-fifth World Health Assembly, in 1992, unanimous support had been expressed for resolution WHA45.5, on nursing/midwifery, and concern voiced about the limited nursing resources within WHO. The International Council of Nurses had considered that emphasis must be laid on nursing as an essential service rather than on the profession, and had called for sufficient resources to ensure
nursing input at programme and committee levels. The Director-General’s report showed that the overall number of filled WHO midwifery positions had decreased by 43%, from 46 in 1991 to 26 in 1996 - figures which should be considered in relation to the total complement of WHO staff. In 1992 it had been reported that nurses represented approximately 3.2% of the professional positions throughout WHO, a proportion which had now fallen to 1.6%; that trend was inconsistent with the 1992 Health Assembly resolution. She recommended wise use of resources focused on specific targets. She therefore fully endorsed the amendments proposed by Malawi.

She emphasized the value of the Global Advisory Group on Nursing and Midwifery, which had recently developed a strategic plan focusing on factors that would enable nursing to make a maximum contribution to global health goals. It was vital that monitoring by the Health Assembly should continue, especially over the next six years, to ensure that the strategic plan was observed and was productive. The International Council of Nurses recommended adoption of the draft resolution with the proposed amendments.

Professor MASSOUGBODJI (Benin) said that a training programme for medical, surgical and obstetric supervisors in her country’s national university hospital centre, designed to improve the management of nursing and obstetric care, had in effect brought about an improvement in the quality of care in those services. Her delegation therefore fully supported the draft resolution, which echoed to her country’s concern.

Mrs HERZOG (representative of the Executive Board) said that the amount of interest expressed on the question under discussion, both in the Health Assembly and in the Executive Board, reflected the importance attached to the role of nursing and midwifery in health development throughout the world.

Dr KONÉ-DIABI (Assistant Director-General), referring to remarks made in the discussion about the drop in the proportion of nurses occupying posts in the professional category in WHO, said the situation was being reviewed in order to overcome difficulties and to take a more innovative approach. As part of the restructuring of the services concerned, a special interdivisional group on nursing care was being established, with the chief scientist responsible for nursing serving as the focal point. The group’s purpose was to make the best use of the available skills and competences in a coordinated and synergetic approach to the development of nursing and midwifery. Post descriptions for health professionals were being revised so that nurses and midwives would be encouraged to apply for positions in WHO. The Director-General and the Regional Directors would give their full support to those measures, which reflected the increasing importance of the role of nurses and midwives for the development of health systems.

Dr HIRSCHFELD (Nursing), replying to the United States delegate concerning the report on the reorientation of education and practice for nurses and midwives called for in resolution WHA48.8, drew attention to paragraph 9 in section II of document A49/4, which summarized the changes in education reflected in a survey to which replies had so far been received from 150 countries - a 79% response rate. At its ninety-eighth session, in a few days’ time, the Executive Board would be reviewing the report of the WHO Expert Committee on Nursing Practice. Further details on the reorientation of education and practice would be provided at the ninety-ninth session of the Executive Board in January 1997, if the United States delegate so desired.

The draft resolution recommended by the Executive Board in its resolution EB97.R1, with the various amendments proposed, was approved.¹

The meeting rose at 16:50.

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA49.1.
FIFTH MEETING
Thursday, 23 May 1996, at 9:00
Chairman: Professor B. SANGSTER (Netherlands)

1. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4) (continued)

Revised drug strategy (Resolutions WHA47.13 and EB97.R14)

The CHAIRMAN drew attention to the draft resolution, on the revised drug strategy, recommended by the Executive Board in resolution EB97.R14.

Further, the following draft resolution, on the quality of biological products moving in international commerce, was proposed by the delegations of Argentina, Australia, Bahrain, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Ecuador, Egypt, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Morocco, Namibia, Nicaragua, Peru, Togo, United States of America, Uruguay and Venezuela:

The Forty-ninth World Health Assembly,
Noting the increasing movement across international boundaries of vaccines and other biological and biotechnological products aimed at prevention and/or treatment of diseases, together with the rapid development and introduction into public health programmes of medicines produced by modern biotechnology;
Recalling previous resolutions of the Health Assembly mentioning the vital need to ensure the quality, safety and efficacy of both established and new biological products;
Bearing in mind the responsibility of governments to ensure that biological products, whether imported or manufactured locally, are of good quality;
Recognizing the specialized technical expertise needed for evaluating and controlling biological products;
Recalling the role of WHO in coordinating technical assistance to countries from various sources, including assistance given on a bilateral and multilateral basis, and aware that, according to its Constitution and the decisions of previous Health Assemblies, WHO’s coordinating role is one of its most important functions,

1. URGES all Member States:
   (1) to use only vaccines and other biological products of recognized and certified quality, safety and efficacy and to adopt WHO requirements as part of their national regulations or to ensure by national regulations that products are at least as safe and as potent as those prepared in accordance with the requirements of WHO;
   (2) to strengthen their national regulatory authorities and national control laboratories;

2. REQUESTS the Director-General:
   (1) to strengthen the mechanisms for providing clear norms and active leadership to guarantee the quality, safety and efficacy of biological products;
   (2) to ensure that the importance and global effectiveness of WHO’s biological standardization programmes is given the greatest attention and that decisions taken by the WHO Expert Committee on Biological Standardization are widely disseminated in good time;
   (3) to keep Member States informed of the development of new biological products and of their potential value and application;
(4) to extend the assistance offered to Member States within the limits of existing resources to develop and to strengthen their national regulatory authorities and control laboratories so as to increase their competence in this area.

In his own opinion, the importance and complexity of the drug regulatory issues raised in the second draft resolution were such that the Committee should hear expert opinion in order to be able to discuss the content satisfactorily.

He invited the Committee to begin by considering the draft resolution recommended in resolution EB97.R14.

Dr ANTELO PÉREZ (representative of the Executive Board), introducing the draft resolution, explained that the Board had reviewed the revised drug strategy, including the role of the pharmacist, in the light of resolutions WHA47.12 and WHA47.13. Members had praised the success of the Action Programme on Essential Drugs and had welcomed the news that 60 countries were implementing a national drug policy while 120 countries had a national list of essential drugs. The Board had agreed on the need for WHO to continue its work on ethical criteria for drug promotion.

The importance of national pharmaceutical policies could not be overestimated, and a greater effort must be made to ensure the rational utilization of drugs. The use of generic names was vital for rational use and also reduced drug costs.

The Board considered that pharmacists had an important role to play in assuring drug quality and in performing certain regulatory functions, as well as in supplying information on the appropriate handling of drugs. It had expressed concern regarding the importation of low-quality drugs and the lack of adequate quality control of industrially produced drugs, emphasizing WHO’s responsibility in the promotion of appropriate manufacturing practices. Other topics discussed had been the privatization of the purchase and sale of drugs, the trend towards drug deregulation, the growing importance of drugs in the financing of health care, the provision of assistance to countries establishing national pharmaceutical enterprises, the advisability of making extensive use of WHO’s recommendations on pharmaceutical legislation, and the considerable value which recommendations for the fixing of drug prices would have for a number of countries.

Dr MILLER (Barbados), speaking as one of the original sponsors of resolution EB97.R14 in the Executive Board, said that after consultations with delegates to the current Health Assembly and with other members of the Executive Board it had been felt that the draft resolution recommended in it could be strengthened by making some of the statements in the operative section more explicit and by adding some paragraphs. There were several proposed amendments. First, a new paragraph 1(4) should be added, reading:

- to establish and strengthen as appropriate programmes for the monitoring of the safety and efficacy of marketed drugs;

the remaining subparagraphs being renumbered consequentially. Secondly, paragraph 2(4) should be replaced by:

- to disseminate the interagency Guidelines for Drug Donations produced by WHO in May 1996 and to encourage, in collaboration with all interested parties, its use and review after one year.

Thirdly, paragraph 2(5) should be replaced by a new text reading:

- to strengthen market intelligence, review in collaboration with interested parties information on prices and sources of information on prices of essential drugs and raw materials of good quality, and provide this to Member States.

Fourthly, a new paragraph 2(7) should be added, reading:

- to continue the development and dissemination of information on pharmaceutical products, thereby assuring the safe, effective and rational use of drugs.

Paragraph 2(7) would accordingly be renumbered 2(8).

Dr LUETKENS (Germany) said that in his country drugs intended for export were generally subject to the rules prohibiting the marketing of unsafe drugs and were protected against fraud, although exceptionally drugs that did not meet the necessary requirements might be exported if the competent authority in the country of destination had issued an import authorization indicating that it was well informed of the grounds on which marketing had been refused in Germany. In addition, Germany participated in WHO’s Certification
Scheme and was therefore willing to provide the importing country with information on the status of the marketing authorization and the correctness of the manufacturing procedure and to confirm that information by a certificate. Considerable use was made of that possibility.

The pharmaceutical industry had a self-regulation code for marketing, especially in developing countries, making it obligatory to provide exact, proper and objective information on pharmaceutical products and to describe them in such a way that the information given complied not only with the legal requirements but also with ethical principles. Any criticism of the marketing strategies of individual companies abroad was to be submitted to the management of the pharmaceutical enterprise concerned, which, by virtue of its membership in the self-regulation system, had undertaken to ensure that the code was complied with.

His delegation supported the draft resolution recommended in resolution EB97.R14.

Professor PICO (Argentina) said that it was very important that WHO should continue to promote the rational use of drugs. The progress made by the Action Programme on Essential Drugs was most welcome. Valuable support received from WHO for the development of Argentina’s national food, drugs and medical technology administration was already having a positive effect on the country’s health activities, especially the control of drugs and biologicals. WHO had not only helped with the design and start up but was also providing continuing technical assistance and making periodic assessments of the performance of an agency which had been placed at the disposal of the subregional marketing authority Mercosur.

The drug programme had been one of WHO’s most successful undertakings over the past few years. In order to adapt it to the new world situation, its activities should be strengthened in the light of current knowledge of health economics. The essential drug concept had constituted an important support for health sector reform, which should be continued with new strategies. For that reason Argentina was among the 26 Member States sponsoring the draft resolution on the quality of biological products moving in international commerce to which the Chairman had drawn attention. Being absolutely convinced of the vital need to guarantee quality, safety and efficacy in drugs and biologicals, Argentina also supported the draft resolution recommended by the Executive Board in resolution EB97.R14, as well as the amendments to it.

The CHAIRMAN said that any support expressed for the draft resolution recommended by the Board would be taken to include support for the amendments proposed by Barbados.

Dr NIGHTINGALE (United States of America) said that the brief report on the implementation of the revised drug strategy demonstrated that substantial progress had been made in the work of WHO’s various pharmaceutical components, both the normative components and those concerned with technical cooperation. The United States Food and Drug Administration especially valued the emphasis given to safety, quality and efficacy and appreciated the high standard and practical utility of the information-sharing documents and of the helpful articles that appeared in drug bulletins and circulars.

He strongly endorsed the amended form of the draft resolution contained in resolution EB97.R14, which presented a very appropriate series of recommendations to be implemented by Member States and by the Director-General.

Mr GARCÍA (Spain) said that his delegation fully supported the draft resolution recommended by the Executive Board but wished to make a few minor amendments to it. First, paragraph 1(3) should be amended to read:

to enhance drug regulatory mechanisms and mechanisms for the inspection, surveillance and control of drug quality and safety;

which would cover the full range of requirements that a drug ought to meet. Secondly, somewhere in paragraph 2 a new subparagraph should be added requesting the Director-General "to encourage the regulation of appropriate conditions for the storage and distribution of drugs". Finally, another new subparagraph requesting the Director-General to encourage research and development in respect of drugs for rare and tropical diseases should also be added in paragraph 2.

Dr SHAFEI (Egypt) supported the draft resolution as amended. Egypt had 24 indigenous pharmaceutical companies, whose production met 94% of local requirements, with strict quality controls. WHO had an important role to play in supervising measures to control the activities of pharmaceutical
companies. The Organization should provide assistance in the search for and development of drugs for rare diseases, as well as helping to ensure that the stocks of drugs required to deal with sudden epidemics could be made speedily available. It was very important that health authorities in developing countries should be provided with adequate information about the drugs they intended to use. His country supported the use of nonproprietary drug names and the preparation of pricing protocols.

Dr VIOLAKI-PARASKEVA (Greece) said that, as part of its revised drug strategy, WHO should provide operational support for national drug policies based on essential drug programmes. The promotion of education and training for health workers and the public was particularly important. She supported the draft resolution recommended by the Executive Board, as amended, but proposed two further changes: the addition of a new preambular paragraph reading:

Recognizing with satisfaction the increasing awareness of all parties concerned of their responsibilities in the implementation of the revised drug strategy; and the amendment of paragraph 1(2) to read:

to increase efforts to promote the rational use of drugs through intensification of training and education of health workers and the public.

Mr CHAUHAN (India) said that the Federal Government of India developed the legislation governing drug regulation, while the state governments were responsible for its enforcement. India had produced pharmaceuticals to the value of 700 million rupees in 1992-1993, and output was likely to reach a value of 1600 million rupees by the year 2000. A number of measures were planned to improve drug regulation, including the establishment of six new regional drug testing laboratories and a national drug authority, which would be responsible for new drugs, updating the essential drugs list, monitoring adverse drug reactions, controlling clinical trials and similar activities. A National Institute of Biologicals was being set up to supervise quality-testing of vaccines, blood and blood products, and laboratory reagents.

The Indian Ministry of Health and Family Welfare had recently compiled a national essential drugs list of approximately 300 drugs. Standards designed to improve the quality of drugs used in traditional medicine were also planned. He supported the draft resolution, as amended.

Mr AMEDON (Togo) supported the draft resolution, with one further amendment, to the original paragraph 1(5), which would read:

to eliminate inappropriate donations of drugs and adopt national regulations governing other types of donation.

Dr LOSSEV (Russian Federation) supported the draft resolution with the amendments proposed by Barbados and Spain, although they would slightly widen the scope of the activities of the Action Programme on Essential Drugs.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) noted with satisfaction that the interagency Guidelines for Drug Donations acknowledged that the wishes of potential recipients of drug donations must be taken into account. The amendment to paragraph 2(4) called upon the Director-General to collaborate with all interested parties in a review of the guidelines in 1997.

The United Kingdom was concerned to ensure that any information on the prices of drugs and raw materials which was approved by WHO was confined to drugs and materials that were of good quality and up to date. A list currently available on the World Wide Web and supported by the Action Programme on Essential Drugs included drugs and materials which appeared to be based on a pharmacopoeia that was nearly 10 years old. It would be helpful to know when that list would be updated. He supported the draft resolution, as amended by Barbados and with the following further amendment to operative paragraph 2(5): "... prices of essential drugs and raw materials of good quality, which meet current requirements of internationally recognized pharmacopoeias or equivalent regulatory standards, and provide this information to Member States".

Dr RABESON (Madagascar) said that his country had developed a national pharmaceuticals policy with the assistance of WHO, France, Germany and Switzerland. The World Bank and the European Union had
helped to set up a central purchasing authority for drugs and medical supplies. Prescribing guidelines had been drawn up, and some physicians had received special training in pharmacology. He supported the draft resolution recommended by the Executive Board.

Mr NGEDUP (Bhutan) also expressed support for the draft resolution, as amended.

Mr CHIBAMBO (Malawi) said that his country had adopted a national drug policy in 1991, instituting a systematic approach to the choice of medicines in the public sector. A national quality control laboratory assessed the quality of drugs before they were approved for use, using the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce and other protocols. An independent drug regulatory authority, the Pharmacy, Medicines and Poisons Board, was now fully operational. A task force of police and customs officers had been set up to curb the import of illegal drugs, and many drug dealers had been arrested. The Government was considering how best to overcome the shortage of personnel in the pharmaceutical industry. Other problems facing the Government were the difficulty of obtaining narcotic drugs, even in emergencies, and the provision of instructions for the use of donated drugs only in a foreign language. Such problems were dealt with in the draft resolution, which Malawi endorsed.

Ms STEGEMAN (Netherlands) said that the Director-General’s progress report (document A49/4, section III) provided no information on the important subject of drug donations. The Netherlands supported a campaign conducted by a number of nongovernmental organizations to inform both the Netherlands public and the pharmaceutical industry about the adverse effects of drug donations. She supported the interagency Guidelines for Drug Donations, and hoped that the Organization would be involved in their implementation. It was important to ensure that possible loopholes in the guidelines were not exploited, such as the donation of drugs which did not appear on the WHO essential drugs list or the waiving of authorization in advance for drug donations in emergencies.

She supported the draft resolution, as amended, on the understanding that "market intelligence" in the amended paragraph 2(5) covered pricing mechanisms. She suggested the inclusion after paragraph 1(2) of a new paragraph reading:

to promote efforts to adopt legislation concerning national essential drugs policies.

Dr DINARVAND (Islamic Republic of Iran) said that, although his country produced 97% of its medicines, it had to import most of the pharmaceutical raw materials needed for their formulation; that was very expensive, so he considered it important to retain the original text of paragraph 2(5) of the draft resolution, which requested the Director-General "to determine ways to monitor and report on prices and pricing mechanisms for essential drugs and raw materials". His Government subsidized the sale of medicines, which were made available at very low cost; as a result it was having problems with overconsumption, which had financial implications, and there were also side-effects associated with the unnecessary use of drugs. His country was experimenting with setting up prescription control committees in all provinces, which provided information to prescribers reminding them of the content of prescriptions. The measure had been found to be very effective in reducing drug consumption and encouraging the rational use of drugs. His country had adopted a national drug policy based on essential drugs and the generic concept 17 years ago, and it had ensured equitable access by all people to essential drugs. The Islamic Republic of Iran was very much concerned about the impact of the World Trade Organization on pharmaceutical industries in developing countries, and proposed that the resolution should be amended to include an additional subparagraph to paragraph 2, which would read as follows:

to report to the Fifty-first World Health Assembly on the impact of the World Trade Organization on national drug policies based on essential drugs and generic concepts.

Dr OPOLSKI (Poland) welcomed the Director-General’s progress report on the implementation of the revised drug strategy (document A49/4, section III) but said there was still an imbalance between commercially produced drug information and the information made available to prescribers and consumers; in some countries that could have an unfavourable impact on the fulfilment of existing drug policies. While supporting the draft resolution recommended by the Executive Board and the various amendments proposed at the current meeting, Poland was particularly interested in developing a clear strategy for the review and
assessment of the effectiveness of WHO's Ethical Criteria for Medicinal Drug Promotion, and was ready to collaborate closely with WHO thereon.

Mr FREIJ (Sweden), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), said that WHO's normative and advocacy functions in the development of national drug policies had to be maintained and strengthened; that was a crucial matter at a time of changing health care systems and greater decentralization and privatization. The Organization could support Member States with guidelines, based on sound evidence, on the various elements of national drug policies including safety, quality, rational use and ethical promotion. That required analysis and evaluation of the various mechanisms that existed, and the comparative drug policy analysis project in nine countries was an important step in that direction. As was stated in the draft resolution recommended by the Board, enforceable drug legislation was urgently needed in many countries, since there continued to be an imbalance between commercially produced drug information and independently validated information on drugs for prescribers, dispensers and consumers. Systems had to be put in place to monitor the safety and quality of drugs and to implement the WHO ethical criteria and norms. The Nordic countries looked forward to the report on the multi-country participatory evaluation of WHO's Ethical Criteria for Medicinal Drug Promotion, to be presented to the Executive Board in January 1997. They were, however, concerned that WHO's drug programmes in some sense stood at a crossroads: there were requests for assistance to be given to more countries in implementing essential drug programmes according to well-established and successful guidelines, but on the other hand the world was changing and new situations had to be faced. WHO must be able to develop technical excellence in its normative functions within strategic areas.

Paragraphs 2(4) and 2(5) of the draft resolution were important, since access to reliable price information on quality-assured raw materials was essential for the local pharmaceutical industries of many countries. Broad-scale implementation of the strategy of rational use of drugs required partners, not least among them the World Bank. Maintaining standards of excellence was a prerequisite for productive partnerships, so WHO must continue to invest in research and development. Resources being limited, it was necessary to select the agenda for action carefully; the Nordic countries fully agreed that the design and implementation of drug policies on normative functions should be a primary focus of the Organization in the years to come. Available financial and programme resources within the two divisions concerned should be used in a coordinated way to achieve optimum cost-effectiveness.

Dr WIUM (Norway) said that two expressions used in the draft resolution needed clarification. First, he took it that the "interested parties" mentioned in the amended paragraph 2(4) meant those specified at the time of the adoption of WHO's revised drug strategy by the Thirty-ninth World Health Assembly in 1986, namely, governments, the pharmaceutical industry, prescribers, universities and other teaching institutions, professional nongovernmental organizations, the public, patients' and consumer groups, the mass media, and WHO (document WHA39/1986/REC/1, Annex 5, paragraph 45). Secondly, the original text of paragraph 2(5) had used the word "monitoring", but Norway had been informed that the expression "market intelligence" which replaced it was a broader notion that included the monitoring of both prices and pricing mechanisms. If his understanding of the two expressions he had mentioned was confirmed, Norway was ready to adopt the draft resolution with the amendments proposed.

Mrs MEGHJI (United Republic of Tanzania) said her country already had a national drug policy and a national plan for the pharmaceutical sector, and regarded the draft resolution as a timely guideline. The key to the community's rational use of drugs was to strengthen information, education and communication. The private pharmaceutical sector and private pharmacies would have to be closely monitored and fully involved. Her country valued and encouraged international collaboration on questions regarding the use, export and import of drugs, and on dealing with the distribution of counterfeit drugs; it was through such efforts that countries would become sensitive as to the drugs they exported and imported and would put in place an efficient monitoring mechanism. The United Republic of Tanzania supported the resolution recommended by the Board and wished to emphasize the need to avoid the importing of non-essential and expired or near-expiry drugs by developing countries.
Dr CICOGNA (Italy) also supporting the draft resolution, emphasized how important it was that WHO should improve its ability to provide support and technical assistance to Member States in strengthening their drug regulatory structures. He noted with concern that five posts had been abolished since 1995 in the Action Programme on Essential Drugs (DAP) and the Division of Drug Management and Policies (DMP). That seemed to be a disproportionate response to the budgetary crisis in a field where there was a clear need for WHO technical advice and expertise.

Mr KAMWI (Namibia) expressed support for the activities carried out by the Division of Drug Management and Policies (DMP) and was pleased to note that in the face of increasing resistance to anti-infective agents a programme was being developed to control the spread of resistance, linking the rational use of essential anti-infective agents to surveillance. In the subregion in which Namibia was situated it was alleged that some US$ 70-80 million worth of counterfeit drugs was being circulated; he was glad that the increase in substandard and counterfeit medicines had prompted the launching of a comprehensive strategy to detect and deter the manufacture and distribution of such products, and that, in the light of advances in modern communications technology, the need was foreseen to apply appropriate and affordable technology for drug safety and regulatory communication. Namibia would welcome a mechanism to determine how the prices of pharmaceutical products were set.

Mr SAKAMOTO (Japan) expressed his country’s support for the draft resolution recommended by the Executive Board and the amendments proposed by Barbados.

Dr CHATTY (Syrian Arab Republic), also supporting the draft resolution, said it was still very hard for smaller developing countries which were putting a great deal of effort into establishing a sound national drug industry to find sufficient objective information on how and where to obtain good raw materials and what price to pay for them. He wondered if more could be done to help them; the same applied to blood and blood products.

Mr KASONGO-NUMBI (Zaire) supported the draft resolution and expressed appreciation for the statement made by the delegate of Germany regarding the control of drug exports. In order to strengthen the control of drug exports and imports, he proposed the insertion in paragraph 1 of a new subparagraph to the effect that Member States should be urged to permit the export only of pharmaceutical products expressly authorized by the competent officials of the importing country.

Mr OUAZAA (Algeria) said that access to drugs was becoming a matter of concern to his country in a way that it had not been before. The question was whether the availability of drugs should be allowed to be determined by a country’s socioeconomic situation. Unfortunately the drug market continued to be dominated by commercial pharmaceutical information; provision of information that was objective and genuine was not the concern of manufacturers or distributors. Very often it was official departments which sought out and offered such information. Donations of drugs from various nongovernmental and other sources remained a source of concern for the public authorities, which had to ensure that they met the current regulations and safety conditions. Thought also had to be given to how drugs were used: by definition they were toxic and needed to be handled with care. Most developing countries had national drug policies, but they were often poorly formulated and had to conform to specific political, economic and sociocultural environments. Governments seemed to be more sensitive to proposals and recommendations from WHO. While national drug policies were backed up by university research studies, the fact remained that the drug policies of most developing countries contained the same core provisions.

International and interregional cooperation must be promoted. Algeria belonged to a regional grouping in the Maghreb, and while that grouping took the form of South-South cooperation, it was worth noting that, as far as the effort to combat counterfeit drugs was concerned, the flow of drugs was exclusively in a North-South direction. The developing countries were encountering difficulties with information for prescribers, and it was important to begin the process of acquiring a result-oriented approach to treatment at the student level. National drug policies required political will, and the regulatory mechanisms and quality control they instituted governed not only individuals but the whole drug structure.
Regarding the role of the pharmacist, resolution WHA47.12, which called on pharmacists to develop their profession at all levels in accordance with the reports of the WHO meetings held in New Delhi in 1988 and Tokyo in 1993, offered hope and promise for a group of workers whose role as distributors of pharmaceuticals was an eminently social one.

Dr SIDHOM (Tunisia) said that drugs accounted for an ever-increasing proportion of the total budget of health institutions and structures, and physicians occasioned what was often sizeable expenditure by their manner of prescribing. He would like the next report of the Director-General to include a paragraph on the role of the doctor as prescriber. He supported the draft resolution, with the amendments proposed by Barbados, and in order to emphasize the need for regional or subregional coordination of national strategies he proposed the insertion after paragraph 2(1) of a new paragraph reading:

to encourage Member States, as far as possible, to establish a system for the coordination and harmonization of their national strategies.

Dr MUÑOZ (Chile) expressed support for regulatory policies designed to improve access to drugs and for the strategy and programmes aimed at providing the public with guarantees of quality in regard to drug supplies and technology utilization. National formularies should be constantly updated and the pharmaceutical industry should be required to supply essential drugs at reasonable prices. Chile therefore supported the draft resolution and the proposed amendments. For the reasons set forth in that resolution and in the statement by the delegate of Tunisia regarding medical prescriptions, it was to be hoped that WHO would continue to work towards equitable access to and rational use of drugs.

Dr ÁVILA DÍAZ (Cuba) said that 87% of his country’s demand for drugs was met by local manufacturers, which were subject to State regulatory quality control. The activities of the national epidemiological and pharmacological surveillance centre were being decentralized to municipal level.

The aim of promoting general access to safe, low-cost and high-quality drugs was obviously linked to the question of pricing of drugs and raw materials. He supported the draft resolution and the proposed amendments, though he would have welcomed the opportunity to see a revised text incorporating all the proposed changes.

Dr MTSHALI (South Africa) said that her country had recently adopted a national drug policy and essential drugs list with WHO’s assistance. She fully supported the draft resolution with all the proposed amendments.

She urged the Director-General to provide technical, financial and other forms of assistance to help countries, especially developing countries, to become self-reliant in drug and vaccine production so that they were not in thrall to multinational pharmaceutical companies and were able to respond to changing market and economic conditions.

Professor YU Zonghe (China) said that his delegation fully supported the draft resolution.

Dr OWONA-ESSOMBA (Cameroon) said that his delegation broadly supported the draft resolution but proposed that paragraph 1(6) should be expanded to include the same provisions as paragraph 2(4). It would then read:

to eliminate inappropriate drug donations by implementing the interagency Guidelines on Drug Donations produced by WHO in May 1996 and to promote their use in collaboration with the other interested parties.

Dr MAHJOUR (Morocco) said that quality control was a key aspect of action to ensure general access to essential drugs. He therefore supported the draft resolution, in particular paragraphs 1(3), 1(4), 1(5), 2(3) and 2(6).

Mr YANG (Republic of Korea) said that shortages of essential drugs had impeded disease control in a number of countries. He urged WHO to review the supply of and demand for essential drugs and to report the results to the next World Health Assembly.
Dr FEKADU (Eritrea) said he fully supported the draft resolution and the views of the delegates of Togo and Malawi regarding drug donations. While developing countries welcomed such donations, they strongly recommended that all donated drugs should feature on the national list of essential drugs and should meet the needs of the recipient country. Unnecessary donated drugs were a burden in terms of customs clearance, transportation, storage and eventual disposal.

Mr CÓRDOBA (Colombia) expressed support for the draft resolution. He agreed with the delegate of the Netherlands and other speakers that it should include a reference to drug pricing mechanisms. Furthermore, the Organization should carry out a more thorough economic analysis of the use and supply of drugs and study the implications for the pharmaceutical sector of the agreements of the World Trade Organization.

Mrs DROBYSHEVSKAYA (Belarus) said that her country had drawn on the standards and principles established by WHO in formulating its national drug policy. A drugs bill was currently before the Supreme Council and a strategy for ensuring general access to drugs was being finalized. Since 1992 the Ministry of Health had been operating a register of drugs to keep counterfeit and substandard products off the market. Cooperation agreements had been signed with the competent authorities in France, Ukraine and United States of America, and agreements with other countries were being prepared. The list of essential drugs was continually updated and formed the basis for drug supply contracts.

The topic of drug donations was of vital importance and WHO should publish its guidelines on the subject as soon as possible. Provision should be made for a mechanism that would induce donors to comply with WHO recommendations instead of using recipient countries as a dumping-ground for substandard drugs.

WHO seminars should take into account the different levels of development of national drug policies in newly independent States. In developed countries, practical on-the-job pharmaceutical training was more effective than seminars. It would be useful to prepare recommendations on the privatization of pharmaceutical institutions. Lastly, she suggested that seminars should be held on organization of the work of pharmacies, pharmaceutical stock management, centralized and decentralized drug purchases and other practical matters.

She expressed support for the draft resolution.

Dr SULEIMAN (Malaysia) fully supported the Organization's work on the rational use of drugs and the Action Programme on Essential Drugs. Malaysia was developing a national list of essential drugs and working on drug education for consumers.

He supported the draft resolution with the amendments proposed by Barbados. He would like to see greater emphasis placed on the cost of drugs.

Dr HLA MYINT (Myanmar) said that a new drugs act had been promulgated in Myanmar two years previously. A list of essential drugs and a national formulary for drugs had also been introduced. He fully supported the draft resolution.

Dr LA RIVIÈRE (Canada) wondered how the Committee proposed to reconcile the numerous amendments proposed to the draft resolution. New paragraphs and new topics had been introduced in line with the rapidly evolving scope of the discussion. For convenience and to save time, the Committee should perhaps restrict its amendments to those proposed by Barbados.

WHO must clearly develop its involvement in standard-setting activities, in the monitoring of aspects of drug marketing and in other related areas, all of which called for proper documentation and careful study, particularly by the Executive Board.

Dr KUNENE (Swaziland) supported the draft resolution and looked forward to publication of the Guidelines for Drug Donations, as the poor economic performance of his country meant that it continued to rely on donations, particularly from Western countries. Despite concern that some of the donated drugs were not appropriate, Swaziland had no option but to accept whatever was offered. Drug pricing was also a serious issue; in particular the cost of drugs for treating patients with HIV/AIDS was prohibitively high. He
requested WHO's assistance in ensuring that such drugs became affordable, so that no patient was denied treatment.

Mr DE PIERREDON (Order of Malta), speaking at the invitation of the CHAIRMAN, commented that the Order of Malta had long been involved in assisting people who were suffering because of inadequate access to medicinal drugs. A system had been established for the collection, transport and distribution of drugs donated by various groups and individuals. For several decades, the Order had obtained drugs by buying them, or as donations from pharmaceutical companies or, more recently, by recovering unused drugs from pharmacists and individuals. Unused drugs were sorted without charge by pharmacists, who rejected opened boxes and vials and items, if they were for shipment overseas, for which less than a year remained before the stated expiry date. As the recipients agreed to the shipment and its contents before dispatch, there was no risk that the donation would be returned. In France, there were about 100 collection centres and four shipping centres, and almost 1000 tonnes were shipped annually to 80 countries. Other centres existed, for example in Italy, Switzerland and United States of America.

The Order was thus fully aware of the numerous difficulties that arose at each stage of a humanitarian action and understood why WHO had considered it necessary to establish rules for activities that were inspired by a spirit of generosity but could have unwanted effects if inadequately planned. The Order of Malta supported the planned Guidelines for Drug Donations and the draft resolution, as its own actions complied closely with the main recommendations outlined in those documents. He emphasized, however, that unforeseen circumstances often led to exceptional situations; action should not be precluded for that reason. The Order of Malta welcomed the channelling of generosity from people who had a surplus of drugs to those who lacked the basic means of relieving their suffering.

Dr BALASUBRAMANIAM (International Organization of Consumers' Unions - Consumers International), speaking at the invitation of the CHAIRMAN, said that Consumers International, a federation of 215 consumer organizations in 90 countries, worked closely with Health Action International, a global network of health, development and consumer groups active in more than 70 countries. The draft resolution recommended by the Executive Board would strengthen implementation of the revised drug strategy and national drug policies; it was particularly important for the least developed countries. When drugs were marketed in a way that led to their irrational use, it was the consumer who suffered. For instance, the marketing of antihistamines as appetite stimulants for children in countries where malnutrition was rife and commonly led to loss of appetite aggravated the situation by diverting scarce resources from the purchase of food. Wide dissemination of WHO's Ethical Criteria for Medicinal Drug Promotion and their incorporation into national legislation could prevent such errors, but the preliminary results of a study under way in six Asian countries indicated that the criteria were not being applied adequately. WHO should implement a concerted plan of action to combat unethical drug promotion and its negative effects on health.

Although drug donation guidelines had been prepared by WHO, many donations continued to be inappropriate. One of the poorest countries in Africa had received a shipment of 100 000 tablets of loperamide, an antidiarrhoeal agent that did not prevent dehydration, the major cause of death from acute diarrhoea; furthermore, the tablets had arrived only one month before their expiry date. In emergencies, particular attention was needed to ensure that drug donations corresponded to the real local health needs, were essential drugs and were accompanied by full information in locally understood languages. Health Action International could distribute and encourage use of the guidelines and contribute to their review after one year.

WHO's review of its Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce had shown that it failed to function as intended and highlighted the need for reformulation and effective regulation. Member States and industry had an important role to play in assuring the quality of exported drugs and the information accompanying them.

Drug prices were always a cause of concern. A comparative survey of the retail prices of 11 essential drugs carried out by Health Action International at the end of 1995 had shown wide variations in the prices of both generic and brand-name drugs; 10 commonly used essential drugs in 16 dosages were much more expensive in some developing countries of Asia than in several industrialized countries. It should be noted that in developing countries 70%-90% of the total expenditure for pharmaceutical products was met by the consumers, although a significant percentage of the population of those countries lived below the absolute
poverty line. Expansion of WHO's efforts to strengthen market intelligence and to review prices and pricing mechanisms for essential drugs and raw materials, together with provision of that information to Member States, could help national governments to develop and implement sensible pricing policies and could help to avoid situations in which poor consumers paid unnecessarily high prices. Those conclusions reflected the recommendations of the international conference on national drug policies that had been jointly sponsored by the Australian Government and WHO in October 1995.

There were four key issues: assuring better control of drug promotion by monitoring, implementing and reviewing ethical criteria; ensuring that drug donations met the needs of recipients by wide dissemination of WHO's guidelines; assuring the quality of exported and imported drugs within an appropriate regulatory control system by implementing the Certification Scheme; and promoting the use of generic drugs, establishing pricing policies and disseminating international drug prices.

He assured WHO of continued collaboration to improve access to essential drugs and to independent information leading to more rational drug use.

Dr ARNOLD (International Federation of Pharmaceutical Manufacturers' Associations), speaking at the invitation of the CHAIRMAN, said he had misgivings on two scores about the draft resolution under consideration, although the proposed amendments had somewhat assuaged them. The pharmaceutical industry made substantial donations each year of drugs that were essential for saving lives, preventing disease and relieving acute and chronic suffering. While the proposed guidelines would discourage donations that did not meet those objectives, they might result in a situation in which most really useful donations could be made only by invoking the provisions for special circumstances or exceptions. He therefore welcomed the proposal that the guidelines should be reviewed after the first year of use in the light of the experience of Member States and of the members of his Federation.

The dissemination of information on the pricing of essential drugs and raw materials raised further questions. A transparent, competitive market resulted in the best prices, and there was no reason why valid information should not be provided to potential buyers. It was important, however, that, given the international credit accorded to information issued by WHO, prices or sources of essential drugs and raw material should be publicized with due care. WHO must ensure that the material met current international specifications and was provided by a manufacturer who observed the standards of good manufacturing practice. In many cases, material was offered by brokers, and its origin and quality were uncertain.

Mr GALLOPIN (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that he represented almost 500,000 pharmacists, all of whom played a part in fighting disease. His Federation had been active in implementing resolution WHA47.12, and most national associations had discussed the possibility of joint action programmes with their governments. It was recognized that pharmacists played a key role in drug management, which was achieved by a partnership of health professionals. The Foundation for Education and Research of his Federation had sponsored international conferences in Bangladesh, Chile and El Salvador to provide further education for pharmacists; it was planned to hold conferences in West Africa, Kazakhstan and the Syrian Arab Republic. In 1993, his Federation and WHO had cosponsored a meeting that had resulted in recommendations on pharmaceutical care, dealing primarily with disease management by the use of prescribed medicines. The Federation considered, however, that protocols should also be developed for the supply of non-prescription medicines to the public, as people were encouraged to take more responsibility for their own health. He suggested that WHO should organize a meeting on that subject, which was of particular importance for developing countries.

Dr ANTEZANA (Assistant Director-General) said that the discussion demonstrated the importance to Member States of pharmaceutical and biological agents, blood products and other preparations used in health care. The world health report 1996 showed that one of the factors hampering control of newly emerging diseases was lack of adequate treatment. The elements of equity, universal access, and the quality, safety and efficacy of drugs had been highlighted. All the comments, and particularly the technological and economic concerns of developing countries, would be taken into consideration.

In answer to the question by the United Kingdom delegate about updating the price-indicative list of drugs and raw materials, he said that the list was based on a joint publication of the International Trade Centre and WHO and was revised frequently, the most recent re-evaluation having been undertaken 18
months previously; another was planned before the end of 1996. The information provided by WHO was evidence-based; technical cooperation was a major tool for providing guidelines and standards based on evidence derived at the country level.

The changing, important role of pharmacists in respect of technological developments had been noted. A unit on blood safety had been established at WHO and would collaborate with other units to assure the safety of blood and blood products used in both prevention and therapy. Standards would be set in consultation with regional offices and with individual countries.

The Executive Board had recommended that a report on progress in establishing ethical criteria should be presented in January 1997.

Dr THYLEFORS (Secretary) suggested that, in view of the number of amendments proposed to the draft resolution recommended by the Executive Board in resolution EB97.R14, the Committee might wish to see a revised text that incorporated them all, while maintaining the intention of the original. To avoid possible omission and duplications, the task of revision might be entrusted to a drafting group composed of the delegations that had put forward amendments, together with any other delegations that might wish to participate.

It was so agreed (see summary record of the eighth meeting, page 93).

The CHAIRMAN informed the Committee that in informal discussions the sponsors of the draft resolution on the quality of biological products moving in international commerce (to which he had drawn attention at the start of the meeting) had said they were willing to withdraw their text if the Committee concurred with its aims and intentions and agreed that the importance of the topic warranted a closer analysis of the technical and legal implications than could be made at the present time.

The Committee might also wish to agree that an ad hoc working group should examine those implications in time for a report to be submitted to the Executive Board at its ninety-ninth session, with a view to recommending a resolution for adoption by the Fiftieth World Health Assembly.

Professor PICO (Argentina), Dr LARIVIÈRE (Canada), Dr NIGHTINGALE (United States of America), Dr HERNÁNDEZ (Venezuela), Dr NARRO ROBLES (Mexico), and Mr GARCÍA (Spain) expressed their agreement.

The Chairman's proposal was adopted (see summary record of the ninth meeting).

Reproductive health (Resolution WHA48.10)

Mrs HERZOG (representative of the Executive Board) said that the Board had reviewed the Director-General's report on the implementation of resolutions EB95.R10 and WHA48.10, the latter of which requested the Director-General "to develop a coherent programmatic approach to research and action in reproductive health within WHO to overcome present structural barriers to efficient planning and implementation". It had also had the benefit of updated information from the Executive Director responsible for Family and Reproductive Health.

A Reproductive Health programme had been established comprising research and technical support divisions. In addition to promoting a comprehensive reproductive health approach in country programmes through primary health care, the Reproductive Health programme would concentrate mainly on three global priority topics: family planning, maternal and neonatal health, and reproductive tract infections, including sexually transmitted diseases. The Reproductive Health programme was closely linked to the Adolescent Health programme and to the Women's Health Development programme. In recognition of the impact of reproductive ill-health on future generations and of the need to ensure a continuum of care across the course of life, those programmes were all linked to a Child Health and Development programme within the overall framework of Family and Reproductive Health.

Reproductive health was a priority for WHO as well as for developing countries in view both of the need to provide resources and of the opportunity it afforded for WHO to assert its world leadership role.
The Executive Board had strongly endorsed the new approach and reformulation of programmes under the Family and Reproductive Health heading.

Dr ALVIK (Norway), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), welcomed the new and more unified approach to reproductive health reflected in resolution WHA48.10 and being implemented in WHO. Every effort should be made to ensure the adequate participation of representatives of developing countries in the advisory and technical committees for the new Reproductive Health programme. Increasing interagency cooperation and a better focused role for WHO, as well as the Organization's contribution to the guidelines for the Resident Coordinator system, had been noted with satisfaction. WHO was in a position to bring about a balanced response to reproductive health needs through well-researched, tested and technically sound strategies and tools for improving access to and the quality of reproductive health services, with well-defined links to broader health policies.

Matters pertaining to women's health and to relations between the sexes should be dealt with in appropriate collaboration with the Reproductive Health programme. More resources were needed in order to ensure the integration of aspects concerning relations between the sexes in all WHO's programmes and related normative work. Data on reproductive health throughout the world needed to be of better quality and widely disseminated to facilitate policy development and accurate reporting on progress.

WHO should avail itself, without restriction, of all opportunities where advocacy would contribute towards reducing maternal mortality, morbidity, unwanted pregnancies and unsafe abortions; towards making it possible for adults and adolescents of both sexes to make informed choices in matters related to sexuality and reproduction; and towards providing quality services in line with people's needs. There should be regular reporting to the World Health Assembly on the programme area under discussion, and the Nordic countries requested that a comprehensive report on reproductive health should be prepared for the Fiftieth World Health Assembly.

Dr AKIN (Turkey) said that reproductive health should be an integral part of primary health care - a point that had been discussed thoroughly at the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995. For many countries it was a priority health issue and the importance accorded to it by WHO and other bodies of the United Nations system was noted with appreciation by Member States. However, WHO's programme, to be successful, would have to be implemented at country level. That would mean providing technical guidance and the tools needed for assessment and research, which could be achieved if WHO collaborating centres were strengthened. Those centres could also play a useful role in ensuring that the care provided was of good quality and that it was monitored and evaluated. Technical cooperation among developing countries was another available tool for implementing and sustaining the Reproductive Health programme.

Dr KASAI (Japan) welcomed the restructuring of the Family and Reproductive Health programme area and called for the collaboration of Member States in a sector where the health of women and children was most at stake. Japan had undertaken to increase substantially its contribution in that area.

Dr MUÑOZ (Chile) said that it was of the utmost importance that there should be an integrated approach to reproductive health care aimed specifically at adolescents and young people and linked to programmes on mother and child health, family health and control of sexually transmitted diseases.

2. FIRST REPORT OF COMMITTEE A (Document A49/42)

Dr SINGAY (Bhutan), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

The meeting rose at 12:35.

¹ See page 208.
IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4) (continued)

Reproductive health (Resolution WHA48.10) (continued)

Dr DAULAIRE (United States of America) commended WHO’s efforts to develop a comprehensive approach to reproductive health. He supported the call for substantive results made by the delegate of Norway on behalf of the Nordic countries. The 1994 International Conference on Population and Development had urged governments to form specific action plans on reproductive health. Although reproductive "health for all" was desirable, WHO must find a way to allocate finite resources in the most appropriate way, emphasizing the protection of women during the most vulnerable stages of their reproductive lives. Within a reproductive health framework, the Organization must determine priorities that would have the maximum positive impact on women, men, adolescents and children. While continuing to focus on safe motherhood, WHO should go beyond advocacy for women’s health to find public health approaches that could be implemented in a practical, cost-effective fashion. Donors should continue to support programmes in areas given priority. The exchange of information and consistent allocation of funds should continue to be a major aim.

Continued research was needed into the quality and cost-effectiveness of reproductive health service delivery models and into contraceptive development, use and acceptance. Consumer needs and views should be reflected in the design, implementation and evaluation of programmes. That might lead to a better understanding of relations between the sexes, including the role played by men in women’s health.

In defining the components of reproductive health programmes, WHO should focus on a public health approach and ensure that any structural changes made to programmes were not detrimental to those that were more successful but served to strengthen the weaker ones.

Mrs MANYENENG (Botswana) fully endorsed resolution WHA48.10 and supported the call made by the Nordic countries for WHO to play a stronger role in promoting reproductive health. The importance of women’s health both during and beyond the reproductive years could not be over-emphasized. Developing countries faced not only high maternal mortality and morbidity rates, but also the resulting physical, mental and emotional disabilities.

Botswana had developed a comprehensive reproductive health programme but, in common with many developing countries, experienced a shortage of trained health personnel, and therefore needed assistance in human resource training, as well as technical support. It was hoped that the programme could be extended to women beyond child-bearing age.

Dr VIOLAKI-PARASKEVA (Greece) welcomed the attention being paid to reproductive health. Owing to the sensitive nature of the issues involved, it had been neglected in previous years. She hoped that resources for strengthening reproductive health in the context of primary health care, including family health, would be increased. However, the elaboration of reproductive strategies should respect religious beliefs and ethical and cultural values.

She supported the call from the Nordic countries for a comprehensive report to be presented to the Fiftieth World Health Assembly through the Executive Board.
Dr KIMAMBO (United Republic of Tanzania) said that, with high rates of fertility and maternal mortality, her country particularly valued efforts made in the area of reproductive health. While commending the action taken by WHO, she was concerned that the number of changing titles under which it was described - e.g. maternal and child health, safe motherhood, or the "mother-baby package" - might detract from the value of the work itself.

Dr NARRO ROBLES (Mexico) said that reproductive health implied the capacity of individuals and partners to conduct satisfactory sexual relationships, including the ability to decide freely and in an informed manner on the number and spacing of their children. Reproductive health should be seen as fundamental to primary health care. Services should be universal and multisectoral, with the free and informed participation of the community.

Reproductive health was accorded great importance in national planning in Mexico and, as part of health reforms, a new reproductive health and family planning programme had been instituted.

Reproductive health involved the provision of a wide range of services and the dissemination of information relating to them. All programmes should be carried out with complete respect for the dignity of the individual or couple. He supported the request by the Nordic countries that a report should be presented at the next Health Assembly.

Dr CICOGNA (Italy) commended the activities carried out by WHO in the area under discussion. The rapid social changes in recent years had accelerated the negative trend in women's health. WHO had a key role to play in supporting women's most pressing health needs: equity between the sexes, an end to violence against women and control of the major causes of death, morbidity and disabilities.

Dr MAHMOOD (Malaysia) noted with interest the action taken by WHO in promoting reproductive health programmes in the regions. He supported the priority given to family and reproductive health and the initiative to bring together the three WHO divisions active in those areas under an Executive Director. He supported WHO's broad approach to the health of children, adolescents and women; programmes should be implemented within the context of primary health care and in collaboration with other sectors to make optimum use of resources. WHO should continue its leadership in reproductive health, while collaborating closely with other organizations active in that area, including UNFPA and UNICEF. A coordinated approach was essential to ensure a common set of guidelines at country level. He called for an increase in the budget allocation for what was a priority area, particularly in the early years of programme development.

A reproductive health programme had been set up in Malaysia with the participation of Government and the private sector and nongovernmental organizations. Malaysia had hosted a regional workshop on reproductive health in 1995 and was an active partner in consultative group meetings held by WHO, UNFPA and the United Nations Commission on Population and Development.

Mr RINCHHEN (Bhutan) said that he was heartened to note from the report that numerous activities had been undertaken in the field under discussion since the previous year. Bhutan was currently developing a comprehensive reproductive health programme, in collaboration with WHO and UNFPA. He welcomed the decision to establish a new reproductive health programme which would have priority status, and urged the Organization to continue to play a leading role in that area.

Professor GRANGAUD (Algeria) said the Director-General's report gave a clear picture of the progress achieved in implementing resolution WHA48.10, and also highlighted areas for further development.

Algeria had been making efforts to implement the resolution's recommendations with the support of WHO, UNFPA, UNICEF, UNDP and the World Bank. It had sought to improve the quality of reproductive health and family planning services by creating family planning centres in the obstetrics and gynaecology departments of all hospitals, and had set up national committees for genetics and for reproductive health and family planning. In addition, a system for publicizing and monitoring those services had been set up in each of the country's health regions.

Within WHO, some programme reformulation would be required, since the activities of the new programme overlapped to some extent with those of traditional maternal and child health programmes. As stated in paragraph 10 of the report (document A49/4, section IV), current priorities must be reviewed,
although the integrity of family health programmes should be preserved. He supported the call for a specific study of the question to be made for the following year.

Dr MTSHALI (South Africa) welcomed the move to give greater priority to reproductive health within WHO. The southern African region had established a reproductive health network, in order to develop joint solutions to the challenges it faced. Country-specific programmes were designed to bring down the unacceptably high morbidity and mortality rates associated with unsafe reproductive practices.

She supported the calls for WHO to continue its leadership role and to report on progress to the Fiftieth World Health Assembly through the Executive Board.

Dr LEGNAIN (Libyan Arab Jamahiriya) agreed on the need to expand and reinforce WHO's activities in the field of reproductive health. Her country had introduced a national reproductive health plan which had received a high degree of popular support, and had also improved its medical services, thereby achieving an appreciable decrease in maternal and infant mortality, despite the difficulties engendered by the embargo.

Dr BIHARI (India) said India's family welfare programme provided a wide choice of contraceptive methods to suit individual needs. It sought to promote the reproductive health of the mother through spacing of children and to reduce infant, child and maternal mortality. Although the task of reaching 900 million people over an area of 3.2 million square kilometres was gargantuan, significant achievements had been recorded. Thus, the infant mortality rate had declined from 146 per thousand live births in the 1950s to 73 per thousand, and the total fertility rate had also fallen. The couple protection rate had increased from 10.4% in 1971 to 45.8% in 1995. It was estimated that 182.7 million births had been averted as a result of the programme. Women's life expectancy at birth had risen from 31.7 years in 1951 to 61.7 years by 1991, and for the first time stood higher than that of Indian men, in keeping with global trends. The new orientation of the programme had required a shift of focus to monitoring of contraceptive users, and specific performance targets by contraceptive method had been dispensed with on a pilot basis in 1995 and 1996.

India welcomed the new arrangements for reproductive health activities at WHO headquarters and looked forward to working in close collaboration with WHO in the future.

Mrs DE DIOS (Cuba) said her country greatly appreciated the activities undertaken by WHO in the field of reproductive health. Traditionally, reproductive and sexual health had been dealt with in the context of maternal and child health, but over the past 20 years there had been a shift of focus. Today, her sex were claiming the right to be seen not only as mothers but as women, and as such to be allowed to determine the size of their families. No less important was the right of men to participate in the various stages of the reproductive process, and in decisions affecting the health of the family as a whole. A broader concept of reproductive health should include freedom for couples to exercise their sexuality without fear of unwanted pregnancies or sexually transmitted diseases, and to regulate their fertility in a free and informed manner.

In Cuba, reproductive health care was seen as beginning before conception and extended beyond perinatal care. It incorporated activities to promote reproductive health, such as the provision of information and education as well as preventive activities. While action in the health sector was decisive in helping to develop reproductive health and to prevent maternal and child mortality, political, legislative, intersectoral and interagency action was also important.

Mrs MILLS (Canada) welcomed the merging of the headquarters divisions concerned with reproductive health, women's health and child health under a new integrated programme. She supported the proposal that a comprehensive report on reproductive health should be submitted to the Fiftieth World Health Assembly.

Dr WASISTO (Indonesia) was pleased to note the progress made both by Member States and by the Organization in developing such an important programme, and was encouraged to know that the Director-General was to increase the allocation for it in 1996-1997 as part of the 5% shift in the programme budget to priority areas. He welcomed the integration of headquarters divisions dealing with reproductive health, which should result in more efficient programme implementation.

Indonesia had established a National Council on Reproductive Health, comprising representatives of intersectoral agencies and experts from related disciplines. The Director-General should ensure closer
consultation and coordination within WHO so that countries could receive better technical guidance. Closer collaboration with international donor agencies would also be needed. As the delegate of the United Republic of Tanzania had indicated, there was a danger of duplication of effort and confusion unless the terminology and activities in the area of reproductive health were clarified, and he would welcome the views of competent WHO staff in that regard.

Dr SHAFEI (Egypt) also supported the proposal made by the delegate of Norway. More attention should be paid to the role of nongovernmental organizations and to the importance of community participation, and more funds should be allocated to capacity-building in the developing countries to enable them to participate actively in programmes connected with population, reproductive health and family planning.

Dr SIDHOM (Tunisia) welcomed the proposed reorganization and was pleased to note the planned increase in the budgetary allocation for reproductive health. It would be essential to coordinate with other organizations, such as UNICEF and UNFPA, if success was to be achieved in reducing maternal and child morbidity and mortality. It was also essential for women to play a full role in society, which was currently not always the case. WHO should encourage exchanges of information on reproductive health, particularly among developing countries; Tunisia would be glad to participate in such exchanges. He too supported the proposal made by the delegate of Norway.

Dr SULAIMAN (Oman) considered that a comprehensive report on reproductive health should be submitted to the Health Assembly on a regular basis.

Oman attached great importance to reproductive health since it was crucial to the health of generations to come, to women's health and to health in society as a whole. Reproductive health care should not focus narrowly on child-bearing but should be concerned with all stages of life.

The Organization must continue to play a central role in all aspects of the reproductive health programme, including evaluation and planning to ensure the timely adoption of appropriate measures. Investment in the programme at the global, regional and country level would bring immense benefits to all.

Dr AKBARI (Islamic Republic of Iran) welcomed the progress being made by WHO and other United Nations organizations in reproductive health planning based on a comprehensive, holistic and integrated approach. In that endeavour, it was essential to include all age groups, both sexes and all aspects of health whether biological, psychosocial or spiritual. In order to carry out such comprehensive and integrated activities, national family health departments must be reorganized for the provision of comprehensive care for children, adolescents, those of reproductive age and the elderly.

Mrs ZOBRIST (Switzerland), agreeing with the Nordic countries that it was important to keep an attentive eye on developments in the new coherent approach to reproductive health, endorsed their suggestion that a comprehensive report on reproductive health should be submitted to the Fiftieth World Health Assembly.

Professor PICO (Argentina) said that, as Argentina had already stated in various international forums, its people and Government were firmly committed to the defence of human dignity. Unwavering support for the family was the central pillar of any society founded on social justice. The Argentine Constitution clearly stated that life must be protected from the very moment of conception and that the cultural values and standards of all its people must be respected. Since WHO's cultural and ideological diversity was one of its strengths, Argentina would continue to endorse any strategy aimed at improving the health status and living conditions of women, mothers and children. Argentina was achieving good results with a programme on "health, women and development", a nationwide maternal and child health programme, and a programme directed preferentially to mothers and children at risk.

Dr LOSSEV (Russian Federation) commended WHO's regional and global activities in the field of reproductive health. The programme providing assistance to countries in drawing up national programmes and introducing practical measures in that sector was moving in the right direction.
Mr CHAUDHRY (Pakistan), commending WHO on its efforts to promote reproductive health, welcomed the 5% shift to priority areas that had been made in the WHO programme budget, thus increasing the funds available for reproductive health in 1996-1997. Pakistan had been making considerable efforts in the maternal and reproductive health field, including the launching of the Prime Minister’s Programme for Family Planning and Primary Health Care, which provided for the training and deployment of 100 000 women health workers by 1998. Following training, 32 000 such workers had already been placed in the field with responsibility for provision of basic health care and in particular for public health education in reproductive health. The Prime Minister of Pakistan was to be awarded the Health For All Medal by WHO at the forty-third session of the Regional Committee for the Eastern Mediterranean in recognition of her contribution to family planning and primary health care. She had also been very active in the field of women’s health and had been a forceful advocate for reproductive health at the International Conference on Population and Development in Cairo and the Fourth World Conference on Women in Beijing. A special programme to promote female literacy and women’s development had also been initiated in Pakistan. Pakistan was grateful for the technical assistance WHO was providing in the reproductive health field.

Dr ABELA-HYZLER (Malta) commended the measures taken by the Director-General in implementation of resolution WHA48.10, in particular the merging of the three divisions dealing most directly with family and reproductive health into a single entity. Reproductive health, a sensitive area with strong dependence on cultural values and traditions, was being handled by the Organization in a measured and perceptive way that would no doubt continue to be reflected in the future development of the programme and in the comprehensive report it was proposed to submit to the following Health Assembly. He endorsed the similar views expressed by other speakers, in particular the comments made by the delegates of Greece, Italy and Argentina.

Dr BERLIN (European Commission) said that reproductive and women’s health were being given considerable attention by the Commission both in its public health programmes of promotion and cooperation within the European Union and in its development assistance programmes. The Commission’s activities in Africa in the field of AIDS focused on the reproductive health aspects of the disease; it also supported efforts to provide women with the means to take care of their own health.

The Commission prepared annual reports on the status of health within the European Union. The 1996 report would focus on women and on issues to which the Nordic countries had drawn attention in their call for more specific data on women’s health. He hoped that the report would provide a contribution to the comprehensive report that the Nordic countries, with the support of many delegations, had called for.

Dr DODD (United Nations Population Fund) reminded the Committee that UNFPA was a sponsor, together with WHO, UNDP and the World Bank, of the Special Programme of Research, Development and Research Training in Human Reproduction. At the same time UNFPA had, over a number of years, been funding activities in the Division of Family Health on such subjects as adolescent reproductive health, maternal care, and the development of technical and managerial guidelines on family planning.

UNFPA welcomed the development in WHO of a comprehensive family and reproductive health programme and looked forward to the closer collaboration that would ensue between research and development activities and technical assistance and support activities. UNFPA had appreciated its close involvement in the consultative process followed in developing the new programme and welcomed the attention being paid to questions of relations between the sexes.

The tasks set out in the Programme of Action of the International Conference on Population and Development (ICPD) were clearly beyond the capacity of any single organization. If ICPD goals were to be achieved, it was clear that the organizations of the United Nations system must provide coordinated and coherent support, each in its area of comparative advantage.

In order to assist countries in developing and implementing reproductive health programmes, UNFPA would further strengthen its links with WHO, UNAIDS, UNICEF and other United Nations partners, as well as with bilateral agencies and nongovernmental organizations. That would be achieved through a variety of mechanisms including the task forces on follow-up to the recommendations of international conferences; participation in governance, advisory and consultative mechanisms and meetings; and close coordination of UNFPA support to national programmes at country level.
At the global level, UNFPA would look to WHO to provide the overall policy framework for reproductive health; to provide advocacy for the concept of reproductive health and its implementation; to advise on policies; to identify strategies; to develop and implement a reproductive health research agenda; and to provide technical guidance, including the setting of norms and standards, for the full range of reproductive health components and techniques. That was a not inconsiderable task; UNFPA stood ready to provide its continuing support and collaboration towards its achievement.

Dr MANGUYU (Medical Women’s International Association), speaking at the invitation of the CHAIRMAN, said that reproductive health was a fundamental aspect of socioeconomic progress and sustainable human development, going beyond demographic considerations and family planning to include sexual health and well-being, and must be a priority goal of national health programmes. Although, like other aspects of health, reproductive health was a basic human right, that right was not always respected and was denied to many, in particular vulnerable groups such as poor women and girls. In renewing the health-for-all strategy, specific strategies should be directed to those questions. The sensitive and intimate nature of reproductive health was not an excuse for its neglect; problems including reproductive tract infections and cancers, sexually transmitted diseases and HIV/AIDS had an impact on health in general. They were also aggravated by factors such as poverty and attenuated by education (especially education of women), health information and equitable provision of services.

Since the launch 10 years earlier of the global initiative, motherhood had not become safer and women continued to die or suffer devastating morbidity as a result of pregnancy and childbirth complications and unsafe abortion. Biological differences alone did not explain women’s disparate burden of disease: social, economic and political factors were also involved, such as violence against women and girls, a subject that should be given priority. The knowledge to prevent suffering and death in the area of reproductive health already existed. The governmental and nongovernmental organizations that had attended the International Conference on Population and Development in Cairo and the Fourth World Conference on Women at Beijing must honour their commitments and implement the programmes of action. She welcomed the fact that WHO had placed greater emphasis on reproductive health at headquarters and in the regional offices and had conducted broad consultations in developing the new reproductive health programme. Support should now be directed at country level. For success and sustainability of programmes, community involvement and adequate resources were essential. WHO should take the lead in demonstrating that reproductive health was central to sustainable human development and must be approached in a holistic manner as an aspect of human health that was crucial for the future of the world.

Mrs HERZOG (representative of the Executive Board) said that the importance of the subject under discussion, in the context of the life cycle and the family, could not be overestimated.

Dr TÜRMEN (Family and Reproductive Health), thanking delegates for their support, comments and guidance, appreciated that reproductive health was a priority in the national health programmes of so many countries. WHO would strengthen its activities in the priority areas highlighted by delegates and, if the Committee agreed, would submit a comprehensive report to the Fiftieth World Health Assembly through the Executive Board, as requested by the Nordic countries.

The CHAIRMAN, noting that the discussion had reflected broad support for the request by the Nordic countries that a comprehensive progress report on reproductive health should be prepared for submission to the Fiftieth World Health Assembly through the Executive Board, invited the Committee to agree on a recommendation to that effect.

It was so agreed.

Occupational health (Resolutions WHA33.31 and EB97.R6)

Mrs HERZOG (representative of the Executive Board) said that the occupational health programme had been reviewed at the Board’s ninety-fifth session and that the Director-General’s report outlining the strategy for occupational health for all had been discussed at the ninety-seventh session. The global strategy marked
a step forward in the development of WHO's programme on workers' health and provided an appropriate mechanism for promoting multidisciplinary and multisectoral efforts. It had been developed with the participation of 52 WHO collaborating centres in 35 countries and provided an example of how WHO could achieve maximum results with minimum resources, offering well-designed programmes through which leading institutions throughout the world could unite to achieve a common goal.

The Executive Board had noted that, as occupational health had many implications for the health of communities worldwide, WHO should provide countries with long-term strategies and a framework for the development and strengthening of occupational health and safety. Given the rapid social, political and economic changes in many regions, all of which had led to imbalances, deteriorating working conditions and declining standards of health care for working populations, the need for special preventive action and protection of workers' health had been stressed by the Board, which also considered that occupational health should be associated with the renewal of the health-for-all strategy and be included in areas of collaboration between organizations dealing with health promotion. The draft resolution recommended in resolution EB97.R6 was submitted to the Health Assembly for its consideration.

Mr ESKOLA (Finland) said that nearly 80% of the total number of working people in the world lived in developing countries. Appropriate occupational health services were available to less than one-fifth of that total and their coverage did not correspond to needs. In many countries workers in high-risk occupations such as mining, agriculture and industry had no access to services despite the obvious, urgent needs of an expanding global labour force. It had been estimated that there were about 125 million labour accidents, with 220 000 fatalities, and about 160 million cases of occupational disease annually, along with much evidence of unreasonable physical and psychological workloads, all of which resulted in major economic losses. Furthermore, several industrialized countries had demonstrated that most occupational hazards were preventable.

The proposed WHO strategy on occupational health for all provided a timely and much-needed response to new developments in working life in both industrialized and developing countries and reflected the efficiency of the network of WHO collaborating centres. Comprehensive occupational health programmes were an important factor in sustainable social development. WHO should be encouraged to take the lead in developing occupational health policies and programmes through the implementation of the strategy. He looked forward to seeing the action plan indicating the practical measures that would be taken in collaboration with ILO, the regional offices and individual Member countries. His Government was committed to providing all possible expertise for the effective worldwide implementation of the strategy and supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) said that changing economic structures and the advent of new technology were affecting large numbers of workers. Countries should therefore prepare and implement new occupational health programmes as an essential component of socioeconomic development. The global strategy for occupational health for all required close collaboration between WHO and other United Nations organizations, the European Union and nongovernmental organizations, and coordination with other WHO programmes. She proposed two additions to the draft resolution recommended by the Executive Board: first, a new preambular paragraph, to read:

Convinced that the field of occupational health calls for a broad, multidisciplinary approach;

and secondly, a new subparagraph in paragraph 3, reading:

to give special attention to working people by developing appropriate health care in workplaces as a contribution to the attainment of health for all by the year 2000.

With those amendments, she could approve the resolution.

Mrs TAPAKOUDE (Cyprus) said that her Government was fully aware of the importance of occupational health in support of social and economic development and world peace. It therefore strongly endorsed the draft resolution, which should encourage countries to improve conditions in an effort to promote health worldwide.

Dr MIRCHEVA (Bulgaria) welcomed the development of a global strategy for occupational health for all as an essential tool in the formulation of national policies and programmes on the subject. Referring to
the major objectives for action outlined in section V, paragraph 5 of document A49/4, she suggested that objective (3), "development of healthy work practices", might be strengthened by including a reference to the development of a work culture conducive to health and safety, an important element of occupational health, which could result in worker satisfaction as well as greater productivity. International guidelines were needed for the development of effective strategies in that regard. Special programmes to increase workers' knowledge of safe and healthy practices at the workplace should also be developed and applied. It was not always possible to organize occupational health services "as an integral component of community health services" or "within ... national health systems", as indicated in objective (4). Quality assurance and control of occupational health services should be emphasized: physiologists should be included among the specialists, drawn from national and local organizations, providing expert advisory services, and systems for maintaining high scientific and technical quality of services should be established. Finally, national research programmes were needed to ensure the effective transfer to country level of the results of international research.

She supported the draft resolution recommended by the Executive Board.

Dr LEGNAIN (Libyan Arab Jamahiriya) said that her delegation appreciated the Organization's efforts to improve occupational health, which was one of the main elements for sound social and economic development. She hoped that cooperation would increase between the various WHO collaborating centres and the developing countries to achieve the best results at the lowest cost. She supported the draft resolution before the Committee.

Dr BIHARI (India) said that almost half the population of his country worked in agriculture or industry, often in hazardous conditions resulting in stress and occupational diseases; measures were therefore needed to develop a healthy work environment and to incorporate occupational and environmental health components in the national health policy. Occupational health services should be based on a holistic approach to workers and their families, in a cost-effective manner, and standards should be set in workplaces in keeping with the risks encountered. It was essential to develop a system of registration of occupational morbidity and mortality and to raise awareness of occupational hazards among the public, decision-makers, employers and employees. Research in occupational health must also be strengthened in order to develop safety norms and standards for various work-related hazards.

The National Institute of Occupational Health was preparing a plan of action, within the framework of the Ninth Five Year Plan, which would make optimum use of the existing health care delivery system to provide occupational health services, particularly for the rural workforce.

He supported the draft resolution.

Dr SIRIPHANT (Thailand) strongly supported the draft resolution recommended by the Executive Board. Referring to the Director-General's report, he expressed the view that nongovernmental organizations should play a pivotal and not merely a supporting role, especially in the monitoring and evaluation of occupational health programmes, which often provoked a conflict of interests owing to concern that they might hinder industrial and economic growth. Further, close cooperation with other organizations under the lead of WHO was not enough; the roles and responsibilities of each organization should be defined, since certain questions could be better addressed by, for example, ILO.

Ms VOGEL (United States of America) applauded the comprehensiveness of the global strategy, which could have a significant beneficial impact on the world's workforce. She agreed with the emphasis on support to Member States in developing national programmes in occupational health for all and endorsed the broad range of proposed partnerships, including multilateral, intergovernmental, national and nongovernmental organizations. She was particularly pleased to note the role outlined for the network of WHO collaborating centres in occupational health in order to facilitate implementation of the global strategy. The objective of reversing negative trends in protection of workers by the year 2000 would require an extraordinary improvement in working conditions; a regional approach to those difficulties might be a more appropriate initial response, especially for countries still lacking relevant programmes. The disciplines of epidemiology and industrial hygiene merited greater focus; the former played a crucial role in the design, establishment and evaluation of surveillance systems to determine the need for and effectiveness of occupational safety and
health services, and industrial hygienists played an important preventive role. She supported the draft resolution before the Committee.

Dr AL-JABER (Qatar) said that occupational health services were vital for the economy of any country and that Qatar accorded high priority to providing healthy workplaces. He supported the draft resolution, with the amendments proposed by Greece.

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

The meeting rose at 16:15.
SEVENTH MEETING
Friday, 24 May 1996, at 9:00

Chairman: Professor B. SANGSTER (Netherlands)

1. COMMUNICABLE DISEASE PREVENTION AND CONTROL: Item 18 of the Agenda

Smallpox eradication: destruction of variola virus stocks: Item 18.1 of the Agenda
(Resolution EB97.R24; Document A49/5)

The CHAIRMAN invited the Committee to consider the Director-General’s report (document A49/5) and the draft resolution contained in resolution EB97.R24, whereby the Executive Board proposed that the Health Assembly should recommend the destruction of the world’s remaining stocks of variola virus and other infectious variola materials on 30 June 1999. If the Committee agreed, the word “sequences” might be deleted from the operative paragraph of the resolution, since according to expert opinion it was ambiguous.

It was so agreed.

Dr ANTELO PÉREZ (representative of the Executive Board) said that, since the declaration of smallpox eradication in May 1980 only two laboratories had retained stocks of variola virus: the Centers for Disease Control and Prevention in Atlanta (GA), United States of America, and the Russian State Centre for Research on Virology and Biotechnology in Koltsovo, Russian Federation. The ad hoc committee on orthopoxvirus infections had repeatedly recommended that those stocks should be destroyed, since sufficient information was available from noninfectious material to answer any queries in the future, and the consequences of an escape of infectious variola virus would be devastating now that an increasing proportion of the population was no longer immunized. Consideration of the matter by the Executive Board at its ninety-seventh session had led to the adoption of resolution EB97.R24 recommending, as the Chairman had said, that all remaining variola virus stocks should be destroyed on 30 June 1999. In the meantime, WHO should attempt to achieve a broader consensus in the scientific community and should also sound out opinion outside that community.

Dr ADAMS (Australia) endorsed the view that it was too dangerous to maintain infectious variola virus stocks, since no one under the age of 16 now possessed any immunity against smallpox. Furthermore, all necessary genomic research had been undertaken. He therefore supported the draft resolution recommended by the Executive Board, which he hoped would be adopted unanimously.

Mr ISLAM (Bangladesh) said that, given the many health problems facing the international community, including cancer, AIDS, tuberculosis and cholera, there seemed to be no point in delaying the total destruction of the variola virus. He too supported the draft resolution and hoped that the Health Assembly would achieve consensus on the matter.

Dr WASISTO (Indonesia) agreed that any escape of the variola virus would be very serious and that all necessary information about the pathogen was already on record. He accordingly supported the draft resolution.

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Mr CHAUHAN (India), supporting the draft resolution, said that the remaining stocks of variola virus should be destroyed, but that cloned DNA fragments of the variola virus genome, which were not infectious, should be stored in the two laboratories mentioned in the draft resolution, which would become the international repositories for storage, maintenance, distribution and monitoring.

Dr ÁVILA DÍAZ (Cuba) said that the world could not consider smallpox completely eradicated until the remaining stocks of variola virus had been destroyed. There had already been enough delay. He accordingly supported the draft resolution and hoped that it would ensure that a date for the destruction of the virus would be set once and for all.

Dr AL-MUHAILAN (Kuwait) supported the draft resolution. However, perhaps it would be prudent to collaborate with the United Nations bodies concerned with the control of biological weapons to ensure that no other countries were secretly maintaining stocks of variola virus.

Dr ABDULHADI (Libyan Arab Jamahiriya) also supported the draft resolution. It was imperative to set a deadline for the destruction of the variola virus so as to prevent any risk of an accidental recurrence of the disease.

Dr BOUFFORD (United States of America) said that a two-year scientific and policy review in her country had concluded in favour of destroying the variola virus. The Executive Board had reviewed the matter in depth and had reached consensus on the destruction date of 30 June 1999. She therefore supported the draft resolution and hoped that the international community would commit itself firmly to the chosen date.

Mr PARK (Republic of Korea) expressed his support for the draft resolution. However, previous recommendations on the item had not been fully implemented. He therefore called upon the Director-General to oversee the destruction of the remaining stocks of variola virus, ensuring that no other institutions held stocks unofficially, and to report thereon to the Executive Board and the Health Assembly.

Dr MARANDI (Islamic Republic of Iran) supported the draft resolution, but called upon WHO to provide an assurance that variola virus was not being stored anywhere but in the two laboratories mentioned in the text.

Dr MAJORI (Italy), speaking on behalf of the European Union countries, Dr KHAI MING (Myanmar), Professor PICO (Argentina), Dr WILLIAMS (Cook Islands), speaking on behalf of the small island countries of the Pacific, Dr MAHMOOD (Malaysia), Dr LOSSEV (Russian Federation) and Dr GREEN (Israel) supported the draft resolution recommended by the Executive Board.

The DIRECTOR-GENERAL assured the Committee that WHO, together with the WHO collaborating centres concerned, would ensure that the variola virus was destroyed on schedule and that no stocks of the virus were stored in other laboratories.

The resolution recommended by the Executive Board in resolution EB97.R24 was approved.1

**New, emerging and re-emerging infectious diseases, and revision of the International Health Regulations:** Item 18.2 of the Agenda (Resolutions WHA48.7 and WHA48.13; Documents A49/6 and Add.1)

The CHAIRMAN invited the Committee to consider the following draft resolution entitled "New, emerging and re-emerging infectious diseases: special programme on malaria", proposed by the delegations of Gambia, Mozambique, Myanmar and Namibia.

1 Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA49.10.
The Forty-ninth World Health Assembly,
Noting with concern that the global malaria situation is serious and that malaria remains a major
global priority with an annual incidence of between 300 and 500 million clinical cases, African
countries south of the Sahara accounting for more than 90% of the global burden;
Alarmed by the death toll from malaria of about one million in children below the age of five
years and by the extension and intensification of resistance to many antimalarials;
Deeply concerned at the recent occurrence of extensive malaria epidemics, particularly in Africa,
due to civil disorders, or major ecological changes and movements of refugees and displaced
populations;
Noting with regret that WHO response is inadequate to deal with the explosive situation while
acknowledging the intensive efforts undertaken by the technical staff of the Organization in spite of the
limited resources available for the purpose;
Recalling resolutions WHA38.24, WHA42.30, and WHA46.32 as well as resolutions 1994/34 and
1995/63 of the United Nations Economic and Social Council, which called for increased resources for
preventive action and intensification of the struggle against malaria in developing countries, particularly
in Africa, and urged WHO, as the lead agency in international health, to continue to provide in
collaboration with the United Nations agencies and programmes concerned the technical expertise and
support to the agreed malaria control strategies and workplans;
Recognizing that any further delay in intensifying the struggle against malaria will cost millions
more lives and put the Organization in an untenable situation as the leader of international health work
in disease control,
1. URGES Member States to take action to participate fully in a reestablished action programme
on malaria concentrating on ways and means of preventing and controlling the disease;

2. URGES regional committees to ensure that the programme is vigorously pursued in their region
and that to this end regional plans of action are prepared and adequate resources allocated to the
programme and subsequently in the regional programme budgets;

3. REQUESTS the Director-General to explore the possibility of establishing a special programme
on malaria;

4. FURTHER REQUESTS the Director-General to intensify his efforts to increase the
extrabudgetary resources for the special account on malaria on the basis of a plan of action for
intensification of the programme and to submit a report to the ninety-ninth session of the Executive
Board on the progress made, including the commitment of additional resources.

Mrs HERZOG (representative of the Executive Board) noted that resolution WHA48.13 called upon
the Organization to improve its recognition of and response to new, emerging and re-emerging infectious
diseases and to prepare plans for improving national and international surveillance and strengthening research.
A series of meetings had been held during 1995, and the Director-General had established a new Division
of Emerging and other Communicable Diseases Surveillance and Control whose plan of action had entered
into force in January 1996.

Regarding the revision of the International Health Regulations (resolution WHA48.7), a consultation
on the international response to recent epidemics and the application of the Regulations had been held in
December 1995. The recommendations of the consultation would be considered by the Committee on
International Surveillance of Communicable Diseases during its deliberations to revise the Regulations; the
findings would be reported to a forthcoming Health Assembly.

Dr MAHMOOD (Malaysia) commended the formation of the Division of Emerging and other
Communicable Diseases Surveillance and Control and the revision of the International Health Regulations.
Measures were urgently needed to strengthen national and international capacity for the surveillance,
prevention and control of communicable diseases, which would include timely and effective response to those
that represented new, emerging and re-emerging public health problems. WHO was urged to provide
technical support in developing that capability, and to coordinate effectively the exchange of surveillance information using modern information technology.

Dr KILIMA (United Republic of Tanzania) said that malaria was a major cause of morbidity in his country, contributing up to 31% of the national disease burden. In supporting the draft resolution, he emphasized that the special programme on malaria should be kept small in terms of the number of staff at headquarters, but the direction should be given full authority to manage resources, with minimal use outside the targeted area. Countries should have well formulated plans to enable proper follow-up and to ensure that the resources were used for the control of malaria.

Mr CHAUHAN (India), welcoming the establishment of the new Division, said that the emergence of new diseases and the sudden re-emergence of old ones had disrupted disease control plans in some developing countries. For example, while India had been grappling with HIV/AIDS, the incidence of cardiovascular disorders, cancer, diarrheal diseases and respiratory ailments had increased, malaria and tuberculosis had taken on more virulent forms, and there had also been the sudden appearance of plague. He outlined some of the many disease control projects under way in India and urged WHO to give further technical support to countries and to encourage research on new feasible and cost-effective approaches to disease prevention and control. With the discovery of new pathogens and the development of new intervention techniques, the International Health Regulations needed to be updated.

India supported the draft resolution.

Dr BROOKMAN-AMISSAH (Ghana) warned that the glamour and publicity associated with measures against new diseases might divert resources and attention from the old problems which continued to be a burden in many developing countries; new resources were needed, not a mere reallocation of existing ones. The changing situation called for a critical review of disease control and disease eradication strategies. There had been a tendency in the past to pay too little attention to capacity-building and the development of local skills and expertise; most countries had not trained enough disease control experts. Further, there were very few incentives for local scientists to remain in their own countries. More attention should be paid to such factors if diseases were to be contained.

Mrs SAARINEN (Finland) said that, while supporting the draft resolution and recognizing the serious public health problem posed by malaria in many developing countries, Finland did not wish to see more vertical programmes. It would prefer the expertise and technical support from the strengthened malaria programme to be efficiently distributed to primary health care structures at the community level.

Dr MARQUES DE LIMA (Sao Tome and Principe) said his delegation would like to be included as a cosponsor of the draft resolution.

Dr MUKIWA (Malawi) and Dr MAPETLA (Lesotho) supported the draft resolution.

Dr SHONGWE (Swaziland), supporting the draft resolution, said that more resources should be allocated to the countries of Africa where malaria posed a serious threat to health and development and that a greater effort should be made to strengthen support to countries from WHO headquarters.

Dr MOORE (United States of America) supported the global effort being led effectively by WHO against emerging and re-emerging infectious diseases. She commended the new Division of Emerging and other Communicable Diseases Surveillance and Control on its careful consideration of WHO’s role, taking into account both the unique resources and strengths of the Organization on the one hand and its current resource constraints on the other. WHO was giving appropriate leadership in defining the problems, developing a policy and framework for an effective global public health response, and advocating coordinated global action. It was also involving many partners in those efforts. Coordination with other programmes within WHO, such as the Global Tuberculosis Programme, would also be important. The Organization’s role in implementation would require careful attention, for its participation in some activities might not be feasible or even appropriate. The new Division was already strengthening the part played by WHO collaborating
centres, which would help to extend the Organization's role and scope without drawing appreciably on its resources. The United States was concerned that less than 1% of WHO's regular budget was allocated for the Division's activities, but it was optimistic about continuing progress.

With regard to revising the International Health Regulations, she was pleased with the progress that had been made towards defining clinical syndromes to be included. It would be important not only to reach consensus but also to ensure that laboratory and other resources were available and coordinated as needed to respond to the revised Regulations. Effective means should be sought to cope with the adverse repercussions - for example on trade and tourism - for countries reporting a notifiable disease. She commended the Organization on making its *Weekly epidemiological record* available not only in printed form but also via the Internet.

The United States attached priority to WHO's role in the effective control of malaria and hoped that the unit or special programme would operate credibly and effectively. She endorsed previous comments regarding the focus of malaria control activities at regional, national and local levels.

Mr KAMUGISHA (Uganda) fully supported the draft resolution and WHO's efforts to support national and international efforts to control emerging and communicable diseases, including surveillance and control of epidemics.

Mrs JEAN (Canada) said that the control of communicable diseases, in particular disease surveillance, should be given the highest priority by WHO; Canada was prepared to work with the Organization and share its own experience. She urged an increase in resources for communicable disease control in the 1998-1999 programme budget. Canada fully supported the objectives of the draft resolution but believed that an integrated approach to the management of communicable diseases was best and hoped that that would be taken into consideration when the time came to decide how malaria control activities could be implemented most effectively.

Dr LOSSEV (Russian Federation) supported the plan of action for the new Division; its activities should be coordinated closely with those of the Division of Emergency and Humanitarian Action. He also considered it essential to give support to WHO in revising the International Health Regulations in view of the growing threat from new and emerging infectious diseases. He supported the objectives of the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) proposed three amendments to the draft resolution. In the first preambular paragraph she proposed that the words "malaria remains a major global priority" should be replaced by "control remains a major global priority essential for the achievement of health for all". Secondly, she proposed adding at the end of paragraph 1 the words: "and recommends that malaria control should be developed as an integral part of primary health care in national systems". Thirdly, she proposed that paragraph 4 should be divided into two subparagraphs with the insertion of "(1)" before the words "to intensify his efforts" and the addition of a subparagraph reading:

(2) to reinforce the malaria training programme at the country, regional and global levels.

Dr RABESON (Madagascar) said that malaria was one of the main causes of morbidity and mortality in his country. He supported the draft resolution and the revision of the International Health Regulations.

Dr GAYE (Senegal) said that the control of infectious diseases was one of his country's priorities. He welcomed the establishment of the Division of Emerging and other Communicable Diseases Surveillance and Control and fully supported the draft resolution.

Dr WINT (Jamaica) praised WHO's prompt and appropriate response to the challenge of new, emerging and re-emerging infectious diseases, as outlined in document A49/6. With regard, however, to the urgently needed revision of the International Health Regulations he was concerned that there was no timetable for its completion; he urged the Director-General to keep the Health Assembly up to date on progress. He supported the draft resolution; the special programme should take into account the concern and needs of countries that had eradicated malaria but continued to face the challenge of remaining free of the disease.
Dr ABDULHADI (Libyan Arab Jamahiriya) said that a number of factors had led to the re-emergence of malaria. One that had not so far been mentioned was the threat posed to countries which had made extensive efforts and achieved considerable success in controlling the disease by neighbouring countries which had not adopted similar policies. He therefore proposed that in paragraph 2 "regional plans of action" should be amended to read "regional and subregional plans of action". That would encourage WHO regional offices to collect information and set up programmes to enable groups of neighbouring countries to take action jointly.

Professor BERTAN (Turkey) welcomed the priority being given to new, emerging and re-emerging infectious diseases and the establishment of the new Division. WHO should continue to offer technical guidance and support to Member States in setting up effective surveillance systems, strengthening national as well as regional reference laboratories, and creating the necessary infrastructure and staff. Countries should be encouraged to coordinate their disease control activities at interregional, regional and subregional levels. Through its collaborating centres, WHO could accord direct support when necessary by providing expertise and strengthening infrastructures with teams and trainers in the event of emergencies. Turkey strongly believed in the need for the International Health Regulations to be revised and supported the draft resolution on the special programme on malaria.

Dr MOREL (Brazil) said that malaria represented a serious problem for his country, especially in the Amazon area. He proposed that paragraph 1 of the draft resolution should be amended by adding at the end "including the research and training activities needed to accomplish these goals".

Dr AL-AWADI (Kuwait) expressed support for the amendments proposed to the draft resolution by the delegates of Greece and the Libyan Arab Jamahiriya.

New, emerging and re-emerging infectious diseases would remain on WHO's agenda for some time because of the misuse of antibiotics by physicians and the Organization's failure to give sufficient attention to some of the diseases in question. Programmes focusing on a limited number of diseases should be decentralized and implemented at country level with support from the regional offices. The role of headquarters should be confined to surveillance. The success stories of smallpox and dracunculiasis could be repeated in a number of other areas and the Organization should channel its energies into achieving those attainable objectives.

Dr MAHJOUR (Morocco) welcomed the creation of the new Division and the proposed revision of the International Health Regulations. He supported the draft resolution, with the amendment proposed by the delegate of the Libyan Arab Jamahiriya.

Professor PICO (Argentina), while commending WHO's work to contain and control infectious diseases, asked whether it would not be preferable - and more in line with the aim of restructuring the Organization and enhancing its efficiency - to expand the resources of the Division of Control of Tropical Diseases rather than create a special programme on malaria as proposed in the draft resolution. Argentina recognized the importance of malaria as a public health problem, but considered that there was inconsistency between efforts to streamline the work of the Organization and the proposal to set up a new structure.

Dr IYAMBO (Namibia) said that malaria was a major obstacle to sustainable economic and social development in many developing countries and, as noted in the draft resolution, any further delay in intensifying the struggle against it would cost millions more lives. Countries where the disease was not endemic were also at risk from tourism and voluntary and involuntary population movements. He welcomed the increased interest being shown by international governmental and nongovernmental organizations in malaria control programmes. It was to be hoped that the health sector reform component of the special initiative for African economic recovery being undertaken within the United Nations system, together with activities to control diseases such as malaria, would receive full support by all countries. Although WHO had played a key role in framing the global malaria control strategy endorsed at the Ministerial Conference on Malaria in 1992, if it failed to respond effectively to malaria epidemics action might be taken to establish a cosponsored programme for control of malaria and other diseases outside the Organization.
He proposed that paragraph 3 of the draft resolution should be amended to read:

REQUESTS the Director-General to establish a special programme on malaria taking into account all feasible modalities of such a programme.

Dr SIRIPHANT (Thailand) expressed support for the draft resolution but proposed that greater emphasis should be placed in paragraph 2 on the need for close interregional cooperation.

Dr CHERAGHCHI (Islamic Republic of Iran) expressed the view that the global malaria control strategy should be based more firmly on the community and the family. Capacity-building in the area of human resources for malaria control was of crucial importance and regional training centres and activities should be established and developed. Meetings between neighbouring countries on malaria control should be encouraged.

The strengthening of surveillance systems was an essential component of any integrated programme to control emerging and re-emerging diseases. Experience in the Islamic Republic of Iran showed that the integration of disease control programmes into primary health care systems enhanced the sustainability of such programmes.

Mr VOIGTLÄNDER (Germany), referring under the heading of emerging infectious diseases to transmissible spongiform encephalopathies, observed that the possible link between bovine spongiform encephalopathy and Creutzfeldt-Jakob disease was a very serious matter requiring a great deal of scientific research. He therefore suggested that the staffing of the Veterinary Public Health unit at WHO, which had been reduced to the minimum, should be reconsidered.

Germany was actively supporting malaria control programmes in a number of countries in Africa and Asia and would seek to establish even closer working relations with WHO to that end. He therefore supported the draft resolution.

Professor MASSOUGBODJI (Benin) said that intensified WHO action against malaria was particularly desirable in view of the chemical resistance developed by a parasite that claimed millions of lives each year. The work of the Colombian team engaged in research on a malaria vaccine deserved increased WHO support. She supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) welcomed the establishment of the new Division and its prompt response to the bovine spongiform encephalopathy crisis in the form of scientific guidance for WHO Member States. Greece strongly supported the WHO Mediterranean Zoonoses Control Programme and asked for assurance that WHO’s leading role in zoonoses control and veterinary public health would be maintained and strengthened.

Mr GARCÍA (Spain) joined the delegate of Argentina in requesting further information regarding the position of the proposed special programme on malaria in WHO’s existing structure. He supported the recommendation by the delegates of Germany and Greece for a strengthening of the Veterinary Public Health unit.

Dr MAJORI (Italy) welcomed the establishment of the new Division and expressed the view that WHO should continue to serve as a multidisciplinary forum for the discussion of problems associated with diseases common to human beings and animals. A large proportion of Italy’s voluntary contributions to WHO were used for malaria control and he therefore supported any action designed to strengthen the programme in general and capacity-building in particular.

Dr HENDERSON (Assistant Director-General) thanked delegates for their comments and suggestions on the prevention and control of a number of diseases. The Director-General intended to provide a full report on the WHO response to malaria to the January 1997 session of the Executive Board. In the meantime, existing action in that field would be intensified.
A separate division for malaria control had existed in the late 1980s. As part of the restructuring process, three separate divisions - Malaria, Other Parasitic Diseases and Vector Biology Control - had been amalgamated in the interests of efficiency and to bring malaria control under the Division of Control of Tropical Diseases, which devoted 70% of its resources to that activity. The amendment proposed by the delegate of Namibia requested the Director-General to establish a special programme on malaria. In view of the apparent differences of opinion in the Committee on the degree of integration of such efforts, it might be preferable to keep the original wording of the draft resolution, which he felt might be adopted by consensus.

Dr HEYMANN (Division of Emerging and other Communicable Diseases Surveillance and Control) assured delegates that his Division’s mission statement, which had been translated into a biennial activities plan that was being implemented in close collaboration with the regional offices, would provide a strong international and national basis for all communicable disease detection, prevention and control. By using the example of emerging diseases such as hepatitis C, yellow fever, cholera, plague, meningitis, Ebola fever and the newly identified variant of Creutzfeldt-Jakob disease, the Division would call attention to the weakening infrastructure for the detection and control of communicable diseases and to the threat posed by the relentless spread of resistance to antimicrobials.

Renewed efforts in those areas would ensure that countries were better able to detect outbreaks of unusual diseases and to deal with them promptly. The new Division would work closely with the Division of Emergency and Humanitarian Action to ensure that it was in a position to provide technical input in response to outbreaks that were of international importance. By including veterinary public health within the new Division, the Director-General had ensured that the infrastructure for surveillance and control of zoonotic diseases would also be strengthened.

Professor PICO (Argentina) pointed out that the reply he had received to his question as to the position of malaria control within the Division of Control of Tropical Diseases had been that it indeed comprised 70% of the activities of that Division. If that was so, why should a new programme be created? He reiterated that the existing one should be strengthened and given the resources necessary to meet its stated objectives. Argentina fully recognized the importance of malaria, but in the interests of greater institutional efficiency efforts should not be duplicated.

Dr IYAMBO (Namibia) commented that the draft resolution was already a compromise. Malaria was a heavy burden in Africa and other developing countries, and while he recognized the efforts made by WHO through the existing programme, those activities were not effective in Africa. That was due partly to a lack of funds. However, any funds that were obtained should be used for activities and not to build up a heavy structure at headquarters. Programmes and action should be seen where problems existed and should not be implemented vertically but incorporated into primary health care. In view of the urgency of the problem in the field, he was not prepared to withdraw his amendment.

Mr GARCÍA (Spain) said that, although everyone agreed that WHO’s action against malaria should be intensified, there appeared to be an organizational problem in establishing the mandate. He suggested that paragraph 3 of the draft resolution should be deleted and wording to the effect that the intensified malaria control activities were to be carried out within the Division of Control of Tropical Diseases inserted in paragraph 4.

Mr TOPPING (Legal Counsel) pointed out that the Health Assembly was a legislative, policy-making body, and did not have the authority to instruct the Director-General with regard to administrative structures within the Secretariat. Moreover, the wording of the fifth preambular paragraph made it clear that WHO’s action against malaria was part of an overall programme within the United Nations system. Use of the term "special programme" in paragraph 3 indicated that it would be a cosponsored programme, in which the action of many programmes was unified. Such a special programme could be established only with the agreement of the other organizations involved, which had not yet been obtained. It would therefore be inappropriate for the Health Assembly to adopt the amendment proposed by the delegate of Namibia, whether it referred to a cosponsored programme or to an internal WHO programme.
The DIRECTOR-GENERAL agreed with the delegate of Namibia and other speakers that the programme on malaria should be strengthened, globally, regionally and nationally. In some regions, malaria programmes had been strengthened and some had been decentralized to individual countries, resulting in a significant decrease in the number of cases and even in eradication. The elimination or eradication of malaria, however, also implied a decrease in the population of *Anopheles* mosquitoes. Therefore, the WHO programme against malaria involved not only activities within the Division of Control of Tropical Diseases but also aspects relating to environmental health, health technology and the Special Programme for Research and Training in Tropical Diseases. In consultation with the regional directors, he was strengthening and streamlining the internal structure, mobilizing resources from various divisions. At the same time, support to the regions should be intensified, either by relocation or by direct cooperation with countries. In order for the programme to be efficient, new and cost-effective tools should be used, such as insecticide-impregnated mosquito nets; research on new drugs and on cost-effective vaccines was required; and new mechanisms were needed for the effective incorporation of malaria control activities in primary health care at country level. He would establish an internal task force to review WHO’s malaria programme and would report on progress to the ninety-ninth session of the Executive Board, making a concrete budget proposal for 1998-1999, and subsequently to the Fiftieth World Health Assembly.

He recalled that leprosy control had initially been included with activities against other bacterial diseases and had then been moved to the Division of Control of Tropical Diseases; research on leprosy was conducted within the Special Programme for Research and Training in Tropical Diseases. Integration of those activities had achieved significant results, culminating in the virtual elimination of leprosy in some countries. In order to accelerate control, he had established the action programme for the elimination of leprosy. The establishment of a special or "action" programme depended also on the degree of success of activities and was decided with the advice of the Executive Board.

He informed the delegate of Germany that appropriate action was under consideration to develop a global surveillance system for the agents that caused bovine spongiform encephalopathy and the newly identified variant of Creutzfeldt-Jakob disease.

Dr ANTELO PÉREZ (representative of the Executive Board) noted that the amendment proposed by the delegate of Namibia to the draft resolution would have to be examined with respect to the implications for the other organizations of the United Nations system that would be involved in the programme. A recommendation might be made that the Executive Board should study the question whether a special programme was required and if so how it could best be implemented, taking into account the relations with other organisms of the United Nations system.

The CHAIRMAN hoped that, following the statement by the Director-General, the delegate of Namibia had confidence that the malaria control programme would receive sufficient attention and might therefore consider withdrawing his proposed amendment.

Dr IYAMBO (Namibia) said that he was prepared to withdraw his proposal given that the Director-General had pledged that he would deal with the matter, inform the Executive Board and report to the Fiftieth World Health Assembly. Once the programme had been reviewed, a clearer picture would emerge, and the Health Assembly would be better informed.

The CHAIRMAN asked whether he might take it that the Committee wished to note the report.

It was so decided.

The CHAIRMAN invited the Committee to approve the draft resolution, with the amendments proposed by Brazil, Greece and Libyan Arab Jamahiriya.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA49.11.
2. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4) (continued)

Occupational health (Resolutions WHA33.31 and EB97.R6) (continued from the sixth meeting)

Dr MAHMOOD (Malaysia) reported that Malaysia was undergoing rapid industrialization: as employment in agriculture, forestry and fishery declined, employment in manufacturing, services and construction increased. Female participation in the workforce had risen from 42% in 1980 to 46% in 1993, with an increase from 16% to 30.8% in the manufacturing sector. The Ministry of Health would provide leadership in occupational disease surveillance, primary health care and the formulation of occupational health standards, while providing adequate support for training, development and research. A national seminar on the safety and health of workers had been organized to create awareness about occupational health and safety among health workers. Current work practices would be made more transparent to allow for auditing. The WHO global strategy for occupational health for all would encourage greater participation of the health sector. He supported the draft resolution recommended by the Executive Board in resolution EB97.R6.

Dr KIMAMBO (United Republic of Tanzania) said that occupational health was a priority among health reforms in her country. In view of the emergence of formal and informal small-scale industries, it was essential that communities should be informed about the use of protective clothing and the handling of dangerous materials. Working conditions in most areas were appalling and posed a real danger to the health of workers. Although urban areas were primarily affected, occupational health problems in rural areas should not be overlooked. She supported the draft resolution.

Dr LOSSEV (Russian Federation) observed that diseases in the workplace were also detrimental economically; he welcomed the emphasis on preventive aspects in the global strategy for occupational health for all. The initiative had come at the right time for countries in the process of transition to free market economies. A strategy that extended health care to the entire working population would require an infrastructure for medical services that would involve all the social partners. Further, occupational health and safety at work should be included in all training programmes. It would therefore be appropriate to include a reference to UNICEF and UNEP in paragraph 3(2) of the draft resolution.

Dr MAHJOUR (Morocco) said that, recognizing the importance of occupational health, Morocco had initiated a national occupational health programme in 1990 with the participation of the ministries of health, employment and industry and with support from WHO. The programme operated at regional level and aimed at reducing health risks for workers and health professionals through epidemiological surveillance of occupational diseases, education, dissemination of information, and communication aimed at awareness-raising among workers, as well as providing good quality medical facilities in the workplace. Morocco vigorously supported the draft resolution recommended by the Executive Board and hoped that WHO, in collaboration with other interested United Nations organizations, would ensure its further development in the future.

Dr ADAMS (Australia) expressed support for the draft resolution but suggested that paragraph 3(3) should be amended to read:

to encourage Member States to update education and training curricula for developing human resources for occupational health, including both occupational health and safety professionals (occupational physicians, ergonomists, occupational health nurses, occupational hygienists, and other experts) and professionals responsible for the design and management of the workplace (architects, engineers and managers) and to give them corresponding support.

Dr VAN ETTEN (Netherlands) regarded the strategy outlined in the report as an important step in the direction of a comprehensive policy on occupational health. The proposed collaboration with other organizations represented a welcome pragmatic approach. The Netherlands therefore supported the draft resolution, but would like to see children regarded as a specific high-risk group and therefore proposed that the words "including child workers" should be added at the end of paragraph 2.
Dr ÁVILA DÍAZ (Cuba) said that his country had enacted legislation on occupational health. The concept of primary health care based on the family doctor and nurse had been extended to the workplace, concentrating on health promotion and preventive care. Cuba’s Institute of Occupational Health sponsored research and training programmes and had been designated as a WHO collaborating centre. By encouraging closer contacts between its collaborating centres, WHO would be promoting a truly global strategy for occupational health for all. Cuba supported the draft resolution.

Dr FARSHAD (Islamic Republic of Iran) said that worker involvement in an occupational health programme was instrumental in achieving its aims. Iran had implemented national strategies to provide health care for factory workers. For smaller or rural undertakings and domestic work, occupational health was covered by primary health care. A large proportion of workplaces had been inspected and risk factors assessed, and all workers considered to be at risk were examined annually. Iran supported the draft resolution but would like to see a number of other points included. To control and prevent contamination and deterioration of the ecosystem, countries would have to cooperate in occupational and environmental health activities. Countries producing new chemical substances should take account of their harmful effects in the workplace and should adequately inform all those concerned. There should be a trained occupational health inspector in all factories and mines. Occupational health care for those employed in small-scale industries, particularly in rural areas, would be more effective if it were made an integral part of primary health care services. Finally, occupational health care should be extended to cover office workers, teachers, the armed forces and women at home.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) welcomed the proposed global strategy for occupational health for all as an important element of the health-for-all strategy. Particular attention should be paid to the changing nature of work-related disease, new opportunities for health promotion and prevention of work-related morbidity and mortality, and the responsibilities of employers. He supported the draft resolution and urged Member States to devise national programmes based on the global strategy. The references in paragraph 1 to the scientific use of risk assessment for developing occupational health standards, to occupational health training and to strengthening of research were particularly apposite.

Professor GRANGAUD (Algeria) supported the draft resolution. The emphasis placed on an intersectoral approach corresponded to his country’s strategy for implementing health policies.

Dr BERLIN (European Commission) said that the European Commission had instituted a broad programme on health and safety at work. The relevant European Union legislation was based on three key principles: prevention, employer responsibility, and worker participation. The European Commission had for some time actively cooperated in WHO programmes in that field and was now assisting several countries in central and eastern Europe.

Referring to the draft resolution and to the additional preambular paragraph proposed at the sixth meeting by the delegate of Greece, he suggested that the Committee might wish to consider inserting "and worker participation" after "multidisciplinary approach". Such an amendment would support the views expressed by the delegates of Bulgaria and Islamic Republic of Iran. He endorsed the call from several delegates for the involvement of epidemiologists, ergonomists and industrial hygienists.

Mr CHAUDHRY (Pakistan) said that Pakistan was undertaking initiatives to improve occupational health standards, notably through the setting-up of an environmental protection agency and the promotion of education, research and legislation in the occupational health field. Pakistan commended WHO on spearheading developments in occupational health and supported the draft resolution.

Mrs MOLAPO (Lesotho) also supported the draft resolution, which was most timely. There was a high death toll among Lesotho workers as a result of poor working conditions, in particular in the mines of a neighbouring country.

Dr FEDOTOV (International Labour Organisation) noted that ILO and WHO were the two United Nations specialized agencies directly concerned with occupational health. They shared a common definition
of occupational health and successfully coordinated their activities, in particular within the framework of the Joint ILO/WHO Committee on Occupational Health. That cooperation was very important for developing a multidisciplinary and intersectoral approach to occupational health. The core of ILO action was the provision of international instruments (conventions and recommendations) and a legal framework for the development of national occupational health policies and programmes, as well as an infrastructure for occupational health practice on a tripartite basis. WHO favoured a primary health care approach to reach working populations, and had developed regional programmes and the Global Strategy for Health for All. WHO also promoted the integration of occupational health services within primary health care services. Both considered those services to be part of a country's health infrastructure for the protection of workers' health. Both adhered to the principles of social equity, affordability and accessibility, primary prevention, allocation of duties and responsibilities, recognized ethical values and sustainable community development. With their complementary programmes, they could reach a large audience at national level, from government ministries to employers' and workers' organizations. ILO would therefore cooperate with WHO in implementing its new and powerful global strategy for occupational health for all.

Professor CAILLARD (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN, said that membership of the Commission, which was the main nongovernmental organization concerned with occupational health, currently stood at 2000. Far-reaching changes were taking place in the world of work, particularly in the newly industrialized countries and those still in the process of industrialization. The principle proclaimed by the International Commission 80 years earlier, namely that economic development should be accompanied by measures to protect both workers' health and the environment, was therefore being reaffirmed. The world's working population numbered more than 2400 million and many of them would fall victim to disease and accidents while the Health Assembly was in progress. The aim of occupational health strategies should be to prevent accidents and diseases associated with productive activity and to provide, where necessary, curative health care that would allow individuals to maintain their capacity to work. There was a need to disseminate a "culture of prevention" that would also protect the working environment. The elaboration and implementation of a global strategy for occupational health for all would also involve strengthening the effectiveness of many other programmes, such as those on tobacco abuse, reproductive health and communicable diseases. The International Commission on Occupational Health, which represented all those principally concerned throughout the world, endorsed the WHO global strategy for occupational health for all and would strive to ensure that it reached a wide audience and that it kept pace with newly emerging occupational health requirements throughout the world.

Mrs HERZOG (representative of the Executive Board) said that speakers had recognized the importance of occupational health and that the amendments proposed strengthened the resolution recommended by the Board. The cooperation between WHO and ILO was most encouraging.

Dr NAPALKOV (Assistant Director-General) thanked delegates for their support for the global strategy for occupational health for all and welcomed the proposed amendments. He agreed as to the need to strengthen the regional approach in the global strategy and also lay special emphasis on epidemiology and industrial hygiene. Finally, it should be borne in mind that the full text of the global strategy covered many points which had not been reflected in the brief document submitted to the Health Assembly.

The CHAIRMAN invited the Committee to approve the resolution recommended by the Executive Board in resolution EB97.R6 with the amendments proposed by the delegates of Australia, Greece and the Netherlands.

The resolution recommended by the Executive Board in resolution EB97.R6, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA49.12.
Prevention and control of iodine deficiency disorders (Resolutions WHA43.2 and EB97.R9)

Dr ANTELO PÉREZ (representative of the Executive Board) informed the Committee that, at its ninety-seventh session, the Executive Board had reviewed the Director-General's report on prevention and control of iodine deficiency disorders (document A49/4, section VII), prepared in accordance with resolution WHA43.2. The Executive Board had noted that, although iodine deficiency was still a problem of massive global dimensions, particularly in view of the preventable brain damage from cretinism and the reduced educability that it caused, there were very clear signs that it was on the decline owing to the concerted global action to iodize salt. Several members had observed that the elimination of iodine deficiency disorders (IDD) would be one of the public health triumphs of the century, comparable with the eradication of smallpox and poliomyelitis. The Board had noted the progress made but had underlined the need to intensify prevention and control efforts. WHO should continue to play a leading role in sustaining the programme and in ensuring effective monitoring. The need for continuing coordination with the activities of UNICEF had also been noted.

After a brief discussion, which had included a statement by the International Council for the Control of Iodine Deficiency Disorders (ICCIDD), the Executive Board had adopted resolution EB97.R9, in which it recommended a draft resolution for adoption by the Health Assembly.

Dr BOUANGA (Congo) endorsed the strategy to combat iodine deficiency, which was causing much ill-health in all regions of Congo, even though a control programme had been established.

Mr GARCÍA (Spain) supported the draft resolution recommended by the Executive Board, but proposed that in paragraph 3 the words "to ensure sustainability" should be replaced by "to increase efforts for the sustainability".

Dr DRAME (Guinea) supported the draft resolution: IDD were a serious public health problem in his country. Thanks to the support of WHO and others, Guinea had adopted legislation on the consumption of iodized salt and a five-year eradication plan had been drawn up.

Dr ADAMS (Australia) said that the elimination of IDD, of which only three years previously some 1500 million persons had been at risk, would rank alongside the eradication of smallpox, poliomyelitis and leprosy as yet another remarkable global achievement. Some 750 million persons were affected by goitre and 43 million by IDD-related brain damage. The dramatic increase in the consumption of iodized salt over the past few years meant that, if the current impetus was maintained, IDD could be eliminated completely by the beginning of the next century. WHO, UNICEF and ICCIDD were to be congratulated on their truly remarkable efforts. His delegation fully supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) supported the draft resolution but proposed the insertion in paragraph 3, after the words "URGES Member States", of a new subparagraph reading:

to give high priority to the prevention and control of iodine deficiency disorders whenever they exist through appropriate nutritional programmes as part of primary health care;

the existing text becoming subparagraph 3(2). She further proposed that subparagraph 4(3) should be amended to read:

to mobilize additional technical and financial resources to permit those Member States in which iodine deficiency disorders are still a significant problem to train health and development workers in the early identification and treatment of iodine deficiency disorders and develop or expand the appropriate public health preventive programmes for the elimination of these disorders.

Mr RIXIN (Bhutan) said that IDD could be eliminated by the year 2000, but only with an acceleration of programme implementation and an increase in resources. He urged WHO to continue to pursue the elimination goal vigorously in collaboration with UNICEF, ICCIDD and other organizations. He fully supported the draft resolution.
Mr Y'ONIENE (Zaire) expressed strong support for the draft resolution before the Committee. The marketing of non-iodized salt had been prohibited in Zaire since 1995.

Dr MARQUES DE LIMA (Sao Tomé and Principe) said that IDD were an important public health problem and that the associated brain damage hampered economic and social development. With the help of UNICEF, his country had prepared legislation on the iodization of salt that had already been approved by the Government. Thus it was hoped that in future any salt imported for consumption would be iodized. He supported the draft resolution but suggested that it should include a paragraph inviting those Member States in which IDD were an important problem to draw up legislation if they had not already done so.

Mr AHSAN (Bangladesh) expressed appreciation for the strategic guidance and other activities undertaken by WHO for preventing and controlling IDD. Thanks to the introduction and marketing of iodized salt all over the country, it had been possible to reduce the incidence of IDD in Bangladesh considerably. The Government had successfully initiated a massive public awareness programme to popularize the use of the product. Unfortunately it cost more than normal salt, which discouraged its use among the poorer sections of the population.

The goal of eliminating IDD by the year 2000 could be attained provided national governments received adequate financial and technical support. His Government was heartened by the fact that the need for substantial acceleration of action and increased support had been recognized, inter alia, in countries of south Asia. He supported the draft resolution.

Dr AKIN (Turkey) regretted that, although IDD were a serious health problem in many countries, they had not yet been given the attention they deserved, despite the availability of a low-cost method of overcoming the problem, namely the iodization of salt. The obstacles to the elimination of IDD were not only legislative; the most important was lack of public awareness. In Turkey, large amounts of untreated salt were consumed for economic reasons. A strong national initiative supported by different sectors and by international organizations would be required if IDD were to be eliminated by the year 2000. She supported the draft resolution.

Mr AFZAL (Pakistan) said that a comprehensive programme to eliminate IDD had already been launched in his country and a very intensive health education programme using all channels of communication was being carried out to induce the public to use iodized salt; a recent survey had shown that nearly 30% of households were now using the product, and the number was growing every month. He wished to place on record Pakistan's appreciation for the support given by WHO and UNICEF. His Government was considering the possibility of introducing legislation to encourage the private sector to produce and market iodized salt. Any guidance that WHO might wish to provide would be welcome. In any case, he supported the draft resolution.

Dr MZIGE (United Republic of Tanzania) said that his country attached great importance to adequate provision of micronutrients and supported the draft resolution before the Committee. Any action taken pursuant to that resolution should be integrated in other initiatives to combat micronutrient deficiencies. The United Republic of Tanzania had adopted legislation making it illegal to import salt for human or animal consumption that had not been iodized. Approximately 40% of the country's population suffered from iodine deficiency.

Professor GRANGAUD (Algeria) said that his country had been producing and marketing iodized salt since 1967. By November 1995, 92% of Algerian families had been using the iodized product, and those that had not been could easily have done so. It was clear that use depended on consumer information. He supported the draft resolution but proposed that "social communication" should be included among the activities mentioned in paragraph 3.

Dr MAHMOOD (Malaysia) endorsed resolution WHA43.2 urging the world community to eliminate IDD by the year 2000. It was, however, a cause of concern that, despite the availability of a number of
control methods, IDD were still a problem in many countries. Malaysia had adopted a dual strategy, making supplies of iodized salt available and, in remote areas, iodizing the local water supply.

Dr MTSHALI (South Africa) commended WHO and UNICEF on their efforts to eliminate IDD by the year 2000. South Africa had recently introduced legislation on salt iodization under its comprehensive nutrition programme focusing on micronutrient disorders. She urged WHO and Member States to introduce a mechanism to monitor and prevent the exportation of non-iodized salt to countries having no legislation on the subject. She supported the draft resolution.

Dr AL-JABER (Qatar) said that cases of IDD were still being found in Qatar, especially among children, owing to the inadequate fish content in the diet. He suggested that a reference to education with due regard to cultural differences should be added to the activities listed in paragraph 3 of the draft resolution, which his delegation fully supported.

The meeting rose at 12:35.
IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4) (continued)

Prevention and control of iodine deficiency disorders (Resolutions WHA43.2 and EB97.R9) (continued)

Mrs GASENNELWE (Botswana) said that in Botswana most salt, whether imported or home-produced, was iodized, although non-iodized salt was still in use in some areas, especially near salt pans. A study was planned to ascertain the extent of iodine deficiency disorders (IDD) remaining, with a view to launching an intensive information and education campaign promoting the use of iodized salt as part of the country’s primary health care programme. Legislation on the subject was also planned.

She fully endorsed the draft resolution recommended by the Executive Board in its resolution EB97.R9.

Ms SURENCHIMEG (Mongolia) said her country had begun implementing a project to eliminate iodine deficiency disorders in 1992. Since 1994, iodine supplements in capsule form had been supplied to pregnant women, young mothers and children in areas with a high prevalence of goitre. In 1995, a national programme had been launched with the target of iodizing 70% of all salt used for domestic consumption by the year 1997 and 95% by the year 2000. She thanked the Government of Japan for its offer to supply iodine preparations for that purpose. Mongolia also congratulated WHO and UNICEF for all they had done to help eliminate IDD and supported the draft resolution.

Professor YU Zonghe (China) also supported the draft resolution. Following the eradication of smallpox, the elimination of iodine deficiency disorders by the year 2000 would mark a further milestone in mankind’s struggle against disease. IDD principally affected children in developing countries: to achieve the world target, the international community must mobilize all its forces in order to give those countries the technical and financial support they needed.

China was one of the countries most seriously affected by IDD, and the Government was making intensive efforts at control. It had launched a programme to eliminate iodine deficiency by the year 2000, and had also introduced regulations governing salt iodization. By the end of 1995, the inhabitants of 80% of China’s provinces had been consuming iodized salt. He was confident that, with the active support of WHO and the combined efforts of other Member States, China would achieve its elimination target.

Dr SHAFEI (Egypt), endorsing the draft resolution, said that Egypt had introduced a national programme for the iodization of household salt in areas where deficiency disorders were prevalent. She suggested that the draft resolution should include a request to salt suppliers and producers to supplement their product with iodine, and also a recommendation that education in the need for salt iodization should be included in primary health care programmes.

Ms MIDDELHOFF (Netherlands) commended WHO on its efforts to prevent and control iodine deficiency disorders, in collaboration with UNICEF and the International Council for the Control of Iodine Deficiency Disorders (ICCIDD), as well as on its cooperation with the ACC Sub-Committee on Nutrition, which was a valuable follow-up to the International Conference on Nutrition. She urged WHO to continue that collaboration.
She proposed that in paragraphs 3 and 4(2) of the draft resolution the words "and UNICEF" should be added after "nongovernmental organizations".

Dr MAHJOUR (Morocco) also welcomed the progress achieved over the past 10 years. Since 1990, Morocco had been implementing an IDD control programme based on salt iodization, epidemiological surveillance, and social mobilization. Legislation making the iodization of household salt compulsory had been passed in December 1995. He thanked WHO, UNICEF and ICCIDD for the support they had given to that programme. He endorsed the draft resolution.

Ms GIBB (United States of America), endorsing the draft resolution, said important progress had been made in controlling iodine deficiency, and her country was pleased to be working with UNICEF and ICCIDD in that effort. Her country was particularly concerned about the sustainability and quality assurance of the salt iodization programme. She would strongly recommend that country programmes should include regular monitoring of affected populations, with a view to determining their effect and assessing the progress made.

Dr ÁVILA DÍAZ (Cuba) said one of the priorities of Cuba's national action plan for achieving the goals of the World Summit for Children was remedying micronutrient deficiencies in the population, and in particular iodine deficiencies in children and women of child-bearing age. UNICEF was cooperating in that effort, first by helping to develop iodized salt production, and secondly by assisting in research into iodine deficiency. He supported the draft resolution.

Dr NAKAMURA (Japan) said iodine deficiency disorders, which caused mental retardation and goitre, constituted a major public health problem. However, effective preventive measures existed. Japan had been working with the Government of Mongolia on an iodine deficiency prevention programme with the collaboration of WHO and UNICEF. Technical support by WHO was vital to such programmes, and Japan, for its part, would continue to strengthen its contribution to international efforts to solve the problem. He strongly supported the draft resolution.

Dr WASISTO (Indonesia) was pleased to note the progress made by Member States and WHO in controlling iodine deficiency. Hitherto iodized salt had been consumed by only 50% of Indonesia's population, but since 1995 efforts had been made to increase output and distribute the product at a lower price. Legislation on the subject was currently under consideration. He too supported the draft resolution.

Mr MABOTE (Lesotho) said that iodine deficiency disorders were an endemic problem in Lesotho, especially in the mountain areas. With the assistance of WHO and UNICEF, iodine capsules and iodized salt were being distributed, and he wished to commend both agencies for their efforts.

He supported the draft resolution, with the amendment to paragraph 3 proposed by Spain.

Dr AL-BARMAWI (Jordan) said a study carried out in Jordan, with the help of WHO and UNICEF, on a sample group of 8-10-year-old children had shown that 37% suffered from iodine deficiency disorders. Regulations had been adopted requiring household salt to be iodized, and were enforced by health inspectors. Information campaigns had also been launched to sensitize public opinion, and further research into the problem, particularly as it affected young children, was planned. Jordan hoped to learn from the experience of developing countries in the matter, particularly regarding the effect of adding salt to certain foods.

He supported the draft resolution.

Dr BIHARI (India) said that more than 167 million people in India were at risk of iodine deficiency disorders, and more than 63 million were actually affected. The country was committed to the goal of eliminating IDD as a major public health problem by the year 2000. Production of iodized salt was being increased through a policy of liberalizing private manufacture, and now stood at 6 million tonnes annually. Under the Prevention of Food Adulteration Act, the sale of non-iodized salt was now banned in most states. A national reference laboratory had been set up in Delhi for training medical and paramedical personnel in monitoring the iodine content of salt in urine. Finally, an intensive mass information campaign had been launched, focusing particularly on schoolchildren.
He supported the draft resolution.

Dr BENMILOUD (International Council for Control of Iodine Deficiency Disorders - ICCIDD), speaking at the invitation of the CHAIRMAN, said that the Council fully supported the draft resolution as a necessary step towards the virtual elimination of iodine deficiency disorders by the year 2000. In his report to the ninety-seventh session of the Executive Board, the Director-General, re-emphasizing the magnitude of the problem and the fact that iodine deficiency was the main cause of potentially preventable mental retardation in the world, had described how the global alliance between the national committees, WHO, UNICEF, nongovernmental organizations (essentially ICCIDD) and bilateral agencies had achieved major progress during the past five years.

The draft resolution recognized the need for accelerated action in several regions and emphasized that continued monitoring would be required to ensure sustainability of the elimination of iodine deficiency disorders well beyond the year 2000. Real progress in establishing legislation and implementing procedures for salt iodization had already been achieved, but the efficiency, safety and benefit of the programmes still had to be ensured by the end of the decade. Examples could still be found of failure to achieve optimal efficiency of iodine supplementation as a result of poor or non-existent evaluation and monitoring.

The ICCIDD, as the recognized international expert body in its field, offered a comprehensive consultancy service to countries and agencies. In view of the current emphasis on monitoring and evaluation, a comprehensive methodology and a directory of ICCIDD experts had been drawn up to respond to requests from governments and agencies. Independent evaluation of programmes had been carried out or was under way in at least 25 countries in Africa, Asia, Europe and South America.

The ultimate goal of virtual elimination of iodine deficiency disorders was attainable at low cost by the year 2000 and could also usefully serve as a model for other micronutrient deficiency control programmes. Endorsement by the Health Assembly would strengthen collaboration between national health authorities and the competent professional bodies, and would accelerate action and guarantee attainment of the goal.

Dr ANTEZANA (Assistant Director-General), welcoming the enthusiasm for the subject displayed in the course of the debate, said that the world was on the threshold of a historic public health triumph - the elimination by the year 2000 of iodine deficiency disorders with all their burden of brain damage and learning impairment. WHO would continue vigorously to pursue its work in the field, with particular emphasis on monitoring, standard-setting, research and provision of assistance to Member States, in association with UNICEF, ICCIDD and other international organizations. A comprehensive progress report would be submitted to the Health Assembly in 1999.

Dr THYLEFORS (Secretary) drew the attention of the Committee to a revised text of the draft resolution recommended by the Executive Board in resolution EB97.R9, incorporating the amendments proposed by Algeria, Greece, Netherlands and Spain.

The draft resolution, as amended, was approved.1

Revised drug strategy (Resolution EB79.R14) (continued from the fifth meeting, page 64)

Dr MILLER (Barbados), speaking as chairman of the drafting group that had been set up at the fifth meeting to collate the amendments proposed to the draft resolution recommended by the Executive Board in resolution EB97.R14, introduced the amended text produced by the group.

The draft resolution, as amended, was approved2.

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1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA49.13.
2 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA49.14.
Infant and young child nutrition (Resolution EB97.R13)

Mrs HERZOG (representative of the Executive Board) said that at its ninety-seventh session the Board had reviewed a report by the Director-General drawing attention to the continuing high levels of malnutrition among infants and young children - particularly protein-energy malnutrition, famine deaths, anaemia, iodine deficiency disorders, and blindness caused by vitamin A deficiency. However, there were some encouraging developments: although only an estimated 34% of infants under four months of age in the world were exclusively breast-fed, more than 8000 hospitals in 171 countries had been selected to achieve "baby-friendly" status; and, 15 years after the adoption of the International Code of Marketing of Breast-milk Substitutes, 149 Member States, or nearly 80% of the total, had formally reported to the Director-General on the steps they had taken to give effect to the Code in their countries. The Executive Board had adopted resolution EB97.R13, which did not propose a text for adoption by the World Health Assembly.

The CHAIRMAN directed the Committee’s attention to the following draft resolution, proposed by the delegations of Botswana, Colombia, Congo, Cuba, Czech Republic, El Salvador, Eritrea, Honduras, Iran (Islamic Republic of), Malawi, Malaysia, Mauritania, Mozambique, Nicaragua, Norway, Philippines, South Africa, Swaziland, Sweden, United Republic of Tanzania, Venezuela, Zaire, Zambia, and Zimbabwe:

The Forty-ninth World Health Assembly,
Having considered the summary report by the Director-General on infant feeding and young child nutrition;
Recalling resolutions WHA33.32, WHA34.22, WHA39.28, and WHA45.34 among others concerning infant and young child nutrition, appropriate feeding practices and other related questions;
Recalling and reaffirming the provisions of resolution WHA47.5 concerning the fostering of appropriate complementary feeding practices;
Concerned that health institutions and ministries are under subtle pressure to accept inappropriate financial support for professional training in infant and young child health;
Noting the increasing interest in the monitoring of the industry’s compliance with the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions,

1. THANKS the Director-General for his report;

2. STRESSES the continued need to implement fully the International Code of Marketing of Breast-milk Substitutes, subsequent relevant resolutions of the Health Assembly, the Innocenti Declaration, and the World Declaration and Plan of Action for Nutrition;

3. URGES Member States to take the following measures:
   (1) to ensure that complementary foods are marketed in ways that do not undermine exclusive and sustained breast-feeding;
   (2) to ensure that the financial support for professionals working in infant and young child health does not create conflicts of interest, especially with regard to the WHO/UNICEF Baby Friendly Hospital Initiative;
   (3) to ensure that monitoring of compliance with the International Code and subsequent relevant resolutions is carried out in a transparent, independent manner, free from commercial influence.

He added that, after informal consultations, the following amended version of the draft resolution had also been submitted:

The Forty-ninth World Health Assembly,
Having considered the summary report by the Director-General on infant feeding and young child nutrition;
Recalling resolutions WHA33.32, WHA34.22, WHA39.28, and WHA45.34 among others concerning infant and young child nutrition, appropriate feeding practices and other related questions;

Recalling and reaffirming the provisions of resolution WHA47.5 concerning infant and young child nutrition, including the emphasis on fostering appropriate complementary feeding practices;

Concerned that health institutions and ministries may be subject to subtle pressure to accept, inappropriately, financial or other support for professional training in infant and child health;

Noting the increasing interest in monitoring the application of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions,

1. THANKS the Director-General for his report,

2. STRESSES the continued need to implement the International Code of Marketing of Breast-Milk Substitutes, subsequent relevant resolutions of the Health Assembly, the Innocenti Declaration, and the World Declaration and Plan of Action for Nutrition;

3. URGES Member States to take the following measures:
   (1) to ensure that complementary foods are not marketed or used in ways that undermine exclusive and sustained breast-feeding;
   (2) to ensure that the financial support for professionals working in infant and young child health does not create conflicts of interest, especially with regard to the WHO/UNICEF Baby Friendly Hospital Initiative;
   (3) to ensure that monitoring the application of the International Code and subsequent relevant resolutions is carried out in a transparent, independent manner, free from inappropriate influence.

Dr THYLEFORS (Secretary) explained that the amendments reflected an attempt to eliminate ambiguities and to clarify certain legal aspects of the text. The Committee might wish to consider the original draft resolution along with the amended version.

The CHAIRMAN requested speakers to indicate clearly to which version they were referring.

Mr MSWANE (Swaziland) considered that it would be preferable if the Committee took the original version as the basis for its discussion.

Dr YACOUB (Bahrain) said that his country was proud to be among those having taken measures to implement the International Code of Marketing of Breast-milk Substitutes and enacted legislation to protect mothers and children from commercial promotion which competed with traditional breast-feeding. Bahrain was also pleased to have hosted and cosponsored the recent international training seminar on implementation of the Code. He supported the amended version of the draft resolution.

Dr OTTO (Palau) said that his was a small, young nation which attached great importance to the development of human resources. The improvement of infant and young child nutrition was a major strategy in his country’s plans for health for all. Unfortunately, in the process of Western acculturation, people had been led to feel that breast-feeding was primitive and restricted women’s employment and career prospects. He expressed concern over the exploitation of developing countries by powerful companies using intensive and persuasive marketing techniques. He supported the spirit of the original draft resolution together with all the amendments proposed in the second version, the adoption of which would be of great help to Palau in combating the factors that adversely affected child nutrition.

Mr CHAUDHRY (Pakistan) said that breast-feeding, particularly exclusive breast-feeding, had received considerable impetus in his country through intensive health education programmes. Pakistan strongly supported the amended version of the draft resolution.

Dr STAMPS (Zimbabwe) said that in his country breast-feeding was almost universally practised, but exclusive breast-feeding was not common, as supplementation of breast milk started early, often as a result
of the promotion and marketing of breast-milk substitutes. A number of violations of the International Code by food manufacturers and retail outlets had occurred following trade liberalization. Examples of such practice included the distribution of "free gifts" to health workers and of educational materials to training institutions; the tendentious use of labelling; the sale of expired products; and advertising of products on television and in foreign magazines. Apart from their nutritional drawbacks, a further disadvantage of the use of breast-milk substitutes was their high cost in relation to the minimum wage. In view of such negative factors, the public health regulations were currently being reviewed by a technical committee which included representatives of the food manufacturing industry.

A number of difficulties had been encountered in implementing the provisions of the International Code. Future challenges included: broad information campaigns to educate health workers, retailers, food manufacturers and the public; measures to enable women in formal employment to practise exclusive breast-feeding; the distribution of a breast-feeding shield produced by the Government rather than private companies; the preparation of a joint regional law for sub-Saharan Africa on marketing of breast-milk substitutes, including monitoring guidelines; regulations to protect the increasing number of orphans of AIDS victims; regular Code monitoring activities integrated in the national structure; and closer consultation between the Government and the food industry on nutritional matters. Zimbabwe supported the original version of the draft resolution.

Mr MSWANE (Swaziland) said that 15 years after the adoption of the International Code children were still dying of "bottle-baby syndrome". It had been estimated that 1.5 million babies died each year because they were not breast-fed.

Regarding complementary feeding, he stressed the importance of avoiding the word "weaning", which implied taking the baby off the breast; that was not what was meant by "appropriate complementary feeding practices". Furthermore, when complementary foods were introduced there was a high risk of contamination by pathogens; it was therefore important that mothers should not be tempted to use them too early; but that required manufacturers to take a responsible attitude. Though the health sector always lacked adequate resources, inappropriate financing for health workers and health institutions should be avoided, as it created confusion, with consequent detrimental effects on the prevalence of breast-feeding.

Referring to the major success of the Baby-friendly Hospital Initiative, he hoped that Member States would share UNICEF's concern that it should not be funded by the infant-formula industry. Monitoring was of prime importance in ensuring implementation of the International Code, but it was also essential that monitoring should be carried out in an objective manner, avoiding financing by supposedly "independent" sources.

He appealed to Member States not to allow financial interests and the desire for gain to override WHO's commitment to improving the health of all people, especially women and children. He supported the original draft resolution in its entirety.

Dr MARQUES DE LIMA (Sao Tome and Principe) fully supported the amended version of the draft resolution. He proposed the inclusion of a new paragraph 3(4) reading:

to ensure that the appropriate measures are taken, including health information and education in the context of primary health care, to encourage breast-feeding.

Ms VOGEL (United States of America) said that her country agreed with the terms of resolution WHA47.5 with regard to fostering appropriate feeding practices and favoured in general the content of the amended version of the draft resolution, although some of the wording caused concern.

The period of transition, at four to six months of age, from exclusive breast-feeding to a mixture of breast-feeding and complementary foods was a crucial one, and it was important to consolidate the substantial progress that had been made in knowledge and practice in that area, in both the public and the private sectors. Many factors, including established cultural practices, time and financial pressures on working mothers, commercial interests and advice from health workers, influenced the timing of that transition and the type of complementary food given. Any effective strategy to improve nutrition and health must be directed at those factors by creating effective partnerships between all concerned - governments, health professionals, industry and the public - in an inclusive rather than an exclusive strategy. The fourth preambular paragraph of the amended version of the draft resolution was so vaguely worded that it might be taken to mean that any
financial support for professional training in infant and child health was inappropriate. Surely, that was not the Committee's intention?

The multiplicity of factors affecting the use of complementary foods to which she had referred was inadequately covered by the word "marketed". She therefore proposed that paragraph 3(1) should be amended to read:

to ensure that complementary foods are not promoted or used in ways that undermine exclusive breast-feeding up to four to six months and sustained breast-feeding thereafter.

Dr MTSHALI (South Africa) said that South African infants and young children bore a disproportionate burden of malnutrition and undernutrition. Although South Africa had instituted an integrated nutrition programme with the cooperation and technical assistance of UNICEF, including introduction of the mother-baby package, there was significant pressure from commercial enterprises using persuasive marketing techniques to influence breast-feeding practices. Application of the International Code should be monitored without commercial influence. South Africa would support the amended version of the draft resolution provided that in paragraph 3(3) the word "inappropriate" was replaced by "commercial", as in the original version.

Dr VIOLAKI-PARASKEVA (Greece) drew attention to paragraph 7 in section VIII of the Director-General's report (document A49/4), which referred to the preparation of guiding principles to ensure optimal feeding of infants and young children during emergencies. She proposed the addition of a new paragraph 4 to the amended version of the draft resolution, reading:

REQUESTS the Director-General to disseminate as soon as possible to Member States document WHO/NUT/96.4 (in preparation) on guiding principles for feeding infants and young children during emergencies.

She also proposed the addition of a new paragraph 3(5) reading:

to ensure that the practices and procedures of their health care systems are consistent with the principles and aims of the International Code of Marketing of Breast-milk Substitutes;

and a new paragraph 3(6) reading:

to provide the Director-General with complete and detailed information on the implementation of the Code.

Mrs BANDA (Malawi) said she favoured retaining the original draft resolution. She would, however, accept inclusion of the second preambular paragraph as worded in the amended version.

Dr HERNÁNDEZ (Venezuela) said that the success of breast-feeding promotion and the Baby-friendly Hospital Initiative had resulted in commercial interests attempting to impose themselves in the health field. There was often confrontation on that matter at important national, regional and international public health meetings, where companies blatantly tried to promote their products. More usually, however, they operated in a more subtle manner. She advocated speedy adoption of the resolution in its original, more direct form.

Dr LEGNAIN (Libyan Arab Jamahiriya) said that the 55 countries in which, according to paragraph 4 of the Director-General's report, 34% of infants under four months old were breast-fed were all developed countries. The WHO campaign had not been successful throughout the world. A further problem was the quality of complementary food given after the age of four months; its inadequacy was the main cause of malnutrition. She wished that the Organization would accord the matter priority, concentrating scientific research projects in the poorest countries on identifying food that was cost-effective and could be produced with natural resources. She endorsed the amended version of the draft resolution.

Dr PRATHAPA (Malaysia) said his country shared the Organization's disquiet at the high prevalence of protein-energy malnutrition among children under five years of age in developing countries. It also viewed with concern the slow progress some countries were making towards the nutritional goals of the World Summit for Children. The solution lay in the ability to alleviate poverty and ensure household food safety; there should also be a stronger focus on promotion and protection of women's health through proper nutrition, since that would provide an important input to child nutrition and health.
Malaysia fully supported the WHO training programmes aimed at assisting implementation of the Baby-friendly Hospital Initiative, including short courses for hospital administrators and policy-makers. It was hoped that similar courses could be provided for nongovernmental organizations and for communities, in view of the importance of advocacy and of community support for breast-feeding. Efforts should also be made to implement the initiative in private hospitals, nursing homes and private clinics. Malaysia was trying to encourage more mothers to breast-feed by setting up breast-feeding facilities at workplaces, arranging flexible working hours for mothers to enable them to breast-feed during work time and ensuring strict implementation of the national Code of Ethics for Infant Formula Products.

Monitoring and evaluation of the implementation of the International Code of Marketing of Breast-milk Substitutes also required consultation by countries with WHO and the infant formula industry. He therefore welcomed the move by WHO to formulate a common review and evaluation framework for the Code.

He endorsed the draft resolution in its original version.

Dr ÁVILA DÍAZ (Cuba) said that his country paid considerable attention to nutrition, particularly in relation to maternal and child health care; hospitals covering 85% of the country were already cooperating in the Baby-friendly Hospital Initiative. He proposed an addition reading "this Initiative should be supported and extended as much as possible to attain the objectives of primary health care" to the end of paragraph 3(2) of the draft resolution, which was the same in both versions.

Nutritional status in Cuba had been adversely affected by its present economic situation and the tightened blockade.

Mrs SAARINEN (Finland) said that in her country the promotion of breast-feeding was considered extremely important. She had taken part in the discussion that had led to the submission of the amended version of the draft resolution and agreed with most of the proposed changes. However, she felt that the original formulation of paragraph 3(3) was the clearer of the two versions and concurred with the delegate of South Africa in preferring the word "commercial" to the word "inappropriate".

Dr SILVA (Brazil) endorsed the position of Malawi and Venezuela and fully supported the original version of the resolution, which concluded with the objectives of the breast-feeding programme.

Dr CICOGNA (Italy), speaking on behalf of the European Union, expressed support for the amended version of the draft resolution, with particular emphasis on deletion of the word "fully" from paragraph 2 of the original version. Retention of that word might cause problems for European Union Member States in the application of European Union directives.

Dr EMIROGLU (Turkey) said that in view of the heavy burden of child mortality and morbidity due to malnutrition in many countries, child nutrition merited high priority. Her country had participated in preparing the Innocenti Declaration and had successfully initiated a programme to encourage a Baby-friendly Hospital Initiative in Turkey shortly thereafter. Implementation of such programmes required intersectoral collaboration at the national and international levels and she emphasized the value of the assistance provided by UNICEF and WHO in those initiatives. Furthermore, the agreement made with industry on distribution of free infant formula in maternity hospitals and primary health care facilities had been very effective.

She expressed her support for the amended version of the draft resolution.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) attached high priority to the promotion of breast-feeding and supported the amended version of the draft resolution, paragraph 3(3) of which allowed for participation by industry in monitoring the application of the International Code of Marketing of Breast-milk Substitutes. He shared the concern of other delegations on potential conflicts of interest caused by the provision of financial and other support. Such conflicts were an ethical matter, and in some Member States ethical standards were determined by independent bodies. He therefore suggested amending paragraph 3(2) to read:

to encourage the preparation and distribution by the appropriate body of ethical guidelines for professionals working in infant and young child health on avoiding the possible conflicts of interest created by acceptance of financial or other support.
Dr WIUM (Norway) agreed with South Africa and Finland in preferring the amended version of the draft resolution but with the original wording of paragraph 3(3).

Mr DEBRUS (Germany) said that his country’s Federal Government and the authorities of the federal Länder strongly supported breast-feeding. He endorsed the statement made by Italy on behalf of the European Union. Germany supported the amended version of the draft resolution.

Ms STEGEMAN (Netherlands) drew attention to a discrepancy between the wording in section VIII, paragraph 3 of the Director-General’s report (document A49/4) and that of resolution WHA47.5. The report suggested that WHO recommended "exclusive breast-feeding from birth to four to six months of age", whereas in the resolution the Health Assembly had urged Member States to foster appropriate complementary feeding practices "from the age of about six months". In future WHO reports agreed language should be used. She supported the amended version of the draft resolution, as further amended by South Africa.

Mrs DHAR (India) said that her country had taken a number of steps to combat malnutrition, including the adoption of a national nutrition policy and the institution of an interministerial coordination committee to effect synergy between the various sectors. Success in combating malnutrition, though modest, had been sustained and the percentage of severely malnourished children had dropped to a very low figure, while overall improvement in nutritional status was reflected in rapidly declining infant and child mortality rates. India was committed to improving the nutritional status of its people and supported the original version of the draft resolution, but with the omission of the word "fully" from paragraph 2, on which the Italian delegate had placed emphasis.

Professor GRANGAUD (Algeria) considered that, in the difficult economic conditions of transition to a market economy, it was important to reaffirm strongly the need to promote breast-feeding. He therefore supported the original version of the draft resolution.

Dr MARANDI (Islamic Republic of Iran) endorsed the amended version of the draft resolution. The importance of the International Code of Marketing of Breast-milk Substitutes in protecting the health of infants and young children could not be overemphasized, and he urged all Member States to implement it fully.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that industry, which had always recognized the superiority of breast-feeding, played a vital role in the development, production and marketing of infant formula when a substitute for or complement to breast-feeding was necessary and had an important part to play in providing a stable outlet for agricultural production, as well as employment and training opportunities. Mutual confidence must exist between industry, the authorities, the health professions and consumers to allow industry to play its "partnership" role to the full.

The International Association of Infant Food Manufacturers - a member association of International Special Dietary Foods Industries - agreed that all efforts should be made to ensure that breast-feeding was not discouraged during the first four to six months of life and that monitoring of the application of the International Code of Marketing of Breast-milk Substitutes must be based on clear definitions understood by all parties concerned. Her association had frequently shown its support for the Code in word and in deed, but real progress could be made only if the industry was accepted as a partner by the international health community and by governments.

Dr BÉCHETOILLE (La Leche League International), speaking at the invitation of the CHAIRMAN, said that the League was committed to involvement in international efforts to promote, protect and support breast-feeding. The most important contribution it could make to the programmes of WHO was through its capacity to work directly with women, so that they were able to make the best nutritional choices for themselves and their babies, taking into account their personal circumstances. Support and fellow-feeling characterized the structure of the League, where mother-to-mother assistance, specialized training equipment and widely distributed publications were used to help mothers to begin and continue breast-feeding.
The League recommended that women experienced in the practice of breast-feeding should be invited to participate with WHO on mother and child nutrition programmes, since persons working at community level were best qualified to give their opinion on the usefulness of such programmes.

Although public opinion was currently generally favourable to breast-feeding, links between the breast-feeding mother and her environment still needed strengthening. "Partnerships" between WHO, the private and public sectors, and nongovernmental organizations were to be encouraged; the League could offer expertise in nutrition, childbirth, the art of parenting, the environment and ecology, and education. She invited all Member States to participate in the Fifth World Breast-feeding Week, to be held from 1 to 7 August 1996, under the heading "Breast-feeding: a community responsibility".

From October 1996 the League would be celebrating its fortieth anniversary for a period of one year, during which 8000 breast-feeding advisers working in 60 countries would be reaffirming their firm attachment to the promotion of breast-feeding as a vital factor in the nutrition of infants and young children. It was hoped that during the ensuing 40 years, a growing number of women would experience successful breast-feeding and would be able to share their skills and their enthusiasm with other women.

Dr ANAND (International Organization of Consumers' Unions - Consumers International), speaking at the invitation of the CHAIRMAN, said that Consumers International, through its partner, the International Baby Food Action Network, had been involved in the work of WHO in protecting, promoting and supporting breast-feeding and in implementing the International Code of Marketing of Breast-milk Substitutes.

As a paediatrician and an advocate for the rights of children he had witnessed the suffering that resulted from artificial feeding, particularly in the developing countries. To curb the spread of bottle-feeding, India had introduced strong legislation to restrict the promotion of baby foods and feeding bottles. Similar laws had been enacted in other countries, including Brazil, Nigeria and the Philippines.

The baby food industry claimed that it had given unconditional support to the International Code of Marketing of Breast-milk Substitutes and that the issue could now be dropped from the agenda of WHO. He believed such a claim to be untrue. In India, for example, companies ignored the law and labelled their "baby milks" and complementary foods in ways that induced parents to use them in place of breast-feeding. They also offered financial assistance to doctors. Some of those companies had gone too far and were facing criminal charges. Indian law had given authority to four nongovernmental organizations to take companies directly to court if they violated the law. In many countries, doctors were starting to take a very strong stand against accepting aid from the baby food industry. They were convinced that commercial sponsorship was not in the best interest of the children whose rights they were called upon to protect. All Member States should pass legislation to restrain the marketing of baby foods and should monitor the activities of companies without interference from the manufacturers.

He hoped that WHO would continue to assist Member States to implement the International Code, promote the Baby-friendly Hospital Initiative, and progress towards the targets of the Innocenti Declaration. Consumers International would continue its collaboration in the best interests of the child consumer.

Miss ASHTON (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that the International Confederation welcomed the report of the Director-General on the promotion of breast-feeding, the improvement of infant and child feeding and the status of implementation of the International Code of Marketing of Breast-milk Substitutes. Since 1983, the Confederation had taken an increasingly strong stand on the issue of the promotion of breast-feeding and the marketing of infant formulas. In 1986, it had taken the decision not to accept sponsorship from infant formula manufacturers at any of its meetings and it had encouraged its constituent organizations to take a similar stand. The Confederation had played a major part in the development and promotion of the Baby-friendly Hospital Initiative, encouraging midwives to play a central role in its furtherance in their own countries.

The Confederation supported the amended version of the draft resolution, and in particular, paragraph 3(2), which urged Member States to ensure that financial support for professionals did not create conflicts of interest, especially with regard to the Baby-friendly Hospital Initiative. Efforts to meet the essential needs of mothers for the professional support of midwives in achieving successful breast-feeding could be undermined because of pressures associated with the offer and acceptance of financial and other support from manufacturers involved in the infant formula industry, including the manufacturers of bottles and teats.
The CHAIRMAN invited the Committee to note the report of the Director-General in section VIII of document A49/4 and resolution EB97.R13.

It was so decided.

The CHAIRMAN said that, in accordance with Rules 67 and 68 of the Rules of Procedure, the Committee should first consider the amendments proposed to the amended version of the draft resolution, then that amended version as a whole, and finally, if that were not approved, the original version.

Dr THYLEFORS (Secretary) read out the proposed amendments to the amended version of the draft resolution.

The CHAIRMAN invited the Committee to vote by show of hands on the amendments.

The proposal by the delegation of the United States of America to amend paragraph 3(1) was rejected by 19 votes to 19, with nine abstentions.

The proposal by the delegation of the United Kingdom of Great Britain and Northern Ireland to amend paragraph 3(2) was rejected by 28 votes to 18, with nine abstentions.

The proposal by the delegation of South Africa to amend paragraph 3(3) was adopted by 35 votes to eight, with 12 abstentions.

The proposal by the delegation of Sao Tome and Principe to add a new paragraph 3(4) was adopted by 50 votes to none, with four abstentions.

The proposal by the delegation of Greece to add a new paragraph 3(5) was adopted by 44 votes to none, with 10 abstentions.

The proposal by the delegation of Greece to add a new paragraph 3(6) was adopted by 17 votes to four, with 29 abstentions.

The proposal by the delegation of Greece to add a new paragraph 4 was adopted by 38 votes to none, with seven abstentions.

The amended version of the draft resolution, as thus further amended, was approved by 53 votes to none, with no abstentions.¹

The meeting rose at 18:40.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA49.15.
NINTH MEETING
Saturday, 25 May 1996, at 9:00
Chairman: Professor B. SANGSTER (Netherlands)

1. SECOND REPORT OF COMMITTEE A (Document A49/45)

Dr SINGAY (Bhutan), Rapporteur, read out the draft second report of Committee A.

Miss TOSONOTTI (Argentina) said she had noted with surprise that the report contained no reference to the Committee's decision at its fifth meeting with respect to the draft resolution concerning the quality of biological products moving in international commerce.

The CHAIRMAN recalled that the Committee had recognized and endorsed the aims and intentions of the draft resolution and had decided on a recommendation to the Director-General that he should convene an ad hoc working group to study the technical and legal implications of the draft's proposals in time for a report to be submitted to the Executive Board at its ninety-ninth session, in January 1997. He suggested that he should report that fact to the sixth plenary meeting of the Health Assembly and request that the President should consider it as part of Committee A's report on that agenda item. If approved by the plenary meeting it would then have the status of a formal decision of the Health Assembly.

Miss TOSONOTTI (Argentina) said she was happy to accept that procedure.

It was so agreed.

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 9:30.

¹ See page 209.
COMMITTEE B

FIRST MEETING

Tuesday, 21 May 1996, at 9:00

Chairman: Dr O. SHISANA (South Africa)

1. ELECTION OF VICE-CHAIRMEN AND RAPPOUTEUR: Item 19 of the Agenda (Document A49/37)

The CHAIRMAN expressed gratitude for her election and welcomed those present. She then drew attention to the third report of the Committee on Nominations (document A49/37) in which Professor A.K. Shamsuddin Siddiquey (Bangladesh) and Dr A.Y. Al-Saif (Kuwait) were nominated for the offices of Vice-Chairmen of Committee B and Dr M. Kókény (Hungary) for that of Rapporteur.

Decision: Committee B elected Professor A.K. Shamsuddin Siddiquey (Bangladesh) and Dr A.Y. Al-Saif (Kuwait) as Vice-Chairmen and Dr M. Kókény (Hungary) as Rapporteur.

2. ORGANIZATION OF WORK

The CHAIRMAN appealed to speakers to limit the length of their statements to no more than three or four minutes, due to the constraints of time. Recalling the problems caused by the late introduction of draft resolutions during previous Health Assemblies, she drew attention to resolution WHA47.14 which requested, inter alia, that when a resolution was first initiated and presented at the Health Assembly without prior review by the Executive Board, the Chairmen of Committees A and B, supported by the Director-General, should determine whether the committee concerned had sufficient information and whether to refer the matter to the General Committee.

The role of the representatives of the Executive Board, who would participate in the work of the Committee in accordance with Rules 44 and 45 of the Rules of Procedure of the World Health Assembly, was to convey the views expressed by the Board and to explain the rationale behind any recommendations made for the Health Assembly’s consideration. The Board’s representatives were free to respond to any points raised whenever they felt that clarification of the Board’s position was required. They did not express the views of their governments.

Rules 34 to 91 of the Rules of Procedure would govern the Committee’s work; she suggested that its normal working hours should be from 9:00 to 12:30 and from 14:30 to 17:30.

It was so agreed.

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1 See page 207.
2 Decision WHA49(4).
3. FINANCIAL MATTERS: Item 20 of the Agenda

Financial report on the accounts of WHO for the financial period 1994-1995, report of the External Auditor, and comments thereon of the Administration, Budget and Finance Committee: Item 20.1 of the Agenda (Documents A49/7 and Add.1, A49/28 and A49/33)

Mr AITKEN (Assistant Director-General), introducing the financial report and audited financial statements for the financial period 1 January 1994 - 31 December 1995 and the report of the External Auditor to the World Health Assembly and its annex on extrabudgetary resources for programme activities (documents A49/7 and Add.1), said that a set of graphs had been circulated to provide a simple presentation of what was a fairly complex accounting procedure.

Regular budget programme delivery in 1994-1995 had accounted for US$ 836 million, an increase of around US$ 150 million compared with the previous biennium. The primary growth areas had been health system infrastructure and health promotion; expenditure on disease prevention had risen too, though to a slightly lesser degree, and programme support had been maintained at a level similar to that of the previous biennium.

Extrabudgetary funding was available to the Organization in an amount roughly comparable to that of the regular budget. Such funding had shown a modest growth from US$ 752 million in 1992-1993 to US$ 765 million in 1994-1995 and had primarily been devoted to disease prevention. The slight reduction in amounts allocated to that area was attributable chiefly to the transfer to the Joint United Nations Programme on HIV/AIDS (UNAIDS) of the responsibilities of the Global Programme on AIDS.

There had thus been an increase in overall expenditure in 1994-1995 of around US$ 160 million, with funding for health promotion and disease prevention and control remaining generally stable compared with 1992-1993, while financing for health system infrastructure had risen from US$ 298 million to US$ 406 million.

Over the past 10 years, expenditure had risen overall, but while extrabudgetary expenditure had exceeded that from the regular budget in 1992-1993, the situation had been reversed in 1994-1995, and for 1996-1997 so far, the two sources were virtually equivalent. A major shortfall in contributions had been experienced in 1994-1995, and that had been handled using three techniques. First, the Working Capital Fund, which had been set up specifically to counteract shortfalls in income, had provided US$ 28 million. Secondly, there had been internal borrowing from other regular budget sources. Some concern had been expressed regarding the financial risk to WHO entailed in that technique: not all borrowing, however, was of actual cash. The accounts, which were based on an accrual system, showed all potential debts but none of the credits due to WHO. Many disbursements for 1994-1995 were not actually made until 1996-1997. Thus, about half of the total US$ 178 million shown in the accounts as having been borrowed against current resources would not actually be needed until 1996-1997. The third tool enabling WHO to control its accounts was programme reduction, which went against the Organization’s purpose, but was sometimes inevitable if funds were not forthcoming.

About US$ 100 million of the total debt resulted from the special budgetary circumstances of the major contributor, and around 70% of the remainder was owed by the countries of the former Soviet Union and former Yugoslavia: since about 1990, when the former Soviet Union and former Yugoslavia had been disestablished, there had been major changes in the pattern of contributions throughout the United Nations system. In 1992-1993, when the problem had initially arisen, WHO had cut back its programme by US$ 55 million but that reduction had proved to be excessive. All of the internal borrowing had been paid off within eight months because countries had paid their arrears. When a similar shortfall had arisen in 1994-1995, a less drastic programme reduction of US$ 32 million, or only 4%, had initially been made, which later in 1994 was reduced to 2% and then 1%, this latter reduction to assist with meeting the costs of staff reductions for the 1996-1997 budget.

For 1996-1997, a cautious approach had again been adopted: programme delivery was being held back by 10%, or US$ 84 million, a measure that would be reviewed during the course of the biennium according to the receipt of contributions. All contributions were due on 1 January of the year to which they applied. The major contributor had been unable to finalize its national budget in the course of 1995 but it appeared that that problem had now been resolved and that an announcement would soon be made of the amount to
be paid for 1995. Of the total amount borrowed in 1995, about US$ 46 million had been received to date in 1996, through payment by Member States of arrears on their contributions for 1994-1995.

The report of the External Auditor was to be found in document A49/7 and, in document A49/28, the Director-General had set out his comments thereon in response to a request that such comments be made available to the Health Assembly simultaneously with its discussion of the External Auditor’s report. In addition, a full report on the Director-General’s response to the External Auditor’s recommendations would be submitted to the Executive Board at its session in January 1997 and to the Fiftieth World Health Assembly.

The Administration, Budget and Finance Committee was normally asked by the Board to review the accounts on its behalf prior to the Health Assembly every year. The Committee’s report (document A49/33) showed that it had looked into several matters in detail, including internal borrowing, had asked for close monitoring of the 1996-1997 budget situation to match expenditure patterns with arrears paid, and had called for stress to be laid on certain matters mentioned in the report of the External Auditor. The report also set out the standard resolution by which the Health Assembly adopted the accounts and the report of the External Auditor thereon.

Mr HIGGINS (representative of the External Auditor), presenting the External Auditor’s report on WHO’s accounts and operations for the 1994-1995 biennium, explained that a draft report had been prepared and sent to WHO and, after meetings had been held to determine the factual accuracy and presentation of the findings and to consider updated information and authoritative representations from the Organization, a number of useful revisions had been made. However, WHO had informed the External Auditor that it did not wholly agree with the substance of the report. The revised draft had been sent to the Director-General for his comments in advance of its finalization and submission to the Health Assembly. In fact, he had declined to make any comments to the External Auditor concerning the report, preferring instead to do that separately to the Assembly.

The introduction of the report set out the background, approach and objectives of the audit. The External Auditor had expressed an unqualified opinion on the Organization’s accounts for 1994-1995, stating that they were a fair representation of WHO’s financial position and operations for the biennium. Part 1 of the report described the follow-up action taken by WHO in response to the recommendations made in previous reports on its accounts for 1992-1993 and on the November 1994 audit of the Regional Office for Africa. Part 2 contained an executive summary of the conclusions and findings for 1994-1995, first on financial matters and secondly on broader management issues. Finally, Part 3 set out detailed findings relating solely to the 1994-1995 audit.

In Part 1 of the report, the External Auditor noted the action taken in response to each of the recommendations made. On certain topics, such as headquarters’ inventories and the internal audit, substantive comments had been made in the main body of the report.

In relation to the management and control of fellowships, the action taken by the Regional Office for Africa and the Regional Office for South-East Asia to improve the effectiveness of the programme was welcomed. However, further steps should be taken: first, fellowships could be more closely matched to country needs and programme objectives; secondly, there could be a more positive and effective influence on the fellowship selection process; and finally, the outcome of fellowships as compared to their original objectives should be more closely monitored and their effectiveness assessed.

With regard to the 1995 report on WHO’s Regional Office for Africa, progress had been made towards implementing the recommendations made. The impetus for change imparted by the Regional Director, and the efforts being made by his staff to bring about improvements, were to be commended. Much had already been achieved. However, the audit of the 1994-1995 accounts revealed a number of control weaknesses requiring further attention: one of the Regional Office’s bank accounts remained unreconciled; there was inadequate supporting documentation for some transactions; and there were weaknesses in establishing financial obligations.

The External Auditor had therefore recommended that the Regional Office clear unverified balances in the bank reconciliation and write off differences where further investigation was unlikely to be worthwhile; adequate supporting documentation should be obtained for all accounting transactions, particularly in relation to imprest accounts from country offices. In addition, obligations should be established in accordance with WHO’s financial rules and regulations. In fact, the Regional Office had recognized such weaknesses and had
assured the External Auditor that appropriate action would be taken in all areas where improvements needed to be made. For his part, the External Auditor fully appreciated that a number of improvements in the operating and control environment would take some time to implement.

Concerning the 1994-1995 biennium, and with reference to internal borrowing, the External Auditor had noted that WHO had been obliged to an increasing extent to draw on certain funds to meet income deficits on the regular budget resulting from the delayed payment of contributions. Such a practice jeopardized those funds, which were intended for specific purposes, and might have serious implications for WHO's programmes. The External Auditor consequently recommended a review of the extent to which funds intended for other purposes might properly, and without risk, be used to cover income deficits in the regular budget.

As far as common accounting standards were concerned, in 1995 revised standards, to a large extent based on the relevant International Accounting Standards, had been approved for the whole of the United Nations system. The aim was to provide a framework for accounting and financial reporting across the system. Compliance with the revised standards was a requirement for the 1996-1997 biennium and beyond and implied a number of changes in the presentation of WHO's financial statements and in the Organization's accounting policies. Such compliance would have implications for the External Auditor's opinion on those accounts. Some of the key changes were set out in Part 3 of the External Auditor's report.

With regard to management matters, under WHO's Financial Regulations the External Auditor was empowered to make observations relating to the efficiency of the Organization's financial procedures, the accounting system, internal financial controls and, in general, on its administration and management. In times of ever-increasing budgetary constraints, issues such as financial stewardship, accountability and probity became all the more important, and the External Auditor was uniquely placed to review and report impartially on these issues.

In 1994-1995, the extent to which WHO's systems and procedures safeguarded financial propriety and regularity had been assessed in five separate areas: expenditure and budgetary control; procurement; the custody and control of assets; internal audit; and fraud awareness. In the current biennium, in addition to the routine visits to regional offices, visits had also been made to country offices in Afghanistan, Burkina Faso, the Congo, Pakistan and Viet Nam. The External Auditor's conclusions and recommendations reflected the findings of those exercises, as well as the considerable past experience in auditing WHO's accounts.

In times of budgetary constraints, it was especially important that funds were spent in the most effective way possible. An important means of achieving that was by ensuring that expenditure and budgetary control procedures were operating as intended. The review of controls covering country and regional offices had revealed a number of areas in which stricter compliance with the procedures set out in the WHO Manual was to be recommended. In particular, the External Auditor had recommended that the regional offices improve the quality of financial reporting and accounting returns from country offices, by means of better training and support for staff working in those offices.

As far as local cost subsidies and other contractual payments were concerned, it was recommended that regional offices monitor the receipt of financial statements and technical reports accounting for the proper use of such funds. They should also establish effective follow-up arrangements and targets for the receipt of financial statements and seek to provide for a greater degree of accountability for expenditure before further funds were released. In relation to budgetary control procedures, it was recommended that regional offices exercise greater control over the establishment of obligations to ensure that there was prior budgetary authority for all expenditure. In addition, steps should be taken to improve staff awareness and understanding of the Organization's budget procedures.

Procurement of supplies and equipment was an important activity for WHO. The External Auditor's review showed that there was still scope for savings from increased bulk purchasing and the application of standard procedures for the awarding of contracts. In particular, recourse to bulk purchasing of computer equipment should be maximized; greater consistency and economy should be practised in the purchase of vehicles for field offices; and any departures from established procedures in the awarding of contracts and acceptance of bids should be fully justified and recorded. Although it was the responsibility of the consignee to confirm satisfactory receipt of purchased goods to headquarters or to the regional office concerned, the External Auditor's staff had found a large number of cases over all regions where such had not been the case.
It was thus recommended that regional offices take steps to ensure that field offices complied with standard procedures in providing such reports; outstanding reports should also be followed up.

Notwithstanding the financial and operational importance of purchasing and the particular risks associated with it, WHO had decided against introducing a code of purchasing ethics on the grounds that its general staff regulations adequately covered such risks. Nevertheless, the External Auditor wished to point out that the establishment of codes of ethics was an increasingly common feature of the business world, including the public sector.

In relation to the control and custody of assets, under the United Nations’ accounting standards WHO would be required to disclose the value of non-expendable equipment, furniture and motor vehicles in a note attached to its future financial statements. Currently, the Organization had no reliable information on which to base such a valuation. Accordingly, it was recommended that its procedures for validating, valuing and keeping the Organization’s current inventory up to date be reviewed.

The External Auditor’s review of the inventory procedures at headquarters and regional and country offices had shown that WHO did not have adequate control over such valuable assets. A number of specific recommendations had been made to remedy that state of affairs. As to the disposal of assets, there had been cases where decisions to reuse equipment were not justified or adequately documented. All effective property disposal decisions should therefore be clearly argued, fully documented and approved by the competent property survey committee.

Turning to the matter of internal audit, he recalled that, although in November 1995 the Director-General had retitled the Office of Internal Audit as the Office of Internal Audit and Oversight, the work it carried out had not yet changed substantially. If the new Office was to play an effective overseeing role, it would need to broaden its review and evaluation remit and establish a degree of autonomy from management, in particular through the capacity to report directly to the Executive Board or even to the Health Assembly.

Finally, on the issue of fraud awareness, he pointed out that although responsibility for the prevention and detection of fraud and error clearly lay with management through the operation of adequate accounting and internal control systems, such systems reduced but could not eliminate the possibility of fraud, irregularity and error; it was very difficult, moreover, to guard against collusion. The recognition of, and positive response to, the risk of fraud and irregularity was an important matter, given the greater emphasis being placed by "stakeholders" in the United Nations system on accountability and "oversight". Currently, WHO placed great reliance on the internal control environment and on the oath or declaration contained in Staff Regulation 1.10. Besides general internal financial controls, however, a number of additional low-cost actions and mechanisms were available to management which could help WHO to prevent, detect and respond effectively to fraud and irregularity; examples were provided in Part 3 of the External Auditor’s report. They included the establishment of a formal ethics policy statement, defining, publicizing and applying clear reporting and investigation procedures to help to deter fraud; defining and following consistent disciplinary measures in cases of fraud and misconduct where proven; and amending the Organization’s financial rules to place an express duty on management to report all cases of fraud, presumptive fraud and financial misconduct to the External Auditor.

In general terms, the External Auditor’s report indicated a number of areas in which WHO could usefully improve its operating and financial control environments. Several of the recommendations affected the operations of the regional offices and country offices, as well as headquarters. The positive response to the audit process already received from each of the offices was welcomed and appreciated, as was the cooperation of the Regional Directors and their staff during the current biennium and in previous years. Finally, he expressed gratitude for the Health Assembly’s confidence and support during the period in which the United Kingdom’s National Audit Office had acted as external auditors for WHO.

Mr BAMSEY (Australia) said that the financial outcome of the 1994-1995 biennium should be a source of concern to all WHO Members. The record excess of expenditure over income must be considered a matter for urgent attention, and a concrete plan must be developed to arrest the increasing budget deficits and put a stop to the practice of constant and heavy internal borrowing. As a first step, it should be explicitly acknowledged that what had happened in the past could not be contemplated in the future. Two major problems existed: the non-payment of contributions; and, in some cases, inappropriate financial management.

Members should pay their assessed contributions, which clearly constituted a legal obligation, in full and on time. The cash management of WHO had been made very difficult owing to the uncertainty created
by the non-payment or late payment of contributions. In avoiding a liquidity crisis in the previous biennium, financial managers had taken on debts which would take a long time to repay and might prejudice the high-priority programmes which everyone sought to implement.

In the previous biennium, the Organization had spent US$ 206 million more than it had received. All regular budget funds had been exhausted in order to balance the books but a deficit of US$ 25 million still remained. An absolute limit in the resources available had been reached. High-priority programmes could suffer from the repayment exercise. Financial managers should therefore ensure that stable funding was available over an extended period.

Already in mid-1994, the Organization had been expecting a shortfall in its budget of US$ 70 million to 80 million. The largest contributor had issued a frank warning at the beginning of 1995 about the likelihood of its not paying its contribution. Despite that sobering outlook, savings of less than 1% in the budget for that biennium had been made.

In a letter to Executive Board members in April 1996, the Director-General had forecast that at the end of the current biennium, even with significant payments from the largest contributor and a spending reduction of 10% of the budget, the deficit to be met from internal funds would be in excess of US$ 150 million. Internal borrowing had therefore risen sharply from US$ 50 million in 1992-1993 to US$ 100 million in 1994-1995 and US$ 150 million in 1996-1997. Such a situation could not be sustained.

As the previous biennium's deficit was still being paid off, a larger one would be accumulated in the current biennium. The Working Capital Fund would remain empty, as would regular budget accounts against which borrowings had been made, for example, the Terminal Payments Account. For the first time, Members' contributions received in advance and previously listed as being held in trust had been used to match expenditure in a previous biennium. Even the holding account, which was designed to provide working funds on the first day of a new biennium, had been spent before the current year began. For the first time, WHO had not begun a new biennium with a zero balance. It started 1996 with a minus US$ 40 million accounting entry.

The External Auditor's report contained a large number of useful recommendations and observations, all of which were worthy of detailed study. Most important, it noted that the limit of internal borrowing had been reached and that WHO would face greatly increased challenges in ensuring programme delivery. It warned that it was no longer certain that the funds available would be spent for the purposes intended. The risks being run were too high and the uncertainty too great to tolerate. In the light of all those considerations, Australia believed that the Director-General must, as a matter of urgency, do three things to remedy the situation: give priority to establishing a financial plan and staying out of debt; remove the current debt by curtailing spending to match the cash available from contributions; and replenish regular budget accounts such as the Working Capital Fund and the Terminal Payments Account. Those proposals would provide a way through the current grave financial situation. His delegation wished them to be reflected in the resolution recommended by the Administration, Budget and Finance Committee of the Executive Board in its report (document A49/33, paragraph 14). He consequently proposed that an additional operative paragraph be added to the resolution, to read:

EXPRESSES REGRET at the high level of borrowings and REQUESTS the Director-General to develop a financial plan for 1996-1997 and beyond to bring expenditure into line with expected biennium income and minimize internal borrowings.

Dr AL-RAHMAN (Sudan) submitted that the financial report before the Committee showed, even to non-specialists in financial matters, like himself, that the preliminary measures adopted had not been sufficiently stringent and that technical facilities had not been properly used. Only the funds actually available should be spent. It was consequently necessary to review the system of management to see how targets and objectives could be laid down for headquarters, regional offices and country offices, and to ensure that the resources available were put to the best possible use. The three techniques used to deal with the shortfall in contributions should be pursued; however, the poorer countries suffered particularly from a lack of funds that could be aggravated as a result of programme reduction or a departure from agreed priorities. The External Auditor's report brought to light serious dangers which required urgent attention. Some sort of committee should be established with representatives from the regional offices and perhaps country offices, together with the administration, to review in greater detail the two reports and draw lessons from them. That
was particularly important since the Executive Board had, at its most recent session, been unable to give its full attention to the financial report owing to lack of time. The Board was often in a better position to consider such reports in view of the number of members. Had it been able to consider the report more fully, the financial situation might have been improved; consideration would certainly have been given to the dangers to which attention had been drawn, especially in relation to expenditure on items other than those for which the priorities had been defined. That was especially the case with regard to the original allocations made for communicable disease control and prevention and the development of health programmes.

Mr BOYER (United States of America) commended the excellent work done by the outgoing External Auditor. He also welcomed the innovative document A49/28, containing the Director-General’s comments on the External Auditor’s recommendations, while noting that the tone of some of those comments appeared somewhat defensive and - notably on page 10 - suggested that the recommendations had not entirely been accepted in the constructive spirit intended.

The United States delegation shared the External Auditor’s concern about the difficult financial situation facing WHO. It recognized that slow payment of 1995 assessments by the United States Government was a major factor contributing to those difficulties and regretted it. The appropriation of funds for the payment of 1995 assessments to the United Nations, WHO and nearly 50 other international organizations had not been completed until the end of April 1996 and had not at that time been sufficient to meet the full level of assessments. Nevertheless, it was expected that a substantial payment against 1995 WHO assessments would be made within the coming weeks and thereby alleviate some of the difficulties relating to programme implementation, and that the shortfall in United States’ payments would be between 5% and 10%. However, while expressing its regret at that delay, his Government had been deeply concerned to note that during the 1994-1995 biennium WHO had expended US$ 206 million more than it had collected and that it had borrowed that amount by depleting other important internal funds. Like the External Auditor, it wondered whether that practice of extensive borrowing had not put the overall operations of WHO at risk. It seemed to his delegation that recourse to the accrual basis of accounting, as explained by the Assistant Director-General, implied that a serious gamble was being taken on the funds” not being needed until sufficient payments had been made to cover those borrowings. It was troubling that the Organization was continuing to spend money as though it had no knowledge of potential problems linked to a shortfall in contributions despite warning signals from major contributors over a number of years. WHO must be able to forecast with some degree of accuracy how much money was coming in and it must not continue to spend money it did not have. It would be useful for the current Health Assembly to receive a report indicating the status of collected assessments for the biennium 1996-1997, and the sums obligated, so that Member States could see whether the lessons regarding the cash-flow situation had been learned. The United States supported the proposed Australian amendment to the resolution recommended in document A49/33 and would leave open the question of whether amendment of the financial rules was necessary to ensure that the current situation should not continue.

He further noted that extrabudgetary contributions were declining. Overall, Member States appeared to be having great difficulty in making payments of any kind to WHO; it was thus essential that WHO managers at all levels should compensate for that situation. WHO - he repeated - could not continue to spend money it did not have but, by the same token, Member States could not continue to make demands on WHO for more resources and more programmes than the Organization was capable of underwriting.

After noting that the Administration, Budget and Finance Committee of the Executive Board, in its report, had made some interesting comments on fellowships, procurement, and programme support costs, he turned to the External Auditor’s report and voiced his delegation’s satisfaction that the Regional Office for Africa had made progress towards implementing previous recommendations. On the other hand, there had been virtually no improvement in the situation regarding fellowships. The United States shared the External Auditor’s concern for improved procedures regarding control of inventory, endorsed his recommendations on bulk purchasing and - regarding internal audit - was glad to note that a highly qualified individual had been appointed Chief of the Office of Internal Audit and Oversight, but disappointed to note that little had changed in that Office. His delegation strongly agreed with the recommendations in paragraph 191 of the report and in particular supported the proposal in paragraph 186 that the Chief of Internal Audit and Oversight must have complete autonomy and be able to report the findings of his investigations directly to the Health Assembly or to the Executive Board.
Finally, with regard to expenditure under the Director-General’s and Regional Directors’ Development Programme, listed in Table VIII of the report, he questioned whether monies were always used in the manner for which the discretionary accounts had been created. Not all the expenditure appeared justified and that was of special concern at a time of financial crisis. It might be useful for the External or the Internal Auditor to undertake a review of such expenditure at some appropriate time in the future.

Ms O’SULLIVAN (Ireland) said that her delegation, too, was concerned at the high level of internal borrowing during the period covered by the External Auditor’s report. She therefore supported the Australian amendment to the resolution recommended in document A49/33.

Mr VAN REENEN (Netherlands) voiced serious concern regarding the financial situation of the Organization and agreement with the delegations of Australia and the United States of America. In 1995, only 96 Member States had paid their contributions; all Member States must comply with their legal obligation in that regard.

Three instruments were available to cope with the difficult situation resulting from the income deficit: programme reduction; recourse to the Working Capital Fund; and internal borrowing against other WHO funds. If a complete collapse of the Organization were to be avoided, a proper balance must be struck in the use of those instruments. However, in 1995 reduction in budget implementation had been only US$ 7.5 million, whereas recourse to the Working Capital Fund and internal borrowing combined had produced more than US$ 200 million. It was particularly alarming that internal borrowing - the source of US$ 178 million - had taken place even against advance contributions for 1996. Obviously, the balance had swung too far in favour of internal borrowing.

The income deficit required more structural solutions, such as the setting of further priorities and, even more important, the postponing of the implementation of some programmes. He welcomed the measures announced by the Assistant Director-General, such as the holding-back of 10% for 1996, but wondered whether that measure would be adequate. He strongly supported the Australian amendment to the resolution recommended in document A49/33.

Delegates had been assured on earlier occasions that the Organization would restrict the scope of internal borrowing to regular budget accounts and would not touch extrabudgetary funds - a statement that reassured donor countries. The External Auditor’s recommendation of a review of the extent to which other WHO funds might be used to cover income deficit should be clarified; it would be highly inadvisable to resort to extrabudgetary funds in that connection. He was even more concerned by the Director-General’s ambiguous comments on that recommendation: if the latter indeed related to extrabudgetary funds, he would like an unequivocal statement from the Director-General that he would not follow such advice.

He welcomed the External Auditor’s recommendations on internal audit, particularly that relating to the reporting of the Office of Internal Audit and Oversight. He had some doubts, however, regarding the adequacy of the measures mentioned by the Director-General in his comments on that recommendation. The Netherlands agreed with the External Auditor’s view that a proper and functional internal audit and oversight system was a prerequisite for the evaluation of the effectiveness of programme implementation.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland) regretted that, for the second year running, the Director-General had been unable to reach agreement with the External Auditor on the report submitted. Questioning the utility of document A49/28 given the comments it contained, he said that his delegation had been intrigued by the apparent disinclination to comply with the External Auditor’s recommendations. He sincerely hoped that the impression was a mistaken one, and that the Secretariat and the Executive Board would consider all the recommendations very carefully.

The United Kingdom endorsed the comments made by the United States delegate regarding internal audit and particularly the need for changes of substance in the functioning of the Office of Internal Audit and Oversight. It also shared very much the concern voiced on the subject of internal borrowing. The Secretariat would seem to wish delegates to believe that high levels of such borrowing over the past three bienniums gave little cause for concern. Like all earlier speakers, he strongly disagreed. Of course, all Member States should be urged to pay their contributions in full, but the problem was not merely collective or individual failure to pay contributions. There had been a clear trend over recent bienniums to resort increasingly to internal borrowing to cover income shortfalls, and that trend seemed set to continue. That was not what the
internal borrowing provision was for. It should be a last resort, for use in an emergency, and followed by rapid repayment. It must not become a planning tool for financial management. To cope in the present uncertain financial climate required flexibility, foresight, imagination and readiness to take tough decisions. Delegates expected senior financial management to rise to the challenge. He congratulated the Regional Office for Europe on setting an example in that respect. After the difficult decisions of 1995, that Office was well placed to meet Member States' expectations in the current biennium.

Internal borrowing on the current scale harmed programme delivery and steadily eroded WHO's flexibility to respond to new situations. Perhaps the books might balance one day, long after the close of the biennium, but in the meantime resources were stifled, vacancies frozen and WHO programmes prevented from doing the job Member States wished them to do. Internal borrowing must be brought back to manageable levels and restored to the purpose for which it was intended, and he therefore strongly supported the amendment proposed by the Australian delegation to the resolution recommended by the Administration, Budget and Finance Committee.

Dr TANGCHAROENSATHIEN (Thailand) commended the External Auditor's constructive report and the performance of the African Region in improving its financial management. However, documents A49/7 and A49/28 showed that WHO had not adequately and systematically responded to the recommendations of the External Auditor. He therefore endorsed the views expressed by previous speakers and supported the amendment proposed by the Australian delegate suggesting that a further sentence be added to that amendment, requesting the Director-General to take a comprehensive step to improve financial management efficiency and internal control and audit.

Dr MOREL (Brazil) endorsed comments by previous speakers, particularly the Australian delegate, and suggested the addition, at the end of his proposed amendment, of the phrase "and maximize programmatic actions at the country level".

Mrs PERLIN (Canada), after commending the External Auditor, remarked that the 1994-1995 biennium had been a turbulent period for financial management in WHO, beginning with unexpected payments and ending with a financial crisis due to a significant shortfall in payments of assessed contributions. The news that the major contributor was expected to make a substantial payment on its 1995 assessment was welcome, but failed to allay her delegation's concern about the need to live up to international obligations or about the impact that failure to do so might have on agencies of vital international importance.

While the immediate crisis for 1994-1995 might have been avoided, the biennium had nevertheless ended with an income shortfall of more than US$ 100 million, to cover which the Organization had borrowed very heavily not only from traditional sources such as the Working Capital Fund but also from non-traditional internal sources. Associating herself with previous comments, she voiced grave concern that some US$ 26 million had been borrowed against payments from those countries, including her own, which had paid their 1996 contribution in advance. While that practice might not be explicitly at variance with the Organization's Financial Regulations, it was certainly not consistent with the way in which the contributors intended the funds to be used.

WHO now faced the prospect of entering the 1996-1997 biennium with a shortfall of US$ 100 million. To fund programmes that had been approved and planned for the biennium, an additional US$ 100 million had to be found to pay off the borrowing from the previous biennium. Such deficit financing from biennium to biennium was not sustainable, especially at a time when new investments were required to tackle the urgent emerging global health problems facing the world. Defining a new health-for-all strategy, formulating a new mission and implementing an imaginative programme of institutional reform had been preoccupations of WHO for the past five years, but a new global health charter would be vain if the Organization lacked the financial resources to implement it. Hence there must be sharp focusing on priorities, strong management, more efficient delivery of programmes, a significant reduction of overhead costs, and fundamental programme reviews to avoid duplication. WHO must adjust commitments and expenditure to the income received if it was not to mortgage its future. The Canadian delegation therefore called upon the Director-General to reduce commitments and programme expenditure for 1996-1997 so as to eliminate the deficit of the previous biennium.
Much had been said about the situation of the major contributor and she would once again urge it to meet its obligations in full, on time and unconditionally; however, an increasing number of other countries were also falling into arrears with their contributions and that was impairing the ability of the Organization to deliver its agreed programmes. Some of those countries were poor, others less so; many of the least advantaged Member States did pay their assessed contributions on time, in full and without conditions, and it was unjust and unacceptable that some of those countries were being asked to subsidize more developed and richer ones.

In the light of the concern she had expressed and of the Canadian commitment to a dynamic and financially sound WHO prepared to enter the twenty-first century both with a new mission and with the resources to implement that mission, her delegation fully supported the Australian amendment to the resolution recommended in document A49/33.

Ms GREW (New Zealand) endorsed the views expressed by previous speakers and supported the Australian amendment to the resolution recommended in document A49/33.

The New Zealand Government was seriously concerned about the deterioration in WHO's financial position. The reduced budget in 1996-1997, combined with the shortfall in receipt of assessed contributions, implied unprecedented financial constraints during the biennium. Issues of particular concern included the level of internal borrowing and the sources of the sums borrowed. The Organization must face up to the greatly increased challenges in ensuring delivery of priority programmes, not only because of the need to work within reduced budgetary resources but also owing to cash-flow constraints. More transparent systems were required for the redistribution of funds based on actual income. The Organization must develop more effective priority-setting in technical areas of work. The headquarters structure must be streamlined and a better balance achieved in the functions and resources of headquarters and the regional offices.

Professor AGBOTON (Benin) said that the financial situation outlined in the External Auditor's lucid report gave serious cause for concern, particularly for the developing countries. While there might be valid internal budgetary reasons for the delay in the payment of assessed contributions by certain countries, the developing countries could not but feel that such delays threatened the Organization's objective of making health the cornerstone of national development. He fully concurred with preceding speakers that it must not spend more than it had. However, any reduction in the financing of health development would have equally dramatic consequences. He welcomed the very effective work carried out by the Regional Office for Africa. He enquired whether it would be possible to report on the status of recovery of contributions in the various United Nations agencies so as to assess the attention paid by Member States to health problems in the world.

Dr DEVO (Togo) said that the volume of internal borrowing, an expedient used for a number of years as an indirect consequence of the policy of "zero budgetary growth", was a major source of concern. Prompted by the Bretton Woods institutions, many countries had adopted structural adjustment programmes, the effects of which had been exacerbated by CFA franc devaluation. That gloomy economic picture accounted in great measure for the weak level of WHO's technical cooperation with Member States, particularly those in the African Region, and for the difficulties those countries experienced in meeting their financial obligations. It was doubtful whether the new world trade agreements that had culminated in the birth of WTO were likely to usher in a more equitable international order: mercantile interests seemed to have gained the upper hand over feelings of human solidarity.

Despite the sociopolitical tensions prevailing in many African countries, they still had the political will to honour their commitments, for they did not wish to see WHO founder. More support should be provided for the Regional Office for Africa in its effort to foster clean financial management. Togo therefore supported the Australian and Brazilian amendments to the resolution recommended in document A49/33. Welcoming the good intentions manifested by the major contributor, he submitted that, as WHO's mission for the twenty-first century was being redefined, priorities should be set and matched with the necessary resources.

Mr MROPE (United Republic of Tanzania) acknowledged that non-payment of contributions by certain Member States had constrained WHO to resort to internal borrowing, to the detriment of its financial management. At the Regional Office for Africa, certain problems persisted, although improvements had been
made. Now that funds had been promised by the major contributor, the situation would - it was to be hoped - alter dramatically, and such high-level internal borrowing would no longer prove necessary. He urged other delegations to adhere to their payment obligations and schedules.

Professor BADRAN (Egypt) also expressed concern over outstanding contributions and recourse to internal borrowing, observing that developing countries had been subsidizing more prosperous countries for over a year. WHO should establish why countries were failing to pay. Any consequent reduction in expenditure must not affect disease prevention activities and programme support. His delegation supported the Australian amendment to the recommended resolution.

Mr VALSBORG (Denmark) endorsed earlier interventions, particularly that by the United Kingdom delegate, and consequently supported the Australian amendment to the recommended resolution.

Mr ROKOVADA (Fiji) commended the External Auditor on his report. Further internal borrowing would be financially imprudent and should be excluded, since it caused uneven biennial adjustments and made planning and priority-setting impossible. His delegation endorsed the Australian amendment to the recommended resolution.

Dr STAMPS (Zimbabwe) proposed that consideration be given, in the event of future default on the part of a major contributor whose ability to pay was not in doubt, to the freezing of salaries of its 144 nationals employed by the Organization, 92 of whom - mostly in senior positions - were paid through the regular budget. Such a move should be made before any interference with programmes.

Mr KOVALENKO (Russian Federation) shared previous speakers' deep concern - notably that voiced by the delegates of Australia, the United Kingdom and Canada - over the high levels of internal borrowing and the reduction in programme activities resulting from the financial crisis.

Dr SAMBA (Regional Director for Africa) paid special tribute to the work of the External Auditor and his staff, and stressed the readiness of the Regional Office to comply with all his recommendations, most of which were already being implemented. Stringent internal controls had been imposed; only professionals were now recruited in the financial section; and all finance activities would be fully computerized by the end of the year. Staff training was also being intensified, both in the Regional Office and in the country offices. The Regional Office had been apprised of the External Auditor's comments on fellowships only after the issue of his report; documented responses to those comments had been placed at his disposal and transmitted to headquarters: they demonstrated the efforts that had been made to improve the situation.

He agreed with the Australian delegation and others that WHO expenditure must not exceed available income but pointed out that African Member States would be the first to suffer if programmes were reduced. Moreover, most African countries, including a majority of the least developed in the world, were on schedule with their contributions. As the Canadian delegation had observed, it was paradoxical that poorer Member States were currently subsidizing the more prosperous. The African regional budget of US$ 77 million was shared by 46 countries, each of which needed and had its own country office: US$ 1.6 million per country was hardly sufficient to meet current needs. Expenditure could not be limited to standard technical cooperation - the claimed catalytic effect of which was sometimes debatable - and to normative action, given the acute shortage of the most basic medical supplies such as syringes, needles, condoms, essential medicines and vaccines. As the Regional Director, he could confirm from his visits and contacts that all African Member States would do their utmost to pay arrears. Any which had not done so in a year's time would have excellent reasons, as in the case of Liberia. He urged all Member States, rich and poor, to pay their dues.

The CHAIRMAN, joining in the commendation of the External Auditor's efforts, summarized the main issues raised: the importance of adhering to contribution schedules; the necessity of reducing expenditure while taking into account adverse effects on health programmes; the need to curb internal borrowing; and the need for a sound financial management plan.
Mr AITKEN (Assistant Director-General) stressed that the Director-General fully shared delegates’ concern regarding the financial situation and was not at all complacent. It should be clear to all that WHO had been forced to resort to internal borrowing in order to ensure that programmes were delivered, certainly not to place them at risk. Unpaid contributions received would be used first to pay off internal borrowing for the previous biennium. There seemed, however, to be concern among most speakers that the Organization had indeed taken too much of a financial risk in 1994-1995 as compared with the previous biennium, and that the Organization must be more cautious in 1996-1997 and beyond. The amendment by the Australian delegation had brought that issue to the fore.

With a view to initiating a more detailed analysis of that proposal, as well as the matters raised by the Regional Director for Africa, he suggested that the further amendments proposed by the delegates of Thailand and Brazil might be replaced by a phrase calling on the Director-General to report to the Executive Board at its ninety-ninth session on the implications of the proposal and on related issues. That would permit the subject to be thoroughly aired.

The Secretariat had been criticized for resorting to internal borrowing in order to safeguard the delivery of programmes; but Member States should acknowledge their part of responsibility for that state of affairs: they voted a programme budget and then left it to the Secretariat to guess how much they would actually pay, or rather, not pay. (He paid tribute in that connection to all the Member States that paid their contributions in full and on time, or even in advance.) The difficulty of the exercise was not always recognized. He assured the United Kingdom and Netherlands delegates, respectively, that internal borrowing would be regarded as an emergency measure to meet contribution shortfalls; and that there would never be any borrowing from extrabudgetary-funded accounts. In response to the suggestion by the delegate of Zimbabwe, he said that the staff of international organizations were international, and were all treated equally as such. There could be no special treatment on national grounds.

On another of the subjects that had held the attention of delegates, he said that internal audit reports could now be sent directly to governing bodies along with comments by the Director-General. The Office of Internal Audit and Oversight would be properly staffed and authorized.

In conclusion, he assured the Committee that WHO would be complying with most of the External Auditor’s 14 major recommendations and approximately 37 subsidiary recommendations. The occasional professional difference between accountants, as well as certain other issues such as fraud policy, as it affected staff, might make it necessary to have a broader consultation, for example with the International Civil Service Commission. He believed that the Executive Board, at its ninety-ninth session, would be convinced by the report on the matter of WHO’s seriousness in responding to the External Auditor’s report.

Mr HIGGINS (representative of the External Auditor) confirmed that the recommendation for a review of the extent to which other WHO funds intended for other purposes might properly, and without risk, be used to cover income deficits had by no means been intended as applying to all funds and all sources of money at WHO’s disposal.

He thanked the members of the Committee for their generous comments on the work of the External Auditor and his team; the Regional Director for Africa had spoken kindly of their work; and the Assistant Director-General had given a heartening indication of the serious intent to pursue all the points they had made. The audit process could, the External Auditor and his staff believed, provide a special perspective and make a positive contribution to WHO’s work; even so, they were not used to such expressions of appreciation as he had heard during the meeting.

The CHAIRMAN invited the representative of the External Auditor to convey to him and his staff appreciation for the services rendered to the Organization.

She suggested, following a remark by Mr BOYER (United States of America), that a decision on the recommended resolution on item 20.1 of the agenda be deferred until the text, as amended, had been finalized.

It was so agreed.

(For resumption, see page 118.)
Status of collection of assessed contributions: Item 20.2 of the Agenda (Resolution EB97.R21; Documents A49/8 and A49/29)

Professor LI Shichuo, (representative of the Executive Board) explained resolution EB97.R21, which had been considered by the Board at its January 1996 session and was now before the Health Assembly. The Board had been deeply concerned at the unprecedented level of outstanding contributions and the effect of such delays on the programmes of work approved by the Health Assembly, noting in particular: that as at 31 December 1995, only 56.31% of the 1995 contributions to the effective working budget had been collected, the lowest collection rate in WHO history, leaving US$ 177 293 158 unpaid in respect of 1995 contributions; that only 96 Member States had paid their 1995 contributions in full; that as many as 78 Member States had made no payment whatsoever towards their 1995 contributions; and that unpaid contributions in respect of 1995 and prior years exceeded US$ 243 million.

In resolution EB97.R4, the Executive Board had requested the Director-General to submit a written report to Board members in late March 1996, setting out the financial situation in relation to the regular budget and income/expenditure projections for 1996-1997, together with any action which might be taken to deal with the situation.

In resolution EB97.R21, the Executive Board recommended that the Health Assembly adopt a resolution calling the attention of all Members to Financial Regulation 5.6 on due and timely payment of contributions, urging Members regularly in arrears to take immediate steps to ensure prompt and regular payment, and requesting the Director-General to review additional measures which might ensure a sound financial basis for the implementation of programmes and to report to the Board in January 1997 and to the Fiftieth World Health Assembly in May 1997.

Mr AITKEN (Assistant Director-General) introduced document A49/8, which showed the status of collection of assessed contributions as at 30 April 1996. In the first 21 days of May, a further US$ 4.6 million had been received. WHO had therefore received 32% of its total income for the year - as against 48% on the same date the previous year. One major contributor which had paid a little earlier in 1995 was expected to pay shortly.

The countries which had paid since the issue of document A49/8 were Algeria, China, Guyana, Nicaragua, Palau, Poland, Portugal, Singapore, Turkey, Tuvalu, United Republic of Tanzania and Vanuatu, and arrears of US$ 2.7 million had been received from Chile, Comoros, Cuba, Djibouti, Ecuador, Gabon, Guatemala, Haiti, Nicaragua, Panama, Poland, Republic of Moldova, Romania, Rwanda, Togo and Yemen.

He paid tribute to those countries which had regularly paid their contributions in advance, in at least three of the previous five years: Bhutan, Brunei Darussalam, Canada, Kuwait, Mauritius, Myanmar, New Zealand, Saint Lucia, Sweden, Tonga and Zimbabwe.

Turning to document A49/29, he said that Ukraine had requested that arrears relating to its period of inactive membership, from 1950 to 1991, be waived. On the independence of Ukraine in 1991, the Health Assembly had decided to ask it to pay only 5% of its total arrears, and had accorded a moratorium of ten years before any payments were due. Nonetheless, Ukraine had asked that the arrangements made five years previously be waived. It was for the Health Assembly to decide on the action to be taken.

Mr ROSALES DÍAZ (Nicaragua) stated that Nicaragua had paid its contribution for 1996 in full. It welcomed the good intentions expressed by contributors which were in arrears. Yet tens of thousands of people were dying of curable diseases and of poverty. Good intentions did nothing for them. Nicaragua urged those countries which were in arrears to remedy that situation. Such countries included big actors on international markets, where commercial opportunities were worth millions of dollars. People who were dying of hunger needed action.

Mr AITKEN (Assistant Director-General) stressed the importance of prompt payment. The Organization had to have a clear contribution record and clear contribution payments by 1 January each year in order to comply with its own Financial Regulations. In practice, that did not happen. The best option was to be informed as quickly as possible as to when payments would be received.
The draft resolution recommended by the Executive Board in resolution EB97.R21 was approved.¹

The CHAIRMAN invited the Committee to consider the request by Ukraine.

Mr BOYER (United States of America) submitted that the case of Ukraine was quite different from that of South Africa which would - he understood - be taken up later. Ukraine had not been prevented from working with the Organization. A generous payment plan had already been set up. It seemed neither necessary nor appropriate totally to waive the Ukrainian arrears. Otherwise any country with a change of government might seek the same treatment.

Mr VAN REENEN (Netherlands) fully endorsed the view put forward by the delegate of the United States of America.

Mr LÓPEZ LUNA (Honduras) stated that Honduras agreed with deferred payments but did not agree with waiving the debt entirely.

The CHAIRMAN noted that there was no support for the request by Ukraine.

Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: Item 20.3 of the Agenda (Resolution WHA41.7; Documents A49/9, A49/30 and A49/32)

Mr AITKEN (Assistant Director-General) said that the Committee had before it a report by the Administration, Budget and Finance Committee (document A49/9) on the status of Members in arrears to an extent which would justify invoking Article 7 of the Constitution. Since the issue of that document, the voting rights of Haiti had been restored as a result of payments made which reduced its unpaid prior years’ arrears: that country’s name should be added to the second preambular paragraph of the resolution recommended in paragraph 9 of the report and deleted from the third preambular paragraph. Since the opening of the Health Assembly, Guatemala had made a payment which justified the addition of a sixth preambular paragraph to read:

Having been informed that as a result of a payment received after the opening of the Forty-ninth World Health Assembly, the arrears of contributions of Guatemala had been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

and the deletion of Guatemala from the list in operative paragraph 6(1).

The Organization had received US$ 147,775 from Cuba, together with an offer to discuss a payment plan. It had also received a small payment from Togo. Those payments were not sufficient to restore the voting rights of the two countries. It was for the Health Assembly to decide whether or not to restore those of Cuba, as it had requested.

Dr RUIZ ARMAS (Cuba) stated that in the past Cuba had always paid on time. From 1989 onwards Cuba had been in the grip of an economic crisis, its gross national product falling by 35%. Financial resources available for health care had fallen by one-third between 1989 and 1993. Moreover, Cuba had no access to sources of finance such as the World Bank or the Inter-American Development Bank. Apart from paying US$ 202,000 to WHO in 1996, Cuba had helped 61 developing countries over the previous three decades, sending them health technicians, experts, doctors or nurses. Over 800 Cuban technicians were currently working in over 40 countries. Cuba was a special case. It requested other Member States and the Director-General to accept its proposal for a deferred schedule of payments.

Dr SOLARI (Uruguay) deeply regretted the delay in payment of his country’s contributions. Amounts in respect of 1993 and subsequent years were still outstanding. That did not however reflect any loss of trust.

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA49.3.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland) supported the resolution recommended in paragraph 9 of document A49/9. While it welcomed Cuba's payments and commitments for the future, the United Kingdom did not support the restoration of that country's voting rights. It would not be fair to those countries which made Herculean efforts to pay for the Health Assembly to make exceptions.

Mr PRODANCHUK (Ukraine) was greatly concerned by the views expressed. He regretted Ukraine's arrears, but pointed out that his country had suffered more than any other from the redistribution of the former Soviet Union's contributions to the United Nations organizations. Ukraine was facing an unprecedented situation and had seen a tremendous increase in its assessed contribution for 1993-1994. That increase had also been reflected in its rate of contributions to WHO. Although the United Nations General Assembly had decided to decrease the percentage of Ukraine's contribution for 1995-1996, it was felt that the level set did not reflect the country's actual ability to pay in the current period of transition to a free market economy. Ukraine had been the first country, on a voluntary basis, to renounce nuclear armaments; and it had ratified the Treaty on the Non-Proliferation of Nuclear Weapons. That, together with action to remedy the consequences of the Chernobyl disaster and to decommission the power station, made severe demands on the national budget.

Participation in WHO's activities, notably in pursuit of health for all, was a major health strategy for Ukraine. Drawing attention to the letter from the Minister of Health contained in document A49/30, he said that Ukraine would contribute to WHO's budget as soon as the economic situation permitted.

In reply to a question from Dr AL-RAHMAN (Sudan), Mr TOPPING (Legal Counsel) explained that Article 7 of the Constitution provided that a country might be deprived of the right to vote. The Forty-first World Health Assembly in 1988 had adopted a set of principles on the application of Article 7. According to those principles, if a Member had fallen behind with its payments for two years the Health Assembly should consider whether to suspend the voting privileges of that Member as from the following Health Assembly. Since then the Health Assembly had adopted a resolution each year identifying those countries that were two years in arrears and providing for the automatic suspension of their voting privileges with effect from the beginning of the following Health Assembly. Pursuant to that system, the resolution before the Committee had been recommended by the Administration, Budget and Finance Committee of the Executive Board, which had met immediately before the Health Assembly.

Mr IBRAHIMA (Mauritania) announced that arrangements had been made for a bank transfer in settlement of its arrears in a matter of days.

Dr KHALIFE (Lebanon) said that following a recent transfer of US$ 140 000, Lebanon was completely up to date with its contributions to WHO.

Dr AL-RAHMAN (Sudan) requested further clarification on the amount of arrears that a Member due to lose its voting privileges had to pay in order to have them restored.

Mr AITKEN (Assistant Director-General) replied that, legally speaking, one dollar might be the sufficient amount required to reduce a Member's arrears of contributions below a two-year total, but in many cases a much larger sum was required. The actual date of payment was also a determining factor.

Dr JAIDI (Libyan Arab Jamahiriya), recalling that his country had formerly paid its contributions in advance and had always been deeply committed to WHO, said that an unfair air blockade and frozen assets abroad had led to difficulties in making full payments to WHO and other international organizations. He had
the unfortunate impression that the Organization was not willing to assist in overcoming the difficulties that hampered the delivery of health services in the Libyan Arab Jamahiriya.

Mr AITKEN (Assistant Director-General) said that Cuba’s intention to enter into discussions on a plan of payment had been noted; the Director-General would report on arrangements made to the Fiftieth World Health Assembly to enable it to consider the restoration of voting privileges to that country.

The resolution recommended by the Administration, Budget and Finance Committee in document A49/9, as amended, was approved.¹

The CHAIRMAN drew attention to the draft resolution on the application of Article 7 contained in paragraph 10 of document A49/9.

Mr AITKEN (Assistant Director-General) said that the issue was whether to reduce to one year the two-year period of arrears after which a country would be subject to automatic loss of voting privileges. The one-year grace period would be retained. It had originally been mooted as a step that had been taken by other organizations. The Administration, Budget and Finance Committee had taken note and passed it on to Committee B, without making a recommendation on acceptance.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland) supported the draft resolution.

Dr SOLARI (Uruguay) opposed the draft resolution. Countries that had spoken on arrears during the current and previous Health Assemblies had generally given internal economic reasons for their difficulties, rather than considering the value or otherwise of the Organization’s efforts to improve the health situation in the world in general or in their own particular countries. As well as being confronted by domestic economic problems, some of the countries in arrears, his own among them, were owed more by the United Nations system than the debts that were jeopardizing their voting rights. Moreover, no specific reasons had been given for reducing the period from two years to one.

Dr AL-RAHMAN (Sudan) urged the Committee to reject the draft resolution. A decision on the matter should be deferred until the following year. In the meantime, the Executive Board might come up with an alternative solution to the Organization’s financial difficulties.

Mr VAN REENEN (Netherlands) agreed with the United Kingdom delegate that the resolution should be approved. The new statement of principles would help to overcome the Organization’s financial problems, which were largely due to lack of payment discipline among Member States.

The CHAIRMAN noted the absence of a quorum and suggested that a decision on the resolution be deferred until the next meeting.

(For continuation, see summary record of the second meeting, section 1, page 122.)


At the request of the CHAIRMAN, Mr ASAMOAH (Secretary) introduced the text - finalized after further consultations - of the amendment earlier proposed to the draft resolution contained in paragraph 14 of document A49/33. It took the form of an additional operative paragraph reading:

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA49.4.
EXPRESSES REGRET at the high level of borrowings; and REQUESTS the Director-General: to develop a financial plan for 1996-1997 and beyond to bring expenditure into line with expected income and to minimize internal borrowings; and to report to the ninety-ninth session of the Executive Board in January 1997 on this matter, including the impact on activities in countries, and other issues raised by the External Auditor in his report to which priority attention should be given, as well as steps to improve financial control and internal audit.

Dr SOLARI (Uruguay) said that the amendment should take account of the suggestion by the delegate of Brazil that priority be given to expenditure at the country rather than the central level, and of the point made by the Assistant Director-General about the establishment of priorities. The criteria for establishing priorities, which had not been spelled out, might include maintaining action specifically to rectify conditions most injurious to health, particularly in the least developed countries.

Mr POINSOT (France) asked what was meant by the term "expected income" in the draft amendment. Did it, as indeed it should, cover payment of obligatory contributions on time? If so, that should be spelled out.

Mr AITKEN (Assistant Director-General) said he understood the assumption in the resolution to be not that every contribution would be paid on time, but that a judgement should be formed on how much of the contributions would be received and when. Such planning was of course done, difficult though it was. He would report on the implications of the resolution to the Executive Board as was stated.

In reply to the delegate of Uruguay, he suggested that the phrase "including the impact on activities in countries" took care of the concern expressed by the delegate of Brazil. The text of the amendment would be typed and distributed for consideration by the Committee at the next meeting.

Dr KHALIFE (Lebanon) said that while the income deficit of some US$ 206 million was a large amount, it was not a disaster, and that the problem was not insoluble. On the other hand, certain parties appeared to have political motives, and such motives should most certainly not be allowed to affect the health situation. Submitting that the non-payment of contributions rather than internal borrowing was the vital issue, he underlined the special predicament of the developing countries and proposed that the amendment contain a reference to the importance of maintaining health priorities, especially the eradication of certain diseases and the promotion of health among the most vulnerable groups.

The CHAIRMAN announced that a new draft of the amendment would be circulated for consideration by the Committee at the next meeting (see page 121).

The meeting rose at 13:00.
1. FINANCIAL MATTERS: Item 20 of the Agenda (continued)

Arrears of contributions of South Africa: Item 20.4 of the Agenda (Document A49/10)

Mr AITKEN (Assistant Director-General), introducing the item at the invitation of the CHAIRMAN, reminded the Committee that in 1995 that matter had been left in abeyance pending a decision in New York on South Africa’s obligations to the United Nations system as a whole. Subsequently, in December 1995, the United Nations General Assembly had decided that South Africa should be held not liable for arrears of contributions relating to its 20-year period of inactive membership of the United Nations, which had also been of the same length in WHO. On the basis of that decision, the Committee might now consider the position for WHO. Since it had reactivated its membership of WHO, South Africa had paid its contributions in full and in a timely manner for 1994, 1995 and 1996.

He drew attention to a draft resolution proposed by the delegations of Botswana, Cyprus, Gambia, Ghana, Lesotho, Malawi, Mauritius, Namibia, Saint Kitts and Nevis, Seychelles, South Africa, Swaziland, Trinidad and Tobago, and Zambia, which reads as follows:

"The Forty-ninth World Health Assembly,
Having studied the report of the Director-General on the arrears of contributions of South Africa;¹
Recalling that on the opening day of the Forty-seventh World Health Assembly in May 1994 all rights and privileges associated with full membership of WHO were restored with immediate effect to South Africa by virtue of resolution WHA47.1 following a period of non-participation from 1966 to 1993;
Recalling further that the Forty-seventh World Health Assembly also decided at that time to defer consideration of the Director-General’s report on the arrears of contributions of South Africa in respect of the period 1966 to 1993 until the Forty-eighth World Health Assembly to be held in May 1995;
Recalling further that, following a request received from South Africa, the Forty-eighth World Health Assembly decided to leave the matter in abeyance for a further year until such time as discussions in New York on South Africa’s financial obligations to the United Nations system as a whole were completed;
Noting that on 15 December 1995 the United Nations General Assembly adopted resolution 50/83 recognizing that, owing to the exceptional circumstances which had previously arisen from apartheid, South Africa had asked not to be held liable for contributions relating to the period 30 September 1974 to 23 June 1994;
Noting further that by resolution 50/83 the United Nations General Assembly accepted South Africa’s request to be exempted from payment of its contributions in respect of that period;
Noting also that in WHO the assessed contributions of South Africa for the period 1966 to 1993 had been placed in the undistributed reserve throughout that period and were therefore not required for financing of effective working budgets during that period;"

¹ Document A49/10.
Expressing satisfaction at the fact that South Africa had paid in full all assessed contributions for the period following restoration of its rights and privileges in WHO and that these payments had been provisionally applied to the 1994, 1995 and 1996 contributions without any intention of prejudging the outcome of decisions to be taken by the Health Assembly,

1. ACCEPTS, owing to the exceptional and unique circumstances of the non-participation of South Africa in WHO during the period 1966 to 1993, South Africa’s request not to have to pay its contributions for that period;

2. DECIDES that these contributions totalling US$ 22 345 060 should be offset against the corresponding amount in the undistributed reserve.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that his delegation thought it right that South Africa should not have to meet commitments from a previous regime. Furthermore, WHO should be in a position to benefit from the opportunities for collaboration in view of the considerable expertise of South Africa in health matters.

The CHAIRMAN asked the Committee to note the addition of Ireland, Kenya, Mozambique, Venezuela, Zaire and Zimbabwe to the list of sponsors of the resolution. He took it that the Committee was ready to approve the draft resolution by consensus.

The draft resolution was approved.¹

Dr Shisana took the Chair.


At the request of the CHAIRMAN, Mr ASAMOAH (Secretary) read out the resolution proposed by the Administration, Budget and Finance Committee in paragraph 14 of document A49/33, as amended during the discussion at the previous meeting:

The Forty-ninth World Health Assembly,
Having examined the financial report and audited financial statements for the financial period 1 January 1994 to 31 December 1995 and the report of the External Auditor to the Health Assembly;²
Having considered the first report of the Administration, Budget and Finance Committee of the Executive Board to the Forty-ninth World Health Assembly,³

1. ACCEPTS the Director-General’s financial report and audited financial statements for the financial period 1 January 1994 to 31 December 1995 and the report of the External Auditor to the Health Assembly;

2. EXPRESSES REGRET at the high level of borrowings;

3. REQUESTS the Director-General:

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA49.5.
² Document A49/7.
³ Document A49/33.
(1) to develop a financial plan for 1996-1997 and beyond to bring expenditure into line with expected income and to minimize internal borrowings;
(2) to report to the ninety-ninth session of the Executive Board in January 1997 on this matter, including the impact on programmes and activities in countries, and other issues raised by the External Auditor in his report to which priority attention should be given, as well as steps to improve financial control and internal audit.

The draft resolution, as amended, was approved.¹

Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: Item 20.3 of the Agenda (Document A49/9) (continued from page 118)

Mr AITKEN (Assistant Director-General), referring to the discussion at the previous meeting on the draft resolution set out in paragraph 10 of document A49/9 relating to a possible reduction of the period during which Members might delay payment without losing voting privileges to one year followed by a year of "grace", suggested that the Committee might wish to consider postponing a decision, pending review at its ninety-ninth session by the Executive Board, which would report to the Fiftieth World Health Assembly.

Dr BERGÉVIN (Canada) agreed with that suggestion, on the general understanding that efforts should be made to encourage Member States to fulfil their constitutional obligations.

Mr MONTALVÁN (Panama) agreed that further study was needed. The Board should distinguish between countries in economic difficulties and the victims of embargoes on the one hand, and those with internal political obstacles to paying their contribution on the other. The year of grace should be granted only to those able to demonstrate real economic and financial hardship.

The CHAIRMAN took it that the proposal was acceptable, and expressed the hope that the views of members of the Committee would be taken into account when the Board considered the matter.

It was so agreed.

2. WHO REFORM AND RESPONSE TO GLOBAL CHANGE: Item 21 of the Agenda

Progress report on reform: Item 21.1 of the Agenda (Resolution EB97.R2; Document A49/11)

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation) recalled that in May 1993 the Executive Board had endorsed the 47 recommendations contained in the report of its Working Group on the WHO Response to Global Change. The report in documents A49/11 and PPE/95.4 described progress in implementing the recommendations, all of which had been acted upon within the time allotted. She stressed that permanent updating of measures already undertaken had been necessary as the recommendations did not constitute an end in themselves, simply launching a reform process which had to be continued within the framework of the management process of WHO.

The following political reforms should be seen as priorities: the development of a long-term policy for WHO, which should inspire a new mission incorporating revised ethical principles and values; the full

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA49.2.
definition of WHO's role at country level; and the establishment of a new personnel policy. Management reforms were also needed: finalization of budgetary reform; strengthening of programme evaluation at all levels, emphasizing quantified targets specific to WHO; and the determination of indicators for each programme. Adequate information should be ensured at all levels through the new unified information systems.

Budgetary reform had given rise to a strategic budgetary system translated into detailed action plans at all levels of the Organization, which were already serving in the planning and monitoring of WHO programmes. Strengthening of management, as well as all other reforms, concerned all levels of WHO, while preserving the programme specificity of individual regions. Thanks to the reforms undertaken over the past few years and structural changes relating to them, WHO's ability to adapt had become an integral part of its "management culture". WHO was now in a position to incorporate the necessary reforms and permanently to adapt to changes under way in the world.

Professor LI Shichuo (representative of the Executive Board) said that the Board had reviewed progress and noted that all 47 recommendations had received attention, fulfilling the requirements of the first stage of the WHO response. There were two main directions, policy and management reform. Several supplementary measures were still required and some measures already taken required continuing improvement.

On policy reform, the Board had been informed that consultations were continuing with Member States and all parties concerned in the development of a new vision for the Organization's mission within an updated health policy. Action was under way to complete the redefinition of WHO's role at country level, and the personnel policy remained under continuous review. Management reform was continuing, with further improvement in programming, planning and management, evaluation of policies and programmes, and the development of quantified targets and indicators for each programme. The development of the programme management information system to facilitate reform was going ahead. Budgetary reform was continuing. The Board had noted that the structures to facilitate reform had been set up and had requested the Director-General to continue the process of reform and ensure changes through the Global Policy Council and Management Development Committee. It had further requested that progress reports be "outcome-oriented", and that interim reports be provided in cases where tasks had not been completed on schedule. It was also important that the effectiveness of mechanisms and structures set up to enable the Organization to respond to change be kept under review.

Mr SAKAI (Japan) urged that the Board monitor the progress of the reform initiative carefully and that Member States work together to remove obstacles to further implementation. His delegation strongly believed that those efforts would reinforce the impact of programmes while maintaining the highest level of WHO's technical expertise.

Mr BOYER (United States of America) supported the comments of the delegate of Japan, and stressed the need for continued monitoring of the reform process. There had been worldwide pressure on all organizations of the United Nations system to seek better ways of making resources go further. Areas needing continued attention were: the shifting of resources to areas of priority; the building of new partnerships with WHO collaborating centres to reduce duplication of effort and reduce expenditure, while maintaining services to Member States; and better programme evaluation with a frank evaluation of health "outcomes" rather than "inputs". His delegation wished to see the creation of a post of "Inspector General" and a more transparent budget system, so that Member States could see how much was being spent on each programme.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) welcomed the implementation of change at WHO, noting that much still remained to be done. Whilst accepting the difficulties of change in a large Organization such as WHO, he stressed the fundamental importance of reform of personnel policy, which was at present not coherent. The team created in 1993 to review personnel policy had taken two years to report, and the substance of the report was light; although it gave interesting options for devising a new policy, there was no timetable for concrete steps. Staff were WHO's most precious resource and he urged a revitalized policy, modelled on good practice elsewhere and using external consultants. A timetable should
be set and adhered to, and the Executive Board should be kept fully informed of progress. Together with others, his delegation was considering proposing a draft resolution on the matter.

Dr RIAZANCEV (Russian Federation) pointed out that although progress had been made in implementing the 47 recommendations of the Working Group, there was still a need to monitor progress in reform. He endorsed resolution EB97.R2.

Dr BERGEVIN (Canada) welcomed the Executive Board's report on implementation of the reform and endorsed the suggestions made by the United Kingdom and the United States delegates. Programme evaluation called for a methodology that made for consistency and objectivity in priority-setting and programme development, as in evaluation of the Organization's performance on the basis of its achievements at the country level.

WHO had initiated means of changing its administrative and programming approaches, which had benefited other United Nations agencies also under pressure to reform. Many remarks on reform had focused on the Secretariat but reform, if it was to succeed, called for Member States to improve their relationship with WHO by changing their attitudes, increasing their political commitment and taking more than discretionary responsibility.

Ms LOBBEZOO (Netherlands) said that in the reform process the Organization had generally acted on the 47 recommendations of the Executive Board's Working Group. However, much still remained to be done, especially in areas that would have a lasting effect on the Organization: namely, its role at the country level, its policy and mission, and further budgetary reform, on which last point she endorsed the comments of the United Kingdom delegate.

Continuation of the reform process being of paramount importance, Member States should be closely involved in it as it affected the Organization, and evaluation should play an important role in any follow-up. The Netherlands therefore endorsed resolution EB97.R2.

Ms INGRAM (Australia) said that reform did not consist merely of ticking off a checklist of measures but of establishing a "culture of reform" with demonstrable outcome.

She welcomed the emphasis in resolution EB97.R2 on "outcome-oriented reporting" and "mechanisms to measure the implementation of reform and its impact on the Organization". It was crucial that the Organization's performance should be measured by its achievements, rather than by the process. For instance, paragraph 8 of document A49/11 supplied figures which, while demonstrating the level of the Organization's efforts and seriousness, did not reveal the tangible results.

Reform was a continuing process; Australia therefore supported the complementary measures outlined in paragraphs 11 and 12.

Staff costs were the Organization's major item of expenditure, so that sensitive, open staffing policies were needed. The staff was arguably the WHO's most valuable resource and should be managed with equity. During a period of organizational change, senior management should heed the staff's proposals and show sensitivity in its related decisions and practices. She endorsed the call for a dynamic and consultative personnel policy.

Mr ZIARAN (Islamic Republic of Iran) said that the reform process had become very complicated and confusing. There was, unfortunately, no clear idea or specific assessment of the effect of implementation of the recommendations on the Organization's ability to respond to new and emerging challenges and to discharge its mandate; a concise report was needed.

Ms GREW (New Zealand) thanked the Executive Board for its efforts to implement the recommendations contained in resolution WHA46.16 and urged it to continue to encourage reform, and to monitor progress so as to ensure achievement of the objectives. The emphasis of the reform should be transparency and value for money, putting available resources to the most efficient and effective use. That, in turn, called for further change in the way WHO conducted its business. It needed to be responsive, relevant and effective in regard to the world's health problems, always remembering its responsibility and
accountability to its Members and to global health. As the Netherlands delegate had remarked, response to
global change was closely linked to budget reform.

New Zealand fully supported the comments made by the United Kingdom delegate regarding personnel
issues.

The fine-tuning of the Organization’s policy and mission should be a constant evolutionary process.

Dr ÁVILA DÍAZ (Cuba) said that WHO reform was not a single action, but a process that called for
proper coordination among countries, regions and headquarters to ensure that the Organization was constantly
fulfilling its mission.

The unfavourable economic situation called for priorities to be established, but they should involve all
countries, starting with each country’s health situation vis-à-vis the region and the world, and should not be
determined purely at the headquarters level.

The WHO collaborating centres could be used to greater effect to help contain costs and enhance the
Organization’s action in countries. Efforts must be made to avoid duplication of the activities of other United
Nations agencies, as duplication was tantamount to misuse of resources.

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation) remarked
that most speakers had evoked problems of evaluation and the need to determine WHO’s activities in terms
of output and whether it was truly effective for the Member States.

In that connection the Director-General had created in January 1996 an evaluation unit in the Division
of Development of Policy, Programme and Evaluation which had set about evaluating the changes and
reforms and creating a complete evaluation system at all levels of the Organization.

With regard to budget reform, the proposed programme budget for 1998-1999 to be presented in 1997
would show the effort made to present WHO’s activities in "product" form, which would greatly facilitate
evaluation of the implementation of the programme budget.

The delegate of New Zealand had stressed the need for increased responsibility for programme
organization and management. Thanks to the evaluation system, budget reform and a strategic budget,
evaluation would be carried out with the Executive Board and the Health Assembly.

It was evident that, as the delegate of Cuba had pointed out, the reform had to be a continuous process
since an organization as highly decentralized as WHO could not be reformed in a matter of months. It had
to be implemented thoroughly at the country, regional and headquarters levels. The Health Assembly would
be kept regularly informed of progress.

On the subject of "partnership" raised by the delegate of the United States of America, new partnerships
were a high priority in the new policy of solidarity being developed for the period 2000 to 2025, which could
be discussed in more detail under the subsequent agenda item.

She referred the comments of the Netherlands, Australia and United Kingdom delegates on personnel
policy to Mr Aitken, who had been chairman of the development team on personnel policy.

Mr AITKEN (Assistant Director-General) agreed with speakers who had emphasized the importance
of personnel policy. Two years of work had culminated in a document referred in January to the Executive
Board, which had basically endorsed it. A series of measures had to be taken to develop that new personnel
policy. A phased programme had already been developed. He admitted that the timetable had not been
sufficiently shared with the Executive Board, promising that that deficiency would be rectified at a
forthcoming session. He appreciated the speakers’ emphasis on the need for rapid development of the
personnel plan; the Executive Board would be kept abreast of every stage of the planning.

In financially difficult times, it was not easy to maintain staff morale and he paid tribute to the
enormous contribution the staff had made to the work of the Organization.

The CHAIRMAN said that the item would be continued when the United Kingdom’s draft resolution
had been received.

(For continuation, see summary record of the eighth meeting, section 2.)
Renewing the health-for-all strategy: Item 21.2 of the Agenda (Resolution WHA48.16; Document A49/12)

Professor LI Shichuo (representative of the Executive Board) said that the Executive Board’s review of progress on renewal of the health-for-all-strategy had shown that while there were steady improvements in some countries, health gains were being reversed in others, and the gap continued to widen between and within many countries. Growing health problems included tobacco-related mortality, decreased immunization rates and antimicrobial resistance.

The starting-point for future development and attainment of health for all was still the primary health care approach adopted at Alma-Ata. One way of reducing inequalities would be to focus on the least developed countries, for example, by giving particular attention to Africa in the strategy to achieve global equity and solidarity for health.

The number of international participants in health would increase, making it necessary for WHO’s unique role in health to be more clearly defined. Partnerships with key health organizations and groups were being built and strengthened to ensure complementarity.

All WHO regions had responded to the call for renewal of the health-for-all strategy, and were working with countries to ensure that the new strategy reflected their needs and priorities and to help mobilize a renewed worldwide commitment to health for all. Action was under way to ensure country involvement, review the strategy’s successes and failures and ensure that the new policy was scientific and focused on priority areas and countries that could contribute most to future health gains.

The Executive Board had noted the progress made in the consultation process, encouraged countries and WHO’s "health partners" to become fully involved and asked the Director-General to report to the ninetieth session of the Board.

Dr ANTEZANA (Assistant Director-General) stressed that renewal of the health-for-all strategy was a common endeavour of Member States for international cooperation, affecting the policy, strategies and commitments of the Organization. "Health for all" had become a global rallying-point for improved health and measures to reduce inequalities. WHO leadership remained vital in the face of threats, such as those described in paragraphs 4 to 10 of document A49/12. Renewal of the strategy, by building on the best practices and values of the past and adapting them to prepare for the next century, should be regarded as an opportunity for health advocacy in countries, international bodies and private and nongovernmental organizations. WHO’s message was that the international community possessed the technological and scientific capability to control, prevent and, in exceptional cases, eradicate many causes of ill-health, disability and premature death. What was often lacking was the necessary political support and the willingness to invest in priority action. Through the process of renewal, the energy and enthusiasm of all partners should be harnessed and channelled to make the most of health for all. Progress had been achieved in all regions and in many countries, but there was still a long way to go.

Analytical capability had improved since the International Conference on Primary Health Care in Alma-Ata in 1978, resulting in a better understanding of the causes of the burden of disease, the effectiveness of action taken and the resources needed to support health systems, thus setting a firm basis for an "evidence-based" or science-based approach to health policy development - an approach strongly supported by the Executive Board at its ninety-seventh session.

By the time WHO celebrated its fiftieth anniversary in 1998, the combined tasks of countries, nongovernmental and private organizations and the United Nations system would have been integrated into a renewed strategy that would take WHO into the next century and should provide the impetus for more forceful and effective joint action to meet the health challenges of the twenty-first century. Countries and peoples should join in clearly defining the role of WHO in a contract that would constitute its new vision and mission.

Mr ÖRTENDAHL (Sweden) observed, first, that revision of the health-for-all strategy must entail a careful blend of renewal and continuity. Countries that had based national strategies on elements taken from basic health-for-all policy statements needed continuity for their national policy-making processes. Secondly, it was doubtful whether all the concepts underlying the Declaration of Alma-Ata would be of continuing relevance in the next century. It was necessary, in particular, to take a fresh look at the underlying structures
of health systems. Today, many more countries faced the possibilities and problems of technological advancement. His own country had to contend with a situation in which the possibilities for medical intervention were growing more rapidly than economic resources. The main focus in the health system was shifting to the provision of care for older people, including the necessary social support to enhance their quality of life. Although primary health care traditionally played an important role, the integration of general health services with the technologically advanced forms of secondary care was proving more applicable to present-day society. The basic division into primary and secondary health care was a concept that might require debate. Signs of the trend towards an integrated health service were the rapidly declining use of traditional hospital inpatient resources and better use of information technology in communication between branches of medicine; the competition between primary and secondary care services for resources, patients, methods and training facilities; and the ever closer cooperation between medicine and social services.

Thirdly, to be able to influence the health policies of countries, the debate on renewal must be based on active participation by Member States; WHO could play an important role in providing intellectual stimulus to those debating the issues. The Fiftieth World Health Assembly should be instrumental in that endeavour, providing an opportunity for a critical review of the intellectual cornerstones of the Declaration of Alma-Ata in the perspective of the fiftieth anniversary of WHO and the thirtieth anniversary of the Alma-Ata Conference.

Mr DEBRUS (Germany) stressed the importance of intensive, permanent and comprehensive consultation with Member States particularly in connection with the renewal of the WHO health-for-all strategy. Provision had indeed been made for consultations throughout 1996 in the booklet entitled "Renewing the health-for-all strategy" which the German Ministry of Health had received at the end of 1995 without any accompanying letter or comment. The involvement of Member States in the renewal process entailed continuing dialogue, which should begin now. That process should no longer be confined to the WHO Secretariat and bodies in which only a few Member States were involved, as was now the case. If the consultation process were to begin only after the regional committee meetings in September 1996 and were then to last only about two to three months, Member States would have little time to prepare a significant response and one that was commensurate with the duration of the renewal process. Difficulties might also arise in incorporating the results of the consultation process already under way in Germany into the strategy, in time for the preparation for WHO's "special event" in May 1998.

Mr ISLAM (Bangladesh) referred to mixed achievements since the International Conference on Primary Health Care in 1978. In his own country, progress had been made in such areas as the supply of safe drinking-water, the use of sanitary latrines, the Expanded Programme on Immunization, birth control and reduction of infant and maternal mortality rates. Nevertheless, primary health care remained a major cause for concern in many least developed countries with the problem of the re-emergence of diseases like malaria and tuberculosis. Credit was due to WHO for its awareness of those issues and for introducing measures to renew the health-for-all strategy. In the renewed strategy, the specific health conditions of least developed countries should be taken into account and adequate technical and financial support provided, notwithstanding a global or regional approach. Special attention should also be given by WHO to countries, such as his own, which were prone to natural disasters.

Ms LAURIDSEN (Denmark), endorsing the statement by the delegate of Sweden on the substance of the renewal of the health-for-all strategy, commented on the structural and organizational viewpoint: efforts to renew the strategy must be based not only on developments after 1978 but also on current and future developments, bearing in mind the greater number of "actors" on the international health scene. Document A49/12 described methods of work used until now but did not reflect any substantial consideration for the future, and, in particular, accorded only a very minor role to Member States, whose involvement was crucial to future political commitment to the revised strategy. The new strategy must build on a global understanding of the main objectives and be conceived in such a way as to be politically acceptable to Member States. Once the new contributions for a revised strategy had been determined, discussions could follow on structural matters. Implementation must be based on regional, national and local cooperation and must ensure that health for all continued to be a priority for all nations. While Denmark supported initiatives to effect substantial changes in internal structure to cope with rapidly changing conditions and needs, care should be
taken not to put the cart before the horse. Coordinated action for the renewal of the health-for-all strategy and services was crucial.

Ms DUPUY (Uruguay) drew attention to a forthcoming regional meeting to be held in June 1996 in Montevideo to examine in depth future health trends and their impact on all countries’ renewed commitment to health for all. She stressed the need for increased national resources to deal with old and new infectious diseases and diseases associated with ageing. The cost of technology and treatment used by developed countries placed impossible demands on countries seeking to meet other development needs equitably and effectively.

Mr HOU Zhenyi (China) said that, since the 1978 Alma-Ata Conference, the "Health for all by the year 2000" slogan had become a household word and represented a policy that had given considerable impetus to health development in all countries. The extension of the health-for-all goal by the Forty-eighth World Health Assembly had been an appreciable step forward. Renewal of the strategy was now needed in order to keep pace with major changes in the world health situation. The renewal process would provide an opportunity for all countries to reconsider the role of health development in their political agendas and to enhance the relevance and appropriateness of strategies. It should reflect regional and national specificities and called for high-level political support. Special attention should be given to those considerations in preparing for the special activities to mark the fiftieth anniversary of WHO.

Referring to China’s contribution to strategy renewal, he reported that, on the basis of an evaluation of national targets, two documents, on China’s progress towards the realization of targets for health for all by the year 2000 in rural and in urban areas, respectively, were being updated. Efforts were being made to incorporate health-for-all goals into overall government action, with emphasis on intersectoral coordination, in which the Government was giving priority to the more disadvantaged regions. Rural health care services were being improved, and greater emphasis was being placed on community health education.

Mrs NORBØ (Norway) said that the health-for-all strategy was conceived through a process which challenged the values, policies, systems and structure for health care delivery, both nationally and internationally. Experience in implementing that strategy had shown that there was a need to be carefully realistic, rather than optimistically idealistic, in view of the fact that health for all depended as much on the politics of health and development as on technologically sound tools.

The Director-General was now calling for a renewal of that strategy. However, before negotiating what should be renewed, it was necessary to examine what should be revised, through a process of identification and analysis of barriers to necessary change. Yet the recognition of new "partnerships for health" had to go beyond mere slogans and be geared to obtaining practical results, focusing on conditions which would make such partnerships creative and effective.

One positive sign was the enhanced budgetary and political emphasis now laid on the social and health sector as demonstrated by the support given to the 20:20 objective discussed at the World Summit for Social Development (Copenhagen, 1995). More than ever before, there were opportunities for coordinated and concentrated resource mobilization and action. The essential features of such joint action were transparency and accountability, backed by more appropriate and consistently used monitoring instruments.

In renewing its health-for-all strategy, WHO should not take its role for granted, as it was only one protagonist among many: leadership had to be exercised and demonstrated. It was only through the renewal of its competence and the rebuilding of its credibility that WHO would be able to make a significant contribution in a new and complex world situation.

Ms INGRAM (Australia) said that in considering renewal of the health-for-all strategy, it was useful to look back to recommendations 2, 3 and 4 of the report on WHO response to global change, to which it essentially constituted a response. The emphasis in the report had been on developing a realistic strategy for WHO which related to its central mission and was both achievable and measurable. It was therefore important to set broadly accepted and workable targets, based on a clear understanding of WHO’s mission.

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1 See document EB93/1994/REC/1, Annex 1, Appendix.
and core tasks, and on an appreciation of the complementarity of the Organization’s role with those of other "international players". Ultimately, it would be WHO’s capacity for leadership within the context of its global health mission that would define its effectiveness.

Commenting on the statement made by the Danish delegate, she had been interested to note certain changes made to the Director-General’s progress report subsequent to its consideration by the Executive Board at its ninety-seventh session. In particular, paragraph 8 of document A49/12 suggested that WHO’s role in the health field and areas in which it had advantages over other organizations had been the subject of positive reflection. She looked forward to a more substantial analysis.

Dr CICOGNA (Italy) agreed with the emphasis laid in the report on the need for harmonization of the components in the renewal process, with a view to reaching a truly global consensus. Consultation and continuity constituted key elements in that process.

He expressed appreciation for the constructive work carried out by the Regional Office for Europe in revising regional health policy; its guidance was of fundamental importance to all European Member States. In that context, he drew attention to the absence of any reference in the report to the European Union, which was playing an increasingly important role in the health field.

Mrs DHAR (India) said that good health was a fundamental right of every human being; health for all should therefore cover all the socially and economically weaker sections of society, particularly in developing countries, although even within developed countries there were pockets of poor and deprived people. The limited resources of WHO should be focused on those underprivileged sectors.

She welcomed the fact that consultation on renewal of the health-for-all strategy was to be expanded. In India, the key documents were being circulated to the relevant departments and agencies in both the public and the private sectors. Health-risk assessments, undertaken on the basis of WHO guidance, ought to form an integral part of the formulation and implementation of all development projects.

Ms VOGEL (United States of America) expressed her firm support for a renewed health-for-all strategy and welcomed efforts to delineate WHO’s philosophy more clearly, together with the areas in which WHO had advantages compared to other organizations, including its intersectoral and international approaches, in a new document. The consultative process was an essential element upon which countries could build in order to tackle their own and global problems. All countries should be aware of the efforts being made, and should receive support for revision of the strategy in the light of their own needs.

She urged that everything should be done to ensure a capacity for evaluation, which was a key to future success. All programmes ought to be equipped with "outcome indicators" facilitating such evaluation, especially in view of constrained resources.

She appreciated the recognition of regional differences in regard to the importance of certain themes and looked forward to further progress reports on the renewal process.

Dr RIAZANCEV (Russian Federation) welcomed the renewal of the health-for-all strategy and noted the progress achieved during the consultative process at various levels. Tangible results depended on the active participation of all the countries concerned, as well as that of WHO’s other "partners". It was vital for them to hear periodic reports from the Director-General on that important matter.

Professor BERTAN (Turkey) appreciated all the efforts put into renewing the health-for-all strategy and endorsed the report and resolution WHA48.16. Each country would implement the renewed strategy in accordance with its own priorities, needs and experience in the application of the previous strategy, assessed through evaluation. However, in the past, most countries had been unable to make a full contribution to the evaluation process because of inadequate surveillance systems. The renewed strategy should therefore incorporate an evaluation component from the outset, and WHO should develop an easy and practical managerial tool for that purpose.

Dr STAMPS (Zimbabwe) said that, like many other countries undergoing economic reform, Zimbabwe had suffered setbacks in extending health for all, principally because of the severe financial stringency and value for money demanded by fiduciary sources. Faced with a 39% per capita reduction in health expenditure
and the spectre of new and re-emergent diseases, good housekeeping had become paramount. The quality and scope of health care services lagged behind those of developed countries, and it was of little comfort to know that, despite increased health expenditure in developed countries, "health outcomes" were not improving. That was an area in which WHO should play a pivotal role, as health outcomes were of greater importance than "inputs".

Zimbabwe, with the assistance of the WHO Regional Office, other United Nations agencies and donors, had made significant progress in health reform, particularly in accountability, transparency and informatics, all of which were essential to the process of change. Zimbabwe's draft strategy for the renewal of health for all could not have been drawn up without the valuable efforts of the WHO Representative in Zimbabwe. His expertise and access to information, which only WHO could provide, had enabled the country's health authorities to tackle current and future health care tasks.

Dr SULEIMAN (Malaysia) expressed appreciation for the progress made in the consultation process. Malaysia had always believed in equity in development, particularly in health. With the country's rapid development, new health technology was being absorbed and health care costs were escalating. Ensuring equity in health care was thus becoming increasingly challenging. Efforts were therefore needed to ensure that health matters were considered at the highest level of government, to engender the political will to implement change, and to obtain support from the private sector and nongovernmental organizations.

The initiative for a broader-based approach to renewal covering global health up to the year 2020 was welcome. WHO could play an important role in that process by helping to ensure equity in health at the country level and to reduce the disparities at the regional and international levels. WHO's efforts would only be successful if the new strategy was acceptable to all countries. Continued emphasis must be placed on values, social justice and a strategy of primary health care.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) suggested that further consideration should be given to the title of the strategy: was the current health-for-all policy being renewed or revised, or was a new policy being developed, with a new programme, which would take into account the changing world and the new challenges which that presented? The word "renewal" might convey the wrong message and misrepresent the creative process and "partnership-building" currently taking place. The United Kingdom looked forward to contributing to that work, particularly the revised European strategy, through the European Region.

Ms LOBBEZOO (Netherlands) said that the fundamental objectives of renewing the health-for-all strategy remained unclear. As the progress report (document A49/12) did not contain any analysis of the current strategy based on evaluation criteria, it was difficult to measure the progress made. It was also unclear how the initiatives taken at different levels would be brought together to formulate a truly global strategy. Member States were not adequately informed by WHO how they could contribute to the consultative process.

In section II of the document, insufficient attention had been given to the important question of health care reforms; WHO had a clear role to play and she hoped that it would respond to the question fully in the future. With regard to cooperation with other international organizations, discussed in section V of the document, she hoped that closer ties would be developed with UNFPA as well as with UNICEF, since reproductive health was and would remain a priority. She wondered whether any consumers' organizations had been approached, as their participation was also important.

The Government of the Netherlands attached great importance to the renewal of the health-for-all strategy and would second a public health expert to assist in the renewal process.

Dr ÁVILA DÍAZ (Cuba) said that Cuba's achievements a decade earlier had only been possible because the Government had had the necessary political will to give priority to the health sector and set up a decentralized health system based on primary health care and a continuous process of reform. In addition, an intersectoral approach had been adopted involving the active participation of the community. The Regional Advisory Group in the Americas had endorsed that approach and had emphasized the need to determine practical mechanisms for implementing policies at the country level, bearing in mind the diversity
of country needs and their existing priorities. The process of renewal had to be more than just a strategy: it needed to be fully understood and endorsed by all countries, and to be given external support.

Over the past few years Cuba had seen its GDP fall by 35% and costs greatly increased because of an unfair embargo. It had nevertheless succeeded in strengthening its health system by focusing on primary health care. It had set up health boards, in which all economic and social sectors participated, and which were responsible for drawing up action programmes. Methods of work had changed, becoming more participatory. Meetings on methodology were held with all local health directors and the Ministry’s involvement reached to grass-roots level. Community councils and municipal, provincial and national authorities were all involved in the renewal of health for all in Cuba, to ensure that health for all would be an important instrument of change in the health of the people instead of merely a slogan.

Dr BERGEVIN (Canada), endorsing the points made by the United Kingdom and Netherlands delegates and recognizing the importance of the renewal process, said that Canada would be contributing to a WHO meeting of experts on intersectoral action for health later in the year, and hoped that other Member States would join in support of that initiative. The renewal of health for all should be linked to the broader strategic planning and reform taking place in the United Nations system, and the various consultative processes should be integrated.

Dr JAYASURIYA (Sri Lanka) said that his country had pursued a health-for-all strategy since 1926, investing heavily in health, education and poverty alleviation, contrary to the advice of certain international organizations at the time. Successive governments had expanded health and education facilities, and the country currently enjoyed a free health service and free education up to university level. Sri Lanka considered education, particularly for women, to be even more important than promoting health services in improving the health of its people. Its policies had ensured a higher human development index than would have been expected on the basis of per capita income. Health for all could only be achieved through a comprehensive strategy of investment in health, education and poverty alleviation.

Mr MOEINI (Islamic Republic of Iran) endorsed the view of previous speakers that the direction of the strategy should be clearly determined. He considered that a "bottom up" approach to the strategy, putting the needs and requirements of individual countries before regional and wider concerns, was the most appropriate.

The CHAIRMAN, summing up, said that there appeared to be overall support for the strategy, although improvements were to be made in certain areas. The strategy needed to be realistic, achievable, measurable, technically sound and go beyond mere slogans. There had to be adequate consultation, and a balance between continuity and positive change. Poverty would have to be tackled. There was a need to clarify WHO's philosophy, its objectives, global strategy and expectations of Member States. Impact assessment should be built into programmes and planning should be on the basis of country priorities. The title of the strategy should be reconsidered, and the strategy should cover health care reforms and decentralization of health care systems based on primary health care and an intersectoral approach.

Dr ANTEZANA (Assistant Director-General), responding to points raised, thanked delegates for their guidance. The delegate of Sweden had made useful comments on the substance of health for all. A number of delegates had stressed the importance of complementarity, both inside WHO and within the wider international community, including nongovernmental organizations. Reference had also been made to indicators and targets. He confirmed that WHO was working along those lines. He welcomed the comments made on regional and country differences, and the importance of taking account of the differing needs and aspirations of peoples and countries. WHO was anxious to implement a country approach and Member States were urged to give the Organization guidance on priorities. Participation along the lines described by the delegates of Cuba and Sri Lanka would result in a "bottom up" approach, which WHO also supported.

Renewal of health for all involved more than paperwork; the aim was to mobilize communities and whole countries to redefine their policies and strategies so as to achieve universal coverage by better health services.
The delegates of the Netherlands and Canada were to be thanked for their support in committing resources to the consultation process.

Dr MACFADYEN (Regional Office for Europe), replying to the delegate of Germany, said that in 1995 the Regional Committee for Europe had considered the health-for-all renewal process, and in particular linking the global and regional processes. A timetable had been set and activities were on course. The Region's Standing Committee had, in February 1996, received a report on progress in revising regional health policy, and in turn had put a proposal to the Regional Office that "evidence-based" policies should be included, such as those developed on alcohol and tobacco. A report would be submitted to the forty-sixth session of the Regional Committee in September 1996 describing progress over the past year. A meeting had been held in Slovakia at which scenarios for the Europe of the future had been discussed. The European Region attached importance to networking with colleagues at headquarters and in other regions. Thus, for example, through the headquarters Policy Action Coordination team, two European countries had been visited, the Region of the Americas had been represented at the meeting in Slovakia, and the European Region would be represented at a conference at Montevideo organized by PAHO on revising health policy in that Region.

The question of targets and their use in and outside the European Region had been considered and case studies had been examined at the national, regional and provincial levels. The question of terminology, raised by the United Kingdom delegate, had been the subject of a linguistic analysis the results of which could be made available.

The CHAIRMAN said that she took it that the Committee wished to encourage countries and WHO's "partners in health" to become fully involved and also wished to request the Director-General to report on progress to the Executive Board in January 1997.

It was so agreed.

The meeting rose at 17:35.
1. WHO REFORM AND RESPONSE TO GLOBAL CHANGE: Item 21 of the Agenda (continued)

Review of the Constitution of the World Health Organization: Item 21.3 of the Agenda (Resolution WHA48.14; Decision EB97(11); Document A49/13)

Professor Li Shichuo (representative of the Executive Board) explained that pursuant to the request made by the Forty-eighth World Health Assembly in resolution WHA48.14, the Executive Board had at its ninety-seventh session considered the question of reviewing the Constitution. In order to assist the Board in its discussions, the Director-General had submitted a short document identifying various issues on the reform of the Constitution that had been raised over the years in the documents and debates of the Executive Board and the Health Assembly.

The Board was of the opinion that before considering whether it was necessary to revise the substance of the Constitution, it was important to clarify the future mission and functions of WHO. It would then be possible to decide what alterations to the Constitution were necessary in order to ensure that the Organization was best equipped to fulfil its future role. The Board had taken decision EB97(11), establishing a special group of six members of the Board to undertake an examination of the mission and functions of WHO and to report on its deliberations to the Board at its ninety-ninth session in January 1997. In the light of those deliberations, it would be possible to decide whether there were any provisions of the Constitution that might need revision.

Dr Chollat-Traquet (Division of Development of Policy, Programme and Evaluation) said that the special group set up by the Executive Board would hold a short information meeting in the week following the Board’s ninety-eighth session. A fuller meeting would be held in the first half of October 1996.

The Chairman said that the report by the Director-General in document A49/13 on the progress achieved in relation to the review of the Constitution had been submitted as a result of a request for such information made at the Forty-eighth World Health Assembly.

Mr Moeini (Islamic Republic of Iran) said that in view of international developments it was clearly necessary to review the Constitution of WHO. However, the process should be based on certain principles. First, the review should not lessen the authority of Member States. Secondly, it was essential to examine the functions of WHO, focusing on the health needs of individual countries and regional and global needs. Thirdly, WHO should play a more active role, dealing more closely with the needs of different countries and regions. In other words, in reviewing the functions of WHO it was necessary to begin at the bottom and work upwards. Furthermore, the Rules of Procedure of the Executive Board and the World Health Assembly should be included in the review. For example, greater transparency in the process of electing the Director-General was essential. Under the existing Rules of Procedure the process was an entirely private matter. The Health Assembly had the right to be more closely involved in the election of the Director-General. The current provision for only one nominee to be presented by the Executive Board to the Health Assembly was insufficient; the Assembly was the Organization’s supreme body, and it would be more appropriate for two or three high-level representatives of the health sector to be presented to it as candidates.
In his view, it was not worth discussing the question of quasi-permanent seats on the Board for certain Member States. Many countries were opposed to such a measure. Furthermore, if the amount of bureaucracy involved in the day-to-day running of the Organization was to be reduced, it was necessary to rationalize the work of WHO in order to meet the needs of the different countries and regions. In relation to the capacities required of Executive Board members, the current procedure should be maintained.

In addition to the above suggestions, a draft resolution should be prepared giving more detailed consideration to the work of the special group established by the Executive Board. All Members of WHO should be allowed to participate in such work. The outcome of the special group’s work should be submitted for consideration at the Fifty-first World Health Assembly. In the meantime the Director-General could ask Member States for their written comments on the WHO Constitution.

Dr ABDULHADI (Libyan Arab Jamahiriya) said that it was important to review the Constitution so as to adapt it to the changes occurring - a sensitive and difficult task, but such reforms could be useful to Member States in the future. Through the Constitution, the Organization had achieved a great deal. Despite the difficulties in applying certain articles, it had made it possible to respond to health needs and problems throughout the world.

The special group set up by the Executive Board should take into account certain factors such as regional distribution, which was a very effective method of work. Before any decisions were taken, the views of Member States should be sought.

Also, decentralization was an extremely important concept. In terms of the current financial crisis, it was clear that many problems could have been avoided and effort and time could have been saved with the help of such a policy.

Traditionally, certain countries had held quasi-permanent seats on the Executive Board, whereas others had been obliged to wait for several years before being elected. As a result, certain countries had greatly influenced the work of the Board. Was such a policy fair or equitable? Board members should provide a cross-section of all Member States. All were equal and no country should have the right of veto. All countries should express themselves freely on subjects of importance, and the Director-General should also do his utmost to ensure fairness for all.

Dr AL-RAHMAN (Sudan) expressed his support for the views put forward by previous speakers. WHO was a specialized scientific organization within the United Nations family and should therefore adopt a scientific approach. Reforms should not be purely symbolic or administrative. The decentralization of WHO’s work would make it possible for the existing regions to develop their potential capacities in services to countries. However, reform in the regions might prove very difficult. It would have a direct or indirect impact on such factors as the transfer of funds between different projects or programmes. Furthermore, certain regions needed more money than others. The interests of Member States should be taken into consideration, since any amendment of the WHO Constitution would affect such interests.

The Executive Board should remain in its current form, which provided an appropriate balance. The creation of permanent seats for certain countries should not be sought, or WHO would be transformed from a scientific into a political organization, no longer able to defend the interests of nations.

Professor REINER (Croatia) said that it was clear that changes in the WHO Constitution and global organization were necessary. The United Nations Secretary-General had supported the call for structural reform throughout the United Nations system, which was currently in a state of crisis. The most important ideas concerned scope, mission, improved management and performance, and consolidated Secretariat structures. It had been emphasized that moves towards reform in the United Nations would affect the specialized agencies, including WHO. The need for change within WHO was thus not merely a theoretical concept.

Most people agreed that it was necessary to amend the WHO Constitution and to redefine its mission. The Executive Board had begun that task, aware that each country and region had an important role to play. The process should be very rapid; otherwise, undesirable consequences might result.

The reasons for reviewing the Constitution were clear; it had originally been drawn up 50 years earlier. In the interim, the world had seen great political and economic changes. The nature of health systems and
diseases had also changed. Greater flexibility and efficiency within WHO were essential to help sick people throughout the world.

Greater decentralization should be advocated to make the Organization more efficient. Reform should start with a realistic analysis of the results previously obtained, taking into account WHO’s successes and failures. The response to global change must be efficient and not just high-flown verbiage. Substantial changes to the Constitution should be discussed very thoroughly and accelerated so as to achieve the Organization’s principal objectives.

Dr GAKO (Philippines) said that, as his Government had officially indicated to WHO in January 1996, it favoured amendment of the Constitution, particularly Articles 24 and 25, to increase the membership of the Executive Board from 32 to 34.

Dr ABELA-HYZLER (Malta) said that in his view there appeared to be some confusion of the Constitution and the Rules of Procedure of WHO. Many of the problems touched on related to the latter. The special group set up by the Executive Board must consider carefully whether it was necessary to change both before detailed proposals were prepared. Was there indeed a need to change the Constitution?

Mr FOWZIE (Sri Lanka) was not opposed to review, but whatever changes were proposed must be thoroughly discussed.

Dr SULAIMAN (Oman) said that on the threshold of the twenty-first century there was a need to embark on a study of the Organization’s Constitution with a view to retaining what was good and eliminating what was bad. He agreed on the need for decentralization on the principle that only one’s nearest and dearest really cared. Consideration must also be given to the paucity of national and international resources.

Mr NGEDUP (Bhutan) agreed that review was necessary, since the world was evolving and nothing was static. He endorsed the comments of the delegate of Malta; a distinction must be drawn between the Constitution and the Rules of Procedure and a careful study made before action was taken.

Mr CHAUHAN (India) said that a great deal had happened since the establishment of the Organization, and the time had come to review its strengths and the weaknesses. He agreed with the delegate of Malta that it was necessary to consider procedural aspects, but it would not be proper to substitute this for the constitutional review. If the conclusion was reached that the Constitution was sound, then obviously it should not be touched, but a total and comprehensive review of the workings of the Organization and its regional offices was indicated.

Dr TAPA (Tonga) said that the Executive Board and its special group had not yet completed work on that crucially important agenda item. The Health Assembly should therefore take note of the progress made
Dr AL-JABER (Qatar) endorsed the remarks of the delegate of Oman to the effect that full consideration must be given to the principle of decentralization. Any amendment must seek improvement and must reflect world change. Account must also be taken of the cost: changes to the Constitution should be as economical as possible. Ease of implementation of any new procedure should also be sought.

Professor PICO (Argentina) said Member States must take due account of the work of the special group. His delegation believed it was necessary to carry out a thorough analysis of programme changes before setting priorities and introducing structural changes. A thorough study could then be undertaken of the necessity of changing the Constitution. If it was agreed that change was required, any proposed amendments must be thoroughly studied. It was not an everyday task; and no change should be undertaken unless proposed by the special group.

Mr RAI (Indonesia) fully endorsed the Executive Board’s decision to set up a special group of six members of the Executive Board to examine the Constitution, giving priority to consideration of WHO’s mission and functions. The fullest possible use should be made of the expertise of all six regions, either through the regional committees or in the special group.

Mr HOU Zhenyi (China) stressed the importance of the review. Profound changes had taken place in socioeconomic conditions and in such areas as environmental protection, HIV/AIDS and health services, since the original Constitution had come into force in 1948. It was vital to adapt to the changing world situation. However, the review was only at a preliminary stage. The first step after establishment of the special group was to study the text and put forward proposals for revision; fair consideration must be given to the interests of all countries and peoples, particularly developing countries.

Dr LÓPEZ BENÍTEZ (Honduras), conceding the appropriateness of some minor editorial changes and regulatory amendments, felt that the Constitution did not need to be overhauled. Its original post-war spirit must be preserved with a view to ensuring continued international cooperation in health matters and effective response to crises. Certain organizational and financial reforms should continue to be implemented at all levels, but constitutional changes should be viewed with caution.

Dr KHALIFE (Lebanon) was not opposed to review if it was in keeping with a changing world and designed to promote rapid response and health for all. It was vital, however, that consensus be reached as to the principles and purpose of change. Excessive decentralization and any consequent alienation or paralysis of the Organization must be avoided.

Dr DLAMINI ZUMA (South Africa) supported constitutional review. WHO must keep pace with a dynamically changing world in its efforts to meet the current needs of Member States. All countries must be consulted to ensure full participation in the reform process. She emphasized that change must not be imposed from without.

Mr KALIMA (Malawi) stressed the need for constitutional review. Due care should be taken to ensure that existing measures that made the Organization operational were not disrupted. Decentralization should be promoted with a view to improving capacities at country level. WHO operations must not be excessively politicized. There was thus no need for any Member to be eligible to designate a person to serve on the Executive Board on a quasi-permanent basis.

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation) assured Member States that their recommendations and comments would be transmitted to the special group of the Executive Board for the review of the Constitution. There would be close cooperation between Member States, the Executive Board and Health Assembly to ensure that no conclusion was reached without the full involvement of countries. As Professor Li Shichuo had said, and as subsequent speakers had confirmed,
WHO's mission would first need to be reviewed and its implications for the Constitution discussed; only then should the necessary changes be determined.

Mr TOPPING (Legal Counsel) further explained that the results of the work of the special group would be transmitted to the Executive Board for consideration and in due course to the Health Assembly. Any changes to the Constitution would in any event require the approval of the Health Assembly by a two-thirds majority.

Reassignment of Member States to regions: Item 21.4 of the Agenda (Resolution EB97.R3; Document A49/14)

Professor LI Shichuo (representative of the Executive Board) explained that no fixed rules currently governed the reassignment of Member States, as the Director-General had pointed out to the Board. Previously, reassignments had been decided by the Health Assembly following the wishes of the Member State concerned. With a view to maintaining an appropriate balance between regions, reassignment had been discussed at the Forty-eighth World Health Assembly and the ninety-sixth session of the Executive Board, and by regional committees in the autumn of 1995.

The Health Assembly was invited to consider adopting the resolution recommended by the Executive Board in resolution EB97.R3 with respect to consulting the regional committees concerned prior to reassigning Member States.

Dr SOMBIE (Burkina Faso) maintained the necessity of establishing geographical, social, cultural and other justifications for reassignments. Supported by Professor BADRAN (Egypt), Mrs DHAR (India), Dr AL-JABER (Qatar), Mr NGEDUP (Bhutan) and Mr RAI (Indonesia), he expressed support for the resolution recommended in resolution EB97.R3 and stressed that there must be full endorsement by regional committees and all countries concerned prior to reassignment of any Member State.

While he respected the sovereignty of individual Member States, Mr NGEDUP (Bhutan) stressed the importance of establishing proper procedures.

The draft resolution recommended by the Executive Board in resolution EB97.R3 was approved.¹

Report of the ad hoc group: Item 21.5 of the Agenda (Resolution EB97.R10; Document A49/15)

Professor LI Shichuo (representative of the Executive Board) drew attention to resolution EB97.R10 on nomination and terms of office of the Director-General, adopted by the Executive Board at its ninety-seventh session. The Board had agreed that the principle specified in paragraph 3 should apply only to future appointments.

The CHAIRMAN drew attention to the following draft resolution proposed by the delegations of Japan and the United Kingdom of Great Britain and Northern Ireland:

The Forty-ninth World Health Assembly,
Having considered the report by the Director-General on WHO reform and response to global change: report of the ad hoc group;² and the recommendation contained in paragraph 3 of resolution EB97.R10, adopted by the Executive Board at its ninety-seventh session, concerning a change in the Rules of Procedure of the World Health Assembly;
Noting that, as a general principle, it is not appropriate to apply such a change to an incumbent Director-General;

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA49.6.
² Document A49/15.
Accepting therefore the proviso recorded in paragraph 5 of document A49/15;
Noting further that its acceptance of this proviso does not mean that the Health Assembly is taking the position that the incumbent Director-General should in fact serve for a further term; and that the question who should serve as Director-General from July 1998 remains to be decided in accordance with the relevant rules and procedures;

AMENDS Rule 108 of the Rules of Procedure of the World Health Assembly as follows:

Rule 108

In pursuance of Article 31 of the Constitution, the Director-General shall be appointed by the Health Assembly on the nomination of the Board and on such terms as the Health Assembly may determine, subject to the provisions of Rules 109 to 112 inclusive. The term of office of the Director-General shall be five years, and he or she shall be eligible for reappointment once only.

Mr ASAMOAH (Secretary) read out the following list of co-sponsors: Argentina, Australia, Bahrain, Bangladesh, Bhutan, Brazil, Brunei Darussalam, Bulgaria, Cambodia, Cameroon, Canada, China, Cook Islands, Czech Republic, Djibouti, Egypt, Fiji, France, Ghana, Honduras, Hungary, India, Indonesia, Iran (Islamic Republic of), Ireland, Italy, Jamaica, Jordan, Kenya, Kiribati, Kuwait, Lao People's Democratic Republic, Malaysia, Mexico, Micronesia (Federated States of), Mongolia, Morocco, Myanmar, Nepal, Netherlands, New Zealand, Oman, Pakistan, Palau, Peru, Philippines, Poland, Republic of Korea, Russian Federation, Samoa, Slovakia, Sri Lanka, Sudan, Thailand, Tonga, Tunisia, Turkey, Tuvalu, Uganda, United Republic of Tanzania, United States of America, Uruguay, Vanuatu, Viet Nam.

Dr DLAMINI ZUMA (South Africa) supported the principle of the resolution but felt that the principle of two terms of office ought to apply to everyone. That was of course no reflection on the incumbent Director-General. For the sake of consensus, South Africa did not oppose the draft resolution.

The draft resolution was approved.¹

2. BUDGETARY REFORM: Item 22 of the Agenda (Resolutions WHA48.25, WHA48.26 and EB97.R4; Document A49/16 and Add.1)

Professor SHAIKH (representative of the Executive Board), introducing resolution EB97.R4, reported that in January 1996, the agendas of the Programme Development Committee (PDC) and the Administration, Budget and Finance Committee (ABFC) had been largely devoted to budgetary reform. In the week before the Health Assembly, the Board had convened a special meeting involving some ABFC and PDC members, the Director-General and his senior staff, to review 1998-1999 budget priorities, it being vital to spend available resources on priorities established by the membership as a whole.²

The Board had also called for a report on the managerial process to be submitted at its ninety-ninth session in January 1997. The Board had endorsed the Director-General’s proposal to transfer 1% of resources in 1998-1999 from global and interregional programmes to HIV/AIDS activities, and to transfer a further 1% to countries in greatest need for diseases that could be eliminated or eradicated. It continued to monitor 1998-1999 budget planning, and would welcome further guidance from the Health Assembly.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA49.7.
² See document A49/16 Add.1.
Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation) reported that the meeting on budget priorities had pointed out that in a period of austerity the number of priorities had to be reduced. It had recommended retaining the priorities defined for 1996-1997 and continuing to monitor the development of priorities. It had requested that a special document on priority-setting should be prepared by the Director-General for the PDC meeting in January 1997.

Mr BOYER (United States of America) held that budgetary reform was the most important aspect of reform. Member States were taking a greater interest in bringing the budget under control.

A number of areas needed greater attention. First, WHO had to "focus" its work, expending greater efforts on fewer activities. The United States of America agreed with the proposal to retain the priorities set for 1996-1997. Indeed it wished to see even more money devoted to those areas in 1998-1999. Secondly, WHO could extend its action by getting other organizations to share the load, through "partnerships". Thirdly, the 1998-1999 budget ought to be shown in comparison not only with past budgets but with expenditure as close as possible to the time when the budget was adopted. Fourthly, transparency was essential. The presentation of the 1996-1997 budget was unsatisfactory because it did not provide enough information on proposed expenditure for programme activities. It was difficult to ascertain how much was spent on each programme, and whether spending had risen or fallen. The United States had been asking for such information for some time, and wished to know why it could not have it for 1996-1997, and whether it could be expected for 1998-1999. Finally, internal borrowing, as said the previous day, must be limited.

His Government was seeking to achieve a balanced national budget. There would probably continue to be deep cuts in the amounts available for international organizations, despite the fact that the appropriation for 1995 would enable the United States to pay almost all its assessed contribution.

In setting the budget level for the 1998-1999 biennium, the financial difficulties of Member States had to be taken into consideration. Recognizing those difficulties, FAO and the United Nations itself had reduced their budgets for 1996-1997. In contrast, WHO's budget had risen by 2.5%. Budgets and expenditure had to be tied to income. Member States too had to exercise self-restraint. Instead of asking for yet more money, countries had to recognize that there was a need to restructure WHO and to focus its work. He appealed to countries to have sympathy with WHO in its struggle to come to grips with financial difficulties.

Dr LEPPO (Finland), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), said that the move towards strategic budgeting was welcome and should be continued. It was difficult to give guidance for the preparation of the 1998-1999 programme budget in view of current financial uncertainties, relating mainly to the ability and willingness of Member States to pay their assessed contributions. The Nordic countries had always stressed the need to ensure core funding for essential functions of the Organization from the programme budget. In the light of the experience of recent years, he counselled prudence in budget preparations: one should fight for the best but be prepared for the worst.

The debate in the Executive Board on priority-setting, while important, had shown the danger of adding so many new areas that practically everything became a priority. The priorities and guiding principles set out in document A49/16 Add.1 were identical with those set in January 1995. While endorsing them, he questioned their practical value in budget preparation. In the light of the domestic experience of the Nordic countries, a more viable approach for WHO in its efforts to optimize resource use might be to determine which activities might be abolished or modified considerably without jeopardizing the key functions of the Organization - leading to potential savings. In particular, savings could be made by avoiding duplication of efforts deriving from fragmentation and compartmentalization, leading to a leaner, less top-heavy management structure. In that respect, he welcomed the work carried out at the request of the Director-General by the group of programme directors and managers.

Noting that the priority-setting exercise within the Executive Board required consideration of both programme development and financial and budgetary aspects, he wondered whether the time had not come for the Board to review its system of subcommittees with a view to the possible amalgamation of bodies whose functions overlapped.

Dr PAVLOV (Russian Federation) welcomed the emphasis placed in the report on the further refinement of WHO's management. The process should make the Organization more effective and dynamic.
While fully supporting the five priority areas and the approaches outlined in document A49/16 Add.1, he expressed disappointment that noncommunicable diseases had not been included as a priority. They were currently one of the most important problems for the majority of the world’s countries, as the statements of many delegations in the debate on The world health report 1996 had shown. He urged the Executive Board to take that into account when examining and adopting priorities for 1998-1999. He was in favour of the recommendation to transfer 2% of resources in 1998-1999 to priority health programmes at country level.

Dr REUSS (Germany) wondered whether in the light of, for example, the recent large increase in WHO membership within the European Region, the quotas for regional allocations were still valid. He proposed that the matter should be brought before the Executive Board in 1997.

Ms FEARNLEY (New Zealand) said that the Organization needed a reliable and predictable income in order to function effectively. It was incumbent on all Member States to pay their contributions regularly and on time.

The 1998-1999 programme budget should provide an executive summary and a more transparent breakdown to show clearly what would be "produced" at what cost. Documentation which was readily understandable to both health and financial experts in countries was useful in obtaining funding from national treasuries at the appropriate time. It would also be helpful if the documentation could include comparisons with actual expenditure in past years. She requested a brief outline of the intended documentary presentation of the 1998-1999 budget.

She supported the Executive Board’s recommendation to maintain the 1996-1997 priorities in preparation for the 1998-1999 budget. Her country had welcomed the decision in the past to reallocate 5% of the budget to priority activities and hoped that the same policy might be adopted again, perhaps with an even larger allocation. She noted the outcome of the debate on internal borrowing and expressed support for application of the principles discussed in the 1998-1999 biennium.

She expressed the hope that the 1998-1999 budget would be prepared on the basis of realistic rates of expected income. A transparent mechanism for the reallocation of funds in the event of a budget shortfall, which could be seen to be effectively reshaping the budget throughout the biennium in accordance with actual income, would also be a significant improvement. Pointing to the relevance of prioritization in that context, she supported the suggestion by the delegate of Finland concerning the identification of activities that could be modified or abolished without jeopardizing the key functions of the Organization.

She welcomed the support given by WHO senior management to recent in-house “brainstorming” in order to find ways of overcoming the Organization’s budget difficulties. The ideas that had emerged reflected a creative approach to problem-solving which augured well for the future of the Organization.

Ms INGRAM (Australia) endorsed many of the points made by previous speakers and agreed on the need for budget transparency and, most important, for a comparison between actual expenditure in the preceding biennium and planned commitments for the following one.

She fully agreed that redirecting resources towards priorities remained central to all the concepts of budgetary reform, as stated in paragraph 2 of document A49/16. Priorities, a prominent subject of debate during the Health Assembly, could not be discussed in a vacuum but should derive from a precise understanding of the Organization’s role and goals, an area requiring serious work. The whole process of budget development and priority-setting required a "top-down" approach. Many governments had been using programme-budgeting methodology for many years as a very effective tool for management and accountability. It was interesting to note in paragraph 12 that the Executive Board had been reluctant to talk about priorities until it had a clearer picture of the Organization’s financial position. Priority-setting must be more than just a listing of areas of activity; rigorous analysis was needed of all programmes against specific goals. She agreed with the delegate of Finland on the need to review activities that could be modified or abolished.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland) endorsed the statements made by the representatives of Finland and New Zealand. Budget reform was heading in the right direction, though it would require refinement as preparations for the next biennium proceeded. Any tendency towards bureaucratization of the new budgetary procedures should be resisted. He shared the views of the delegates
of New Zealand and the United States of America on transparency: it was important to know how resources were actually being spent, and that objective was not incompatible with strategic budgeting. WHO must develop the flexibility to respond to changing circumstances and to shift emphasis within and between agreed priorities. He endorsed the retention of the priorities identified for the 1996-1997 biennium: though that looked retrogressive it would be useful.

Ms LOBBEZOO (Netherlands) said budgetary reform was of major importance for the reform process, and progress had been made. The Netherlands welcomed the presentation of action plans to the Executive Board but agreed with the Board that the guidance for their preparation should be amended to indicate clearly priorities, strategic goals, results and the resources available for programmes. Programmes must be evaluated, as that would help with the preparation of future action plans and budgets and would indicate how effective the work had been. The determination of trends over successive years would also be helpful for planning. Her delegation endorsed the priorities for the 1998-1999 budget as set out in document A49/16 Add.1, but echoed the remarks of the delegate of Finland on the need to determine activities that could be modified or abolished. She hoped that both the Executive Board and the Health Assembly would be actively involved in the budgetary reform process.

Dr LIEBESWAR (Austria) welcomed the report on budgetary reform. Any credible reform must be oriented to the future and must, in the final analysis, strengthen the Organization. Necessary investments should by no means be neglected, a good example being staff training to ensure that WHO could preserve its reputation as a "knowledge-based" organization.

Mr KHAN (Pakistan) said that it was clear that the Organization was likely to face financial constraints for some time to come. The only way to cope appeared to be to cut administrative costs to the maximum and to transfer all possible resources to health care and health delivery through reform on the basis of the priorities mentioned in document A49/16.

The CHAIRMAN, summing up the discussion on budgetary reform, said it showed that it was a most important aspect of reform and that improvements were needed in a number of areas. Priorities must be set by focusing efforts - doing fewer rather than too many things - but the Organization's role must be kept uppermost in mind. Partnership with other organizations must be increased as a way to achieve WHO's goals. The budget's structure should facilitate comparison of current expenditure with that made in years past. Transparency must be pursued in the budget's presentation by incorporating specific details of expenditure and the Organization's activities, together with an executive summary. The size of the budget should be reduced because some Member States had difficulties in paying their contributions.

Strong support had been expressed for strategic budgeting, and the objective of a leaner, more efficient WHO had been emphasized. With regard to regional allocations, the question of whether they were based on a sound formula had been raised, and that required further discussion. A transparent mechanism for fund reallocation in the event of budget shortfalls had been suggested, as had an amendment to the guidelines for budget preparation to allow the Organization to address pressing priorities. The priorities for 1998-1999 had been endorsed by some but were seen by others as needing further improvement, and that should be the subject of additional discussions. Training of staff to give them access to the latest developments in their fields had been advocated. It had been suggested that administrative costs should be cut or frozen and the savings transferred to priority programmes.

Dr CHOLLAT-TRAQUET (Division of Development of Policy, Programme and Evaluation), replying to questions on the progress of budgetary reform, said the recent discussion of priorities had clearly shown the need for their continued consideration after the preparation of the 1998-1999 budget proposals, and for flexibility to allow modification as budgets were being implemented. That tied in with the notion of "partnership", on which good progress had been made but which required gradual measures to ensure a smooth transition.

The allocation of funds for priorities had been far easier in 1995, as areas to receive less emphasis had been determined by the Executive Board. For 1996 that task would be undertaken by the Global Policy
Council and management committees at all levels of the Organization, and an effort would be made to reflect their findings clearly in the proposed programme budget for 1998-1999.

The 1998-1999 programme budget document would be similar to that for 1996-1997, though three major improvements would be sought: first, the "products" at the national, regional and organization-wide level would be more clearly indicated; secondly, a number of numerical targets would be introduced for each of the Organization's programmes - in response to requests from numerous delegations, details not available in the 1996-1997 budget would be introduced; finally, an assessment of programme implementation against the budget approved would be provided in the appropriate financial report.

Mr AITKEN (Assistant Director-General) added that the 1998-1999 programme budget would include figures to show the best available estimates of expenditure for 1996-1997, although since that biennium would still be in progress when the 1998-1999 budget was being prepared, the full picture would not be available. The delegate of the United States of America had asked why the budget had not been more detailed. It was difficult to produce a strategic budget, yet simultaneously to furnish extensive details. The preparation of the strategic budget had helped the Health Assembly and the Board enormously in concentrating on priority-setting. For 1996-1997, the strategic budget had been prepared in time for submission to the Health Assembly, and as the time for implementation had drawn closer, details on the budget's breakdown had been worked out. For 1998-1999, an attempt would be made to provide the Board in January 1997, and the Health Assembly in May 1997, with more detailed information.

On the German request for more discussion of regional allocations, he said the documentation for the Board's ninety-ninth session in January 1997 would contain appropriate figures, and the Board would have an occasion at that time for discussion. There was even a constitutional review aspect to that matter.

Finally, he stressed that the Director-General was extremely conscious of the desire of delegations for the close involvement of Member States, the Board and the Health Assembly in the budget reform process, and would report in 1997, on the basis of the 1998-1999 budget document, on the progress made.

The meeting rose at 12:15.
FOURTH MEETING
Wednesday, 22 May 1996, at 14:40
Chairman: Dr O. SHISANA (South Africa)

1. REAL ESTATE FUND: Item 25 of the Agenda (Resolution EB97.R22; Documents A49/17 and Add.1 and A49/34)

The CHAIRMAN said that document A49/17 Add.1 updated the Director-General’s report (document A49/17) as it pertained to the situation of the Regional Office for the Eastern Mediterranean. Details of the discussions of the Administration, Budget and Finance Committee (ABFC) on the matter would be found in its third report (document A49/34).

Professor SHAIKH (representative of the Executive Board) reported that the Executive Board had considered the report of the Director-General concerning the use of the Real Estate Fund for various building projects and noted the status of implementation of those approved for the period up to 31 May 1996, especially progress in replacing the Local Area Network at headquarters. It had also noted that the Egyptian Government had offered land in Cairo for the construction of a new Regional Office for the Eastern Mediterranean. ABFC had reviewed the proposal and made its recommendation to the Health Assembly (document A49/34). For the period 1 June 1996 to 31 May 1997, the Director-General had presented only one project for financing from the Fund, which required no appropriation from casual income. The Executive Board had adopted resolution EB97.R22, recommending that the Forty-ninth World Health Assembly authorize financing of the proposed project from the Real Estate Fund.

Mr AITKEN (Assistant Director-General) said that ABFC’s discussion of the proposal to transfer the Regional Office for the Eastern Mediterranean from Alexandria to Cairo, based on the Egyptian Government’s offer of land for the purpose, had been extensive. In summary, the Committee had recommended: that the Forty-ninth World Health Assembly approve in principle the relocation of the Regional Office; that the Executive Board be provided, at its ninety-ninth session in January 1997, with a thorough financial analysis of the proposal; and that the matter be discussed again before the Fiftieth World Health Assembly in May 1997, in the light of the Board’s recommendations. The matters now to be discussed were the resolution recommended to the Health Assembly by the Board and ABFC’s recommendations with regard to the Regional Office for the Eastern Mediterranean.

Professor BADRAN (Egypt) submitted that the matter of the transfer of the Regional Office for the Eastern Mediterranean from Alexandria to Cairo should be of considerable interest to the Committee and to the Health Assembly. The Regional Office had been confronted with numerous difficulties owing to its location in Alexandria, including the burden of transport to and from Cairo, and the cramped office space which had necessitated rental of outside premises.

The Egyptian Government had made available highly valuable land in a prestigious area of Cairo. Administrative regulations dictated, however, that if it were not used for building within a relatively short time, the concession would be withdrawn. Since ABFC had approved the move to Cairo, he strongly recommended that consideration be given to providing the Regional Office with at least incremental funding from the Real Estate Fund to begin construction work in the near future. He noted that the Eastern Mediterranean Region had enjoyed a very small share of the Fund over the years.

1 Document WHA49/1996/REC/1, Annex 1.
Dr ISMAIEL (Sudan) endorsed the justifications evoked by the delegate of Egypt and strongly supported the suggested relocation of the Regional Office. He hoped that the Executive Board, preferably in the course of the session following the Health Assembly or else in January 1997, would agree to allocate the necessary funds from the Real Estate Fund, while imposing a spending ceiling.

Mr ZIARAN (Islamic Republic of Iran) endorsed the previous speakers’ remarks and urged the Executive Board to consider allocating the necessary resources from the Real Estate Fund at its forthcoming session, in order to help the Regional Office cope with its growing responsibilities as rapidly as possible.

Dr AL-JABER (Qatar) stressed that the Regional Office for the Eastern Mediterranean was overburdened and its offices dispersed far from Cairo, the centre and capital of Egypt, difficult of access from Alexandria. The Egyptian Government’s offer of land free of charge meant that the only expense would be the construction of the new office. He would therefore strongly support a resolution by the Health Assembly, taking note of the recommendations contained in document A49/34.

Dr ABDULHADI (Libyan Arab Jamahiriya) said that his country was all too aware of the problems posed by the current location of the Regional Office in Alexandria, not only in terms of time lost in travelling by land and air between Libya and Alexandria, but also because, despite recent improvements, the present office no longer met requirements. Since the Egyptian Government was making land available free of charge in Cairo, with its excellent transport and telecommunications links, the Committee should consider favourably the proposed relocation.

Dr SULAIMAN (Oman) thanked the Egyptian Government for its offer of land for a new Regional Office; its transfer from Alexandria to Cairo would result in material improvements beneficial to the Organization as a whole. He urged the Executive Board to approve the necessary resources for the new building from the Real Estate Fund.

Ms LOBBEZOO (Netherlands) said that the Committee’s earlier discussion of item 20 of the agenda had demonstrated that, despite some improvements in the financial situation, budgetary constraints were still severe. Her delegation consequently questioned the priority of the proposed relocation and wondered what the financial implications were. WHO should not enter into open-ended financial obligations. The Netherlands would therefore suggest postponing the decision to relocate the Regional Office pending a clearer picture of the financial obligations. It saw no need for approval in principle at the present stage; moreover, adoption of ABFC’s recommendations could imply legal obligations to accept certain financial consequences which WHO might later regret.

Mr ROBERTSON (Australia) shared the view expressed by the delegate of the Netherlands. While he recognized the need for essential capital works in order to maintain an organization’s assets, WHO was experiencing what was perhaps the greatest financial crisis in its history and was hard pressed to fulfil its essential tasks. Accordingly, each project should be critically assessed with a view to deferral, so that the limited available resources might be reserved for high-priority programme activities. Australia consequently recommended that consideration be given to deferring the proposed expenditure.

Mr AITKEN (Assistant Director-General) wished to reassure speakers on two points: first, the Health Assembly’s approval in principle of the relocation of the Regional Office from Alexandria to Cairo would not imply any commitment to expenditure for construction. Secondly, any proposal for financing would have to be approved by the Health Assembly on the basis of a thorough analysis by the Executive Board, as recommended by ABFC. That Committee deemed it useful for the relocation to be approved in principle so that meetings with the Egyptian Government and other potential contributors could proceed on the basis of the Health Assembly’s indication that Cairo was the preferred choice. Thus, approval of the recommendations contained in paragraph 5 of document A49/34 would imply that while the Organization’s financial situation did not currently permit spending on the project, it would subsequently be reviewed by the Executive Board and the Health Assembly.
The CHAIRMAN took it that the Committee wished to endorse ABFC’s recommendations as set out in paragraph 5 of document A49/34.

It was so agreed.

The draft resolution recommended by the Executive Board in resolution EB97.R24 was approved.

2. PERSONNEL MATTERS: EMPLOYMENT AND PARTICIPATION OF WOMEN IN THE WORK OF WHO: Item 26 of the Agenda (Resolution EB97.R22; Document A49/18)

Professor SHAIKH (representative of the Executive Board) said that the Director-General had reported to the Board at its ninety-seventh session on the status of implementation of resolution EB91.R16, which had established a deadline of 30 September 1995 for reaching the 30% target for the proportion of all professional and higher-graded posts in established offices occupied by women, on the progress achieved in increasing the number of women at the D2 and ungraded levels as requested in resolution EB93.R17, and, as requested by the Executive Board at its ninety-sixth session, on past and future measures to implement the recommendations contained in the policy statement adopted by ACC in February 1995 on the status of women in the secretariats of the United Nations system.

The Board had been informed by its representative on the Steering Committee on Employment and Participation of Women in the Work of WHO that there had been a number of concrete achievements during the previous year: three women had been appointed at high levels at headquarters; the Director General had agreed to release a post for a coordinator of the employment and participation of women in WHO; the Staff Rules had been amended in May 1995 to facilitate employment of spouses; and there had been progress in developing a policy on sexual harassment.

The target of 30% recruitment of women to professional and higher-graded posts in established offices had not been attained by 1995. There had been a small increase in the percentage of women in all grades between 1994 and 1995, mainly due to the drop in the overall numbers of the predominantly male staff. Women had represented only 13.8% of the 2095 members of the different expert advisory panels, so that the problem was not limited to employment positions.

The Health Assembly was invited to consider the resolution recommended by the Executive Board in its resolution EB97.R12.

Mr AITKEN (Assistant Director-General) confirmed that the 30% target for 1995 had only been met at headquarters and in the Regional Offices for the Americas and for Europe. While the ideal target was 50%, much remained to be done to attain even the 30% goal, which would thus be one of the Organization’s constant priorities in its recruitment and appointment policy.

Dr BOUFFORD (United States of America), in her capacity as the Board’s representative on the WHO Joint Committee on the Employment and Participation of Women in the Work of WHO, commented on progress made during the past months, one highlight of which had been the appointment by the Director-General of a full-time coordinator on employment and participation of women in WHO. The Joint Committee had been especially impressed by the exemplary progress made in PAHO in recruiting women to serve in the Americas.

The table on page 2 of document A49/18 was somewhat deceptive since the percentage column suggested that progress had been made between 1994 and 1995, whereas the numbers column showed that there had been no dramatic increase and even some losses in areas where there had been over 30% representation.

1 Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA49.8.
She applauded the issuing of an information circular on WHO's policy concerning sexual harassment, although the Joint Committee was still concerned that the 60-day limit for filing a complaint might be too short; perhaps implementation might be monitored with a view to modification.

Recent years had seen a 50% reduction in the representation of nurses and midwives in WHO. Since the vast majority of nurses and midwives were women, there was a strong case for restoring and increasing that representation.

The health sector had the largest workforce in any country and WHO's contribution to focusing on women's health at the International Conference on Population and Development, held in 1994 in Cairo, and the Fourth World Conference on Women held in 1995 in Beijing, had been considerable. Those were additional reasons why the fullest support should be given to the efforts of the Director-General and countries to increase women's representation generally. More specifically, every effort should be made to recommend qualified women when nominations were sought for expert consultants, members of delegations and posts at WHO.

Dr DURHAM (New Zealand) said her country, which accorded high priority to the full participation of women at all levels in WHO, welcomed the positive steps taken to that end, but was disappointed that the 30% target for the recruitment of women to professional and higher-graded posts in established offices had not been met. The deterioration in the situation in the Western Pacific Region was especially regrettable. Given the impact of women's health on global health and of women's contribution, in both the informal and formal health care systems, to improved health status, failure to recognize their contribution at the regional and global levels was difficult to understand. Increased participation by women was essential to improved effectiveness in WHO's work. She therefore proposed that the resolution recommended by the Executive Board in resolution EB97.R12 be strengthened. A new preambular paragraph should be added, reading:

Noting that improving the participation of women in the work of WHO is an essential factor in improving its effectiveness;

In paragraph 3(2), "presence" should be replaced by "participation". Paragraph 4(3) should be amended to read:

...to establish a high-level advisory committee including senior women to assist them in increasing the participation of women at all levels of the Organization in those regions where the 30% target for the recruitment of women to professional and higher graded posts has not been met.

Mrs GRAVEL (Canada) observed that the targets set by the Organization for nearly 17 years in regard to the recruitment of women to professional and higher-graded posts in established offices were still far from being met - a fact coldly acknowledged in document A49/18 which, moreover, referred to "a disproportionate concentration of women at lower grades". The statistics provided might usefully have been supplemented by the observation in UNDP's *Human development report 1995* that the average number of women working at WHO in all categories was well below that of women in all other organizations of the United Nations system. That situation in no way reflected the role of women in society as a whole, nor did it do justice to the democratization process.

The measures proposed in document A49/18 to improve the recruitment of women also concerned Member States. Obstacles to such recruitment were not only of an administrative but also of a cultural and political nature, calling for a reaffirmation of unequivocal political commitment to change and a review of the information that formed the basis of such commitment. The challenge was to accept women's different approach and response to situations, and to incorporate the wealth of wisdom that they had to offer into decision-making processes at all levels, both within the Organization and in countries. While endorsing the draft resolution before the Committee and the amendments by New Zealand, she feared that the current budgetary situation would have a disastrous effect on any progress in the recruitment of women. Stronger political will should be demonstrated at all levels of the Organization and within Member States so that women could occupy their rightful place. It was regrettable that the full equality between men and women advocated by the Secretary-General of the United Nations remained just an ideal. That being said, credit was due to PAHO for the measures it had taken and the results achieved.
Dr DANIEL (Cook Islands) recommended that the 30% target for the recruitment of women to professional and higher graded posts both at headquarters and in the regional offices should be increased to 50% and that there should be equitable regional and country representation in such recruitment. The Regional Office for the Western Pacific was to be commended for having appointed a woman to a senior post.

Mr NGEDUP (Bhutan), drawing attention to the concerted efforts made in his country to ensure the participation of women in government and other sectors in recognition of their important role, advocated stronger emphasis on that role in WHO and expressed support for the resolution recommended by the Board in resolution EB97.R12.

Ms INGRAM (Australia) welcomed the measures proposed in document A49/18 to facilitate the recruitment and mobility of women, the test of which would be speedy and comprehensive implementation. The approaches of a large number of countries with formal equal opportunity policies might provide models for WHO’s personnel policy. In her own country compliance by managers with equal-opportunity policies was a criterion taken into account in the assessment of managerial performance. Member States themselves had a part to play in improving the position of women in senior posts at WHO by identifying and nominating candidates. She supported the resolution recommended by the Board, as strengthened by the amendments proposed by New Zealand.

On the subject of personnel matters in general, she drew attention to resolution EB97.R11, and said that she looked forward, in particular, to the report that the Director-General was to submit to the Board on a wide range of those matters.

The recent personal promotions for 21 WHO staff members in the professional and general service categories were a cause of some concern. In general, the governing bodies should not become involved in matters of micro-management; but there was a case for the Executive Board to consider them given the current difficult financial situation and the sensitive environment within the Organization.

Ms KIZILDELI (Turkey) supported the draft resolution before the Committee, as amended by New Zealand, and drew special attention to paragraph 3(1). Commending the Director-General’s efforts to improve the participation of women in the work of WHO, she stressed the need for particular attention to be given to areas where the 30% target had not yet been attained.

Mrs DHAR (India) said that it was particularly shocking to see that in 1995 women had occupied only 11.9% of professional and higher-graded WHO posts in South-East Asia, a region which had distinguished itself by the number of women heads of state and government. Amendments to the Indian Constitution made it mandatory for 30% of all posts in elected local bodies to be filled by women, which demonstrated the importance attached by her country to women’s active participation in decision-making. She therefore urged a special recruitment drive at the Regional Office for South-East Asia: governments in the Region would surely find it possible to recommend suitable women candidates of high calibre to fill senior positions, so that at least the 30% target could be met.

Dr NICKNAM (Islamic Republic of Iran), expressing concern about the failure to meet the 30% target in established offices, stressed the need for consistency in Health Assembly resolutions on employment. Drawing attention to resolution WHA48.28, especially paragraph 1 calling for the appointment of nationals of unrepresented and under-represented countries and those below the mid-point of the desirable range, he said that priority should be given to applicants from those countries in the recruitment of staff, especially women. Furthermore, to ensure compliance with the principle of the equitable geographical distribution of posts, developing countries should be given technical assistance to train potential female applicants. He endorsed the points made by India.

He therefore proposed that the resolution recommended by the Board in resolution EB97.R12 be amended to include a reference to resolution WHA48.28 and a request to WHO to provide technical assistance to developing countries for the training of female experts.

Dr TAPA (Tonga) said that Tonga had accorded high priority to the question of the employment and participation of women in WHO over the years. It was disappointing that the 30% target referred to
throughout the discussion had not been met, though gratifying that there had been a slight improvement between 1994 and 1995. As to progress in increasing the number of women at D2 and ungraded levels, the summary of results in paragraph 10 of document A49/18 was both satisfying and disappointing. It was encouraging to note the ACC policy statement on the status of women in the secretariats of organizations of the United Nations system and the actions proposed by WHO’s Joint Committee on the Employment and Participation of Women in the Work of WHO in reviewing that policy statement. He supported the resolution recommended in resolution EB97.R12, with the amendments proposed by New Zealand.

Professor GUMBÌ (South Africa) regretted the failure to meet the targets set for the recruitment of women and the decline in the employment of women in the regions. Greater efforts were needed in the selection and recruitment of women and in capacity-building so as to maximize the potential for the employment of women and ensure that they were adequately represented at decision- and policy-making levels. The progress made at the country, regional and headquarters levels should be reviewed at the next Health Assembly. She expressed support for the resolution recommended in resolution EB97.R12, with the New Zealand amendments.

Dr SILVAMONTEIRO (Cape Verde) stressed the importance attached to the role of women in her country, where they represented 52% of the population and 68% of heads of household. She expressed support for the draft resolution before the Committee and proposed that the 30% target for the recruitment of women to professional and higher-graded posts in established offices be increased to 50%.

Mr VAN REENEN (Netherlands), favouring a higher rate of participation and recruitment of women to professional and higher-graded posts in established offices, expressed support for the recommended resolution as amended by New Zealand.

Mr OBORE (Uganda) said that every effort must be made to ensure that targets were rapidly attained. In his own country, an aggressive policy, based on constitutional provisions and mandatory requirements, had been pursued to ensure the representation of women at all levels of political life and public service, including the Office of the President. His delegation supported the recommended resolution with the amendments by New Zealand.

Dr ABELA-HYZLER (Malta) shared the general concern expressed with regard to the employment of women in WHO and sought the reasons behind the failure to meet the 30% target. In Malta, a social affairs department had been constituted to deal exclusively with the promotion of women; a directory was circulated to all government departments to encourage and assist them in selecting appropriate women representatives for various boards. Several years ago, he had submitted to WHO a list of qualified women to be taken into account when setting up expert groups: increased participation by women in such bodies was as important as any other related issue.

Dr TUMBA (Zaire) expressed full support for the recommended resolution, together with the amendments proposed by New Zealand. Member governments should be encouraged, when putting forward candidates, to include at least one qualified woman for each post, so as to increase the possibility of equitable female representation within WHO.

Mr AITKEN (Assistant Director-General) recalled the three parameters that governed recruitment to the Organization: ability; geographical distribution; and - historically last but by no means least - improvement in the representation of women. Balancing those parameters was no easy task, but he assured the Committee that the second and third were accorded as nearly as possible the same status. There was certainly a lack of female applicants from some countries in some areas - and that sometimes delayed recruitment while a search was made to find a woman candidate for short-listing, as the new rules required. Further, the number of vacancies had fallen over the last four or five years because of financial constraints and reform measures, and that had limited the capacity to advance women's representation.

That interpretation of the situation was, he insisted, personal; and he acknowledged that it did not constitute a satisfactory answer to the question of the 30% target. But he assured the Committee that efforts
were indeed being made to overcome the difficulties he had alluded to, in cooperation with the Joint Committee to which the United States delegate had referred.

In conclusion, he urged Member States, when designating persons to serve as members, advisers and alternates on the Executive Board and delegates or representatives on other high-level bodies, to think first of women candidates. That could be an important signal to the Organization.

Dr ALLEYNE (Regional Director for the Americas) thanked members of the Committee for their compliments on recent successes in the Region of the Americas. Improving the recruitment of women constituted just one aspect of how diversity in any organization could be enhanced. Moreover, there was a correlation between national situations and the state of affairs in international organizations. Another important point was that the presence of women on the staff and their impact on the Organization’s work would be significantly enhanced by greater emphasis on programmes related to women, health and development and the incorporation of such matters in the technical cooperation activities of the Organization as a whole.

A final, perhaps minor but not insignificant point was that the basic documents of the Organization, and resolutions adopted by the governing bodies were not entirely free of sexual discrimination. Steps to remedy that shortcoming could have great significance.

Mr ASAMOAH (Secretary) reminded the Committee of the New Zealand amendments to the resolution recommended in resolution EB97.R12 and suggested that the proposals made by the delegate of the Islamic Republic of Iran might be accommodated by an additional preambular paragraph, after "Recalling resolutions WHA38.12, EB91.R16 and EB93.R17", reading:

Noting resolution WHA48.28;

and by adding the phrase: "and that WHO provides technical assistance for training women in developing countries;" to the end of paragraph 3(3).

The resolution recommended by the Executive Board in resolution EB97.R12, as amended, was approved.¹

3. UNITED NATIONS JOINT STAFF PENSION FUND: APPOINTMENT OF REPRESENTATIVES TO THE WHO STAFF PENSION COMMITTEE: Item 27 of the Agenda (Document A49/19)

The CHAIRMAN said that, as explained in document A49/19, the Health Assembly was called upon to appoint two representatives to the WHO Staff Pension Committee to replace a member and an alternate member whose terms of office expired at the close of the Forty-ninth World Health Assembly. She invited nominations by name of delegates from regions no longer represented on the Committee - the African Region and the Western Pacific Region - for the offices of member and alternate member.

Dr SOMBIE (Burkina Faso) proposed Professor Agboton (Benin) as a member of the WHO Staff Pension Committee for the African Region.

Mr OBORE (Uganda) seconded the proposal.

Dr ABDUL LATIF IBRAHIM (Brunei Darussalam) proposed Dr Tapa (Tonga) as an alternate member of the WHO Staff Pension Committee representing the Western Pacific Region.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA49.9.
Dr DANIEL (Cook Islands) and Mr ROBERTSON (Australia) seconded the proposal.

The CHAIRMAN said that in the absence of objections, she would take it that the Committee wished to convey the following draft decision to the plenary.

Decision: The Forty-ninth World Health Assembly appointed Professor H. Agboton, delegate of Benin, as a member of the WHO Staff Pension Committee, and Dr S. Tapa, delegate of Tonga, as alternate member of the Committee, the appointments being for a period of three years.¹

4. AMENDMENTS TO ARTICLES 24 AND 25 OF THE CONSTITUTION: Item 28 of the Agenda (Resolution EB96.R1; Document A49/20)

Professor LI Shichuo (representative of the Executive Board) said that in 1994 the Regional Committee for Europe had recommended to the Executive Board that there should be an increase in Board membership so as to enable an additional member to come from that Region. At its ninety-sixth session in May 1995, the Executive Board had consequently requested that the Director-General prepare for consideration by the Forty-ninth World Health Assembly draft amendments to the Constitution increasing the Board's membership from 32 to 33. Those draft amendments had been prepared by the Director-General and communicated by circular letter to all Member States six months in advance of the Health Assembly.

During the autumn of 1995, a proposal had been received by the Director-General from the Government of the Cook Islands to increase the membership of the Executive Board from 32 to 34. That proposal, although not considered by the Executive Board as such, had been made pursuant to a resolution adopted by the Regional Committee for the Western Pacific recommending that consideration be given to increasing the number of Members of the Western Pacific Region entitled to designate a member of the Board from the current four to five.

As a result, the Health Assembly had before it two proposals to amend the Constitution so as to increase the membership of the Executive Board from 32 to either 33 or 34. The relevant texts were contained in document A49/20.

Mr TOPPING (Legal Counsel) said that the texts of Articles 24 and 25 of the Constitution had been reproduced on page 2 of the document showing, in square brackets, the textual amendments that would result from incorporating one or other of the two proposals before the Committee. A draft resolution had also been included in the document, offering a means of incorporating into the Constitution whatever decision the Health Assembly might take.

Dr WILLIAMS (Cook Islands) said that the Western Pacific Region, with its 1600 million inhabitants, comprised almost 30% of the world population and deserved nine seats on the Board rather than the present four on the strength of population size alone, yet it had taken 11 years to get the number of its seats increased from three to four. During that time, membership in the Region had risen by almost 60%, from 17 to 27 countries. The Eastern Mediterranean Region, by comparison, with its 22 Member States held five seats on the Board. His delegation nevertheless welcomed resolution EB96.R1 and supported the proposed increases for the European Region from seven to eight seats, and the Western Pacific from four to five, so that the Board would increase from 32 to 34, with the consequent amendments to Articles 24 and 25 of the Constitution.

Mr BOYER (United States of America) said that the Executive Board, as provided under the Constitution, was intended to be a relatively small body of people who could act quickly and efficiently to carry out the business of the Organization, particularly between sessions of the Health Assembly, which currently consisted of 190 Member States. Already the present 32 Board members had to be subdivided into

¹ Decision WHA49(9).
small committees in order to work effectively in certain areas. In addition, the bigger the Board, the more expensive it became from the point of view of travel and per diem. A sum of US$ 500,000 had just been appropriated to expand the conference room table at the Regional Office for the Western Pacific and a bigger Executive Board would mean further expenditure on the Board room at WHO which only just accommodated the present membership.

The growth in the overall membership of WHO and within specific regions was not relevant to the size of the Executive Board. The solution to the imbalances therefore would be to make readjustments within the Board to ensure legitimate proportional representation of each of the regions.

Mr. SAKAI (Japan) expressed support for the proposal by the Cook Islands. It was unfair for such a large region as the Western Pacific to be the least represented on the Board. Member States of the Region did not want an unlimited increase in the size of the Executive Board and felt that WHO should consider the possibility of reallocating seats in the future.

Dr. ABDULHADI (Libyan Arab Jamahiriya) recalled that the Committee had, at its previous meeting, discussed reform in WHO to reflect global changes. It had also discussed amendments to the Constitution, as had the Executive Board. Decisions on the organs of WHO should be taken in a harmonious and coordinated manner. The present proposals for amendment were not urgent and should therefore be deferred for the time being and considered at a later stage in conjunction with amendments to the Constitution in general. In the meantime, the Libyan delegation wished to record its reservations in respect of the two proposals before the Committee.

Dr. TAPA (Tonga) urged the Committee to take its decision on the two proposals before it, one from a rich region and the other from a region consisting largely of small island nations, on the basis of fairness, justice and equity, and to consider whether an increase of only one member, from 32 to 33, would not discriminate against one region. His delegation had no doubt whatsoever that the Cook Islands’ proposal represented the fairest decision the Committee could take. He therefore called on the Committee to be fair by allowing small islands to participate fully in the work of WHO and to have an opportunity for their voice to be heard in its governing body.

Dr. AL-RAHMAN (Sudan) said that although the reasons given for increasing the number of seats on the Executive Board to accommodate the two regions were acceptable, the arguments put forward by the United States were very convincing. An increase in the Board at the present time could lead to further requests for increases by other regions in the future. He therefore suggested that the matter be referred to the Board for further consideration so that a decision might be taken at a later stage in the light of its findings.

Mr. TEKEE (Kiribati) joined other speakers from the Western Pacific Region in requesting the Committee to approve amendments to Articles 24 and 25 of the Constitution to increase the membership of the Executive Board from 32 to 34 and enable the Region to be more fairly represented.

Dr. LAW (Canada), while she sympathized with the points made by the speakers from the Western Pacific Region regarding the imbalances in representation on the Board, supported the suggestion that the proposals be considered in the context of the general review of the Constitution examining whether the best solution lay in increasing the size of the Board, redistributing the seats or developing criteria for the distribution of seats.

Mr. CLERC (France) said that it was clear from document A49/20 that two regions, Europe and Africa, were underrepresented in terms of the number of Member States and current number of seats.

A distinction might usefully be made between the two requests. In recent years, the European Region had been overwhelmed by the emergence of new States and was clearly underrepresented on the Board from the point of view of equitable geographical distribution, which Article 24 of the Constitution was intended to achieve. The proposal of the European Region, moreover, had already been endorsed by the Executive
Board, while that of the Western Pacific Region had not. In the circumstances it would be wise to refer the latter proposal to the Board for consideration.

Dr DURHAM (New Zealand) recognized the necessity for both cost and effectiveness of exercising restraint in altering the size of the Executive Board. Nevertheless, the underrepresentation of the Western Pacific Region was glaringly obvious in terms both of population and of numbers of Member States, and the draft resolution suggested in document A49/20 would rectify that anomaly. New Zealand would be happy for an unofficial moratorium to be implemented once those amendments were adopted. She agreed that thorough consideration should be given to the size and constituency of the Board during the review of the Constitution so as to provide WHO with a streamlined executive arm.

Dr PAVLOV (Russian Federation) pointed out that the recent substantial increase in the number of States - notably in Europe - reflected global changes. WHO should react to such changes, seriously endeavouring to satisfy Members' requests, particularly in view of resolutions from the Regional Committee for Europe and from the previous session of the Executive Board. Increased European representation would enable the Board to operate on a broad geographical basis and permit newly independent States to take a more active part in the work of the governing bodies.

Mr TOPPING (Legal Counsel) summarized the position. Although there had been some expressions of hesitation, there were two proposals on the floor, one by the Director-General pursuant to resolution EB96.R1, and one submitted by the Cook Islands. In accordance with Rule 68 of the Rules of Procedure, the Committee should first consider the proposal by the Cook Islands. As the proposal concerned an amendment to the Constitution, if put to the vote, a two-thirds majority would be required. If the proposal was approved, that would complete consideration of the item. Otherwise, the Committee would move to consider the other proposal.

Dr WILLIAMS (Cook Islands) sought further clarification from the Legal Counsel. Did his mention of a two-thirds majority refer to ratification by Member governments or to the voting?

Mr TOPPING (Legal Counsel) explained that adoption by the Health Assembly would require a two-thirds majority of those present and voting. Entry into force would require acceptance by two-thirds of the Member States of the Organization, notification of such acceptance being submitted to the Secretary-General of the United Nations, as the depositary of the Constitution.

Dr ABELA-HYZLER (Malta) asked the Legal Counsel how long on average it took for an increase in the membership of the Executive Board to be ratified by the Members of the Organization once adopted.

Mr TOPPING (Legal Counsel) said that the most recent amendment to Articles 24 and 25 of the Constitution had been adopted in 1986 and had entered into force in 1994.

Mr BOYER (United States of America) submitted that in addition to the two proposals before the Committee, one from the Cook Islands and the other from the Executive Board, an alternative solution existed which was to defer action until the constitutional review. The Committee could vote on the two proposals, which required a two-thirds majority; or the Chairman might determine whether there was consensus on the alternative.

Mr NGOUBEYOU (Cameroon) said that although the previous speaker had summarized the situation fairly in alluding to just two proposals, from just two regions, Africa should not be considered as absent from the debate. WHO's African Region might comprise 46 Member States, but Africa contained half a dozen additional countries for whom health for all by the year 2000 was just as important. It should therefore be noted that Africa, too, wanted increased representation.

Mr ROBERTSON (Australia) said that as a Member of the Western Pacific Region, his country was very aware of the arguments concerning underrepresentation of that Region. The issue was complex and
all had a stake in ensuring balanced representation on the Executive Board, but there was also a need to limit the number of seats for the sake of effectiveness. He could see the logic of arguments put forward by the United States delegate but was equally sympathetic to the New Zealand concept of a moratorium following a decision on the basis of the proposals before the Board.

In reply to a question by the CHAIRMAN, Mr TOPPING (Legal Counsel) said he interpreted the United States proposal as a motion not to consider the others, which was a procedural motion and should be considered first. It required a simple majority for adoption.

The CHAIRMAN invited the Committee to vote by a show of hands on the motion to defer further consideration of the proposals to increase the membership of the Executive Board, pending the constitutional review.

The motion was approved by 52 votes to 25, with one abstention.

The meeting rose at 17:15.
1. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4)

Tobacco or health (Resolutions WHA48.11, EB97.R7 and EB97.R8; Document A49/INF.DOC./2)

The CHAIRMAN, noting that "Tobacco or health" under item 17 of the agenda had been transferred to Committee B from Committee A by the General Committee, invited Professor Li Shichuo to introduce the relevant documents.

Professor LI Shichuo (representative of the Executive Board) observed that resolution WHA48.11 had requested the Director-General to report on the feasibility of an international instrument for tobacco control and to submit a plan of action for 1996-2000. At its ninety-seventh session, the Executive Board had reviewed the report by the Director-General presenting options for such an instrument, which were described in document A49/4, section VI, and had concluded that the development of a framework convention-protocol approach in accordance with Article 19 of the WHO Constitution was the most desirable strategy. The Board had also considered a plan of action for 1996-2000. The Health Assembly was invited to consider the relevant resolutions recommended by the Board in resolutions EB97.R7 and EB97.R8.

Dr NAPALKOV (Assistant Director-General) briefly introduced the plan of action set out in document A49/INF.DOC./2, which outlined objectives, approaches and activities under three components: national and international control programmes, advocacy and public information, and a research and information centre, the common goal being to combat tobacco use. The extent to which the plan could be carried out would depend on the availability of resources; at present they were insufficient. The Health Assembly might also wish to consider the financial implications of the proposed course of action on the international instrument, which would involve contracting experts, convening expert groups and strengthening technical units of WHO and other organizations of the United Nations system. Since the resources were not available under the regular budget, it would be necessary to mobilize extrabudgetary funds. Some Member States might wish to provide such support for global tobacco control.

Mrs JEAN (Canada) said that tobacco control should be given high priority by WHO. Tobacco consumption was like a worldwide epidemic, reaching catastrophic proportions particularly in the developing countries. If Members of WHO were in earnest about the need for international solidarity for health development, here was a strikingly worthy cause. Every country should establish a national, multisectoral tobacco control strategy. She outlined the steps being taken in her country, with education, research, community involvement and a legal framework including legislation to control advertising and protect the young, which to be effective must act synergistically. She stressed that national anti-tobacco campaigns were losing against the international tobacco trade, smuggling and advertising campaigns. Hence she welcomed the possibility of an international convention and strongly supported the resolution recommended in resolution EB97.R8. Her Government had already promised 1.5 million dollars to WHO and other international
organizations over a three-year period to support the anti-tobacco campaign and the development of a framework convention.

Mr PETTERSSON (Sweden) said that the Health Assembly did not have to be persuaded of the need to combat smoking and bring to an end the global epidemic of a habit representing the greatest cause of preventable disease and premature death. Few efforts could be more urgent or more worthy in the promotion of health throughout the world. After the adoption of many resolutions at previous Health Assemblies, it now seemed feasible to work towards a more binding instrument. An international framework convention for global tobacco control could have a significant impact in reducing tobacco consumption and thereby reducing health inequalities between countries with advanced or less developed tobacco-control policies. His delegation also saw the advantages of a convention taking a broad approach based on Article 19 of the WHO Constitution, as proposed by the Executive Board.

The establishment of a convention-protocol would be a demanding and time-consuming process and would require active measures by Member States as well as the reflection in the overall programme priorities of a high profile for WHO's "tobacco or health" programme. The WHO action plan for 1996-2000 contained important elements, but there should be a clearer focus on the inequalities in health caused by smoking and on socioeconomic aspects, taking into account the differences between men and women. His delegation strongly supported WHO's efforts to provide scientific expertise, comprehensive guidelines and practical advice for the development of national tobacco control policies, and endorsed the plan of action for 1996-2000.

Sweden was willing to share its experience and to take an active part in concerted action to develop a global strategy on a convention-protocol, and therefore supported the resolution recommended in resolution EB97.R8.

Mr ESKOLA (Finland) noted that WHO had been the leading agency in the fight against increasing tobacco consumption and resulting ill-health, and that since 1969 it had adopted some 14 resolutions calling for stronger control of tobacco use. Recent trends in industrialized countries, which had effectively restricted the consumption of tobacco, had resulted in health gains. The reverse had, however, been seen in many developing countries owing to vigorous marketing and a lack of control measures. His delegation strongly supported the new "tobacco or health" action plan and supported the resolution recommended in resolution EB97.R7. The next step for the Health Assembly in its fight against tobacco should be the approval of the resolution recommended in resolution EB97.R8. His delegation supported it; the proposed framework convention would be a suitable instrument for tobacco control and would constitute significant progress. The Finnish Government was prepared to share its experience and to contribute actively to the drafting of a framework convention.

Mr PÉREZ (Spain) said that tobacco consumption was clearly deleterious to health and to the environment, and his Government would therefore continue to support WHO's activities under the "tobacco or health" plan of action. His Government marked World No-Tobacco Day, distributed educational and information material, and took part in world seminars and conferences. The first European conference on tobacco policy in 1988 had been held in Madrid. He stressed the need to discourage smoking in public places, in aircraft and in the workplace, and supported the resolution recommended in resolution EB97.R7. He had some doubts regarding the probability that a framework convention would be approved, but since that would be of undoubted benefit to the anti-tobacco campaign he also supported the resolution recommended in resolution EB97.R8.

Dr KÖKÉNY (Hungary) said that his Government fully supported a strong and clear plan of action for 1996-2000 and even beyond. There was no need to restate the economic and human costs of smoking or to repeat the epidemiological evidence. It was abundantly clear that since the tobacco industry was an international business, control programmes must be coordinated at the international level. Other organizations of the United Nations system, such as FAO, should also be involved. In spite of some doubts as to its feasibility, his delegation strongly advocated an international convention on tobacco control with special reference to advertisement and sponsorship policies. It was no longer possible to tolerate the rising death toll and, since words seemed to be ineffective, action must be taken. Finally, he informed the Committee that
Hungary had decided to introduce a law protecting the rights of non-smokers in addition to its many activities in the fields of education and information.

Mr DEBRUS (Germany) said that his Government strongly supported the expression of concern for public health in the recommendations of the Executive Board and in the WHO "tobacco or health" programme in general. It had adopted many measures and programmes to support smoking-avoidance and protect non-smokers. There were protective regulations for employees in the workplace and a number of provisions for smoking and non-smoking areas in public transport. Support for smoking-avoidance played a very important role in health education. There had been a public information campaign in Germany for many years with the motto "It's not so bad without smoke". Hospitals had also been made a focus for dissemination of the idea of protection of non-smokers.

However, despite his Government's support for the "tobacco or health" programme, his delegation thought that a framework convention would not bring any additional advantages. What was important was step-by-step implementation of WHO's programme as efficiently as possible. The problem would not be solved by adding yet another document, whether a charter or a convention, to already existing declarations of intent. The time had come to implement public health measures and to act in accordance with the many international instruments already in existence.

Dr VAN ETTEN (Netherlands) welcomed document A49/INF.DOC./2 and supported the resolution recommended in resolution EB97.R7. However, although sympathetic to the proposals following the adoption of resolution WHA48.11, he had some reservations regarding an international instrument for tobacco control as described in document A49/4, section VI. No information was provided on the specific aspects of tobacco control to be covered; no analysis had been made of the subjects to be covered by international rather than national instruments; and there had been no evaluation of the practical implications of the proposals, such as a timetable for implementation, financial implications, etc. Hence he could not support the resolution recommended in resolution EB97.R8.

Ms KIZILDELI (Turkey) endorsed the proposed plan of action and suggested that measures should be designed to discourage adolescent smokers in particular. While supporting a framework convention for tobacco control which would make guidelines contained in the action plan legally binding, Turkey would not condone attempts on the part of WHO to regulate tobacco supply, an issue which lay outside WHO's remit. She requested clarification of the phrase "aspects of tobacco control that transcend national boundaries" in paragraph 3(2) of the resolution recommended in resolution EB97.R8. It was to be hoped that the drafting of a convention would be entirely funded by extrabudgetary resources.

Mr ABDESSELEM (Tunisia) commended WHO's concerted efforts to control tobacco consumption over a 30-year period, culminating in the "tobacco or health" programme initiated in the late 1980s. Since 1970, the Health Assembly had adopted 14 resolutions which had resulted in notable improvements with respect to tobacco epidemiology. When elaborating programmes, WHO must bear in mind that tobacco consumption in developing countries was still on the increase. Tunisia welcomed the proposed plan of action which contained provisions for global tobacco-consumption control strategies through country-level programmes and which highlighted the necessity of information dissemination. Although available funds for tobacco control programmes were limited, the money would be well spent: tobacco-related losses amounted to US$ 2000 million annually, of which developing countries bore the main brunt. Tunisia thus fully supported the "tobacco or health" programme, but was concerned lest tobacco-growers be deprived of an income; they should instead be encouraged to grow other crops. Various international organizations such as FAO, ILO, UNDP, the World Bank and WTO had a role to play in implementing international tobacco control strategies.

Tunisia had established a multisectoral national committee in 1993 for reducing tobacco consumption and had disseminated educational material discouraging tobacco consumption to the general public and health personnel. The Government of Tunisia also encouraged the mass media to support World No-Tobacco Day for which various special events were organized. Legislation restricting the use of tobacco in public places had also been implemented.
Mrs DHAR (India) said that developing countries, including her own, were being made more aware of the harmful effects of tobacco. The main opposition to tobacco control policies came from the tobacco industry and its supporters. In India, an estimated 142 million men and 72 million women consumed tobacco; 55% smoked bidis (indigenous cigarettes), 16% consumed western-style cigarettes and 29% chewed or snuffed tobacco (compared to worldwide figures of 3%, 83% and 2% respectively). Of an estimated three million tobacco-related deaths in the world, as many as 800 000 occurred in India. One-third of all cancers in India were tobacco-related, requiring costly interventions - an average of 2000 million rupees each year.

Happily, the movement to curb the tobacco epidemic in India was gaining momentum. A Cigarettes (Regulation of Production, Supply and Distribution) Act had been passed in 1975 which required manufacturers to print the statutory warning "cigarette smoking is injurious to health" on all cigarette packages and - at that time - on tobacco advertisements. (The Prevention of Food Adulteration Act covered the chewing of tobacco and pan masala.) Smoking was now prohibited in hospitals, dispensaries, conference rooms and educational institutions, in 'planes on domestic flights and in air-conditioned coaches, buses and trains. All forms of tobacco advertising were now also banned. Public awareness campaigns had increased through observation of the World No-Tobacco Day, and information had been disseminated through the mass media and the educational system. A comparative study of the economics of tobacco use was currently being conducted. Previous laws had been ineffectual, but more comprehensive legislation was soon to be set before Parliament.

India endorsed the 'tobacco or health' action plan and supported the resolutions recommended in resolutions EB97.R7 and EB97.R8.

Ms AXEN (Denmark) noted the reports of efforts being made at national and international level to reduce tobacco-related damage. Each country was quietly developing its own strategies, and various legal instruments and various programmes had already been drawn up at international level. In time, those proposals and guidelines would be properly implemented and greater global consensus would be reached. The preparation of a framework convention was thus premature. Denmark consequently did not support the resolution recommended in resolution EB97.R8, although it endorsed many of its aims. Denmark did, however, fully support the proposed plan of action.

Professor REINER (Croatia) said there seemed to be consensus that WHO should give tobacco control high priority. In 1995, Croatia had implemented several regulations to protect the rights of non-smokers and to reduce tobacco consumption. A more comprehensive tobacco control act was currently being drafted.

Since the Health Assembly had adopted resolution WHA48.11, little headway had been made towards an efficient, legally binding international instrument for tobacco control. Discussion had been restricted to whether the instrument should take the form of a treaty, convention or protocol; meanwhile, millions of people were dying. He urged swifter action. The delegate of Denmark had pointed out that time was needed. Time, however, was short. Croatia supported the resolution recommended in resolution EB97.R8 as well as the proposed plan of action, but called for urgent preparation of an additional resolution with a view to recommending practical measures to Member States for tobacco control. The moral, political and scientific force of WHO should be used to draft a convention protocol under Article 19 of the Constitution, a model non-binding instrument for Member States initially, to be followed by a more legally binding instrument to include the banning of tobacco advertisements and smoking in public places (especially in health and educational institutions). Well-known personalities should also be discouraged from smoking, especially on television. He called for support and requested the Legal Counsel to explain whether it would be possible to prepare such a resolution with minimal delay.

Dr LIU Yuliang (China) said that China supported the idea of providing guidelines for tobacco control and introducing legislation applicable to the broad mass of smokers. The deleterious impact of tobacco on health had, after all, been scientifically verified, as had its adverse economic impact. There was now increasing international awareness that reduction of smoking was an important yardstick for social progress. With greater consensus at WHO, unremitting efforts on the part of the international community and the governments of all Member States, and increased emphasis on health education, it would be possible to stem the harm caused by tobacco. The development and implementation of international instruments for tobacco control would contribute greatly to the worldwide promotion of healthy lifestyles.
The Chinese Government had always attached great importance to tobacco control and had even advocated prohibition. Since 1979, it had issued several documents and developed instruments for elaborating tobacco control strategies. Over the past two years, anti-smoking programmes in China had flourished, illustrating the effectiveness of legislation; 38 cities in China, including Beijing and Shanghai, had effectively banned smoking in public places. Health education and smoking control publicity had been strengthened through the observance of World No-Tobacco Day. China had national incentives for effective tobacco control publicity, and a "tobacco-advertising-free city" initiative had been introduced in a number of cities. The results of the third national survey on smoking (initiated in December 1995) were to be published in October 1996. The Chinese Government was confident that future generations would continue to benefit from its smoking control programme. China was willing to cooperate with WHO and all its friends worldwide with a view to curbing the consumption of tobacco.

Ms Ingram (Australia) said her country had consistently supported the "tobacco or health" initiatives of WHO and the efforts of other organizations and bodies such as the United Nations Economic and Social Council, encouraging Member States to take positive action to reduce the severe harm caused by tobacco. Australia favoured international legislation for improving global tobacco control, but expressed certain reservations: numerous Health Assembly resolutions outlining a comprehensive approach already existed and could be highly effective. It must be ascertained whether there would be real benefits from yet another international instrument, or whether its costly and time-consuming development would only divert valuable resources from national tobacco control measures.

Australia strongly supported the current international focus on multisectoral collaboration on "tobacco or health", as reflected in resolution E/1995/62 of the United Nations Economic and Social Council (28 July 1995) of which Australia had been a sponsor. Disappointingly, however, the language of the resolution had been rather weak. All health professionals, including specialists currently gathered at the Health Assembly, should work closely with their governments to ensure that strong resolutions were tabled in the Economic and Social Council and at the Health Assembly. The effect of such measures at international level must not be underestimated. Australia strongly supported the leadership of WHO and other United Nations organizations involved in tobacco control and welcomed their continual urging of Member States to implement comprehensive control programmes.

Mr Islam (Bangladesh) said that tobacco use was entrenched in social behaviour in many countries. The development of the habit in developing countries at a time when numerous western industrialized countries were noting a marked decrease in tobacco consumption was a matter of particular concern. Aside from its effects on health, smoking incurred heavy costs for the poorest of the world's populations; Bangladesh faced a severe challenge, since it had an estimated 20 million smokers, many of whom belonged to the poorer sectors of society. Despite the concerted efforts of government and nongovernmental organizations, cigarette-smoking in Bangladesh was spreading at a worrying rate in the rural population.

To ensure effectiveness, the global campaign against smoking should first determine existing weaknesses. Although concrete measures were perhaps premature, the possibility of adopting an international instrument for tobacco control should certainly be discussed. The plan of action should adopt tried measures, yet WHO should always be ready to incorporate new ideas.

His delegation fully supported the resolution recommended in resolution EB97.R7.

Mr O. Olafsson (Iceland) said it should be noted that the chemical and behavioural processes that determined nicotine addiction were similar to those that determined addiction to drugs such as morphine and cocaine and should be classified as such. Many studies had shown that tobacco use was a form of drug dependence and concerted action was needed to combat the habit.

Ms Chavez (United States of America) commended the "tobacco or health" programme. Since the first United States Surgeon General's Report on Smoking in 1964, her Government had adopted a variety of measures and was currently concentrating on protecting children. It was important for WHO to focus on tobacco as a cause of preventable health problems and to coordinate its efforts with the United Nations focal point. She hoped to see greater compliance with restrictions on smoking in United Nations premises.
Dr ALVIK (Norway) supported the views expressed by Sweden, Finland and others. Although progress was being made, 7% of doctors and 17% of nurses in Norway still smoked; the figure was higher in the general population. Tobacco was a major cause of health problems in all parts of the world. Norway therefore supported the resolution recommended in resolution EB97.R7.

Professor LEOWSKI (Poland) reported that the Polish Parliament had passed a Tobacco Control and Health Protection Act in November 1995. The Act, which had come into force on 1 May 1996, protected the rights of non-smokers, promoted tobacco-free lifestyles, created the legal and economic conditions for a reduction in tobacco consumption, informed the general public about adverse effects, decreased the maximum permissible levels of noxious substances in tobacco products, and provided for the treatment and rehabilitation of tobacco-dependent patients. The Council of Ministers was to submit a report to Parliament each year on its implementation. Aware that the law alone was not enough, the Ministry of Health had drawn up a specific action plan for the period 1996-2000.

Mr CLERC (France) supported the resolution recommended in resolution EB97.R8. An international framework convention would be a useful instrument for mobilizing the international community, although insufficient on its own. Tobacco control was primarily a matter for national legislation. France was willing to make a financial contribution to preparation of the international framework convention.

Dr AL-RAHMAN (Sudan), noting the similarity of the views expressed, which he shared, suggested that the Committee approve the resolutions and move to the next item on the agenda.

Dr VASSALLO (Malta) recommended more emphasis on educating young people of school age, using the results of special research, in which WHO's research and information centres could help. Smokers needed help if they were to give up the habit, with radical control of advertising; half-hearted measures were ineffective.

Malta fully supported the resolution recommended in resolution EB97.R8. In 1988 in Madrid the countries of Europe had approved a 10-point charter on tobacco control and many resolutions had been approved in WHO's governing bodies. Yet the problem still existed, and was even more acute in some areas. The framework convention should help decision-makers to act quickly. He recalled that the United Nations had coordinated at least three conventions on drug abuse.

Professor AGBOTON (Benin) supported the action plan for 1996-2000. Billions of dollars were at stake for the tobacco companies. It would therefore not be easy to fight the modern scourge. A global approach within the United Nations system was indispensable. It had to be admitted that developing countries sometimes reaped immediate financial gain from taxes on the production or sale of tobacco products. What was needed were international and national rules to preserve the health of populations. Tobacco advertising was particularly aimed at young people, who were the human capital for a country's future, and those in developing countries were particularly vulnerable. Benin therefore unreservedly supported both resolutions recommended by the Executive Board.

Dr GAKO (Philippines) supported the plan of action for 1996-2000. The Government of the Philippines was financing activities to control tobacco use, such as multimedia campaigns, group discussions and symposia in schools. Many local government authorities had already banned smoking in public places.

Mr OSMAN (United Republic of Tanzania) said that his country stressed public information on the adverse effects of tobacco and all packets of cigarettes made locally carried a health warning. It was surprising that packets without such labelling originated from countries where that was illegal. He called for international efforts to eliminate double standards, and supported the resolution to prepare a convention.

Crop substitution in tobacco-producing countries should be studied, especially where the economy depended upon tobacco.

Dr BERGER (Switzerland) said that in 1995 the Swiss Government had adopted an action plan to reduce the consumption of tobacco, against claims that it ran counter to economic and political interests and
flouted individual responsibility. The painstaking work of changing convictions and behaviour was going ahead with few resources, far fewer than those available to the tobacco industry.

Against such a background, an international legal framework would be welcome. It was especially important for the countries of the South and the East, which were less well equipped to resist the tobacco industry and far more vulnerable to economic arguments. Switzerland therefore supported the resolution recommended in resolution EB97.R8 in principle but hoped that it would rapidly be followed by other measures.

Mr PHILLIPS (Jamaica) said that according to WHO estimates there would in the 1990s be three million tobacco-related deaths per year, rising to 10 million per year by 2020. Most of that increase would occur in developing countries. Action at international level was therefore essential, not only in research and health promotion; a framework convention, an international legal instrument, would also constitute a step towards a more comprehensive international approach. Jamaica therefore supported the resolutions recommended in resolutions EB97.R7 and EB97.R8.

Dr DURHAM (New Zealand) welcomed the leadership of WHO in tobacco control. Even though New Zealand had a comprehensive tobacco control programme, it still needed to concentrate more on young people, Maori people, and women, and was embarking on measures to strengthen legislation and health promotion.

The Western Pacific Region was facing a major increase in tobacco consumption and thus in tobacco-related death and disease. An international plan of action would be welcomed; New Zealand therefore supported the resolution recommended in resolution EB97.R7. However, it shared the reservations expressed by Germany, Netherlands, Turkey and others with regard to that recommended in resolution EB97.R8. The framework convention required further study, with a report to the Fiftieth World Health Assembly. The allocation of resources must be related to the effectiveness of measures for tobacco control, and must not serve for indirect subsidization of the framework-convention approach.

Dr OTTO (Palau) agreed with the observations of the delegates of India and New Zealand, supporting the plan of action. However, other forms of tobacco use, on which few data were available, also needed attention: chewing-tobacco was a very significant problem in some areas of the world. In Palau, 60%-75% of the population chewed betel nut with tobacco. The research component of the plan of action should therefore also focus on such uses of tobacco. Palau supported the resolution recommended in resolution EB97.R7.

Mr KHAN (Pakistan) said that measures taken in his country to discourage smoking included public information, health warnings on cigarette packets, and a smoking ban on airlines' domestic flights. While endorsing in general the plan of action, he warned that it might not be sufficient. Entire communities and their economies were dependent on tobacco cultivation and manufacturing. In order to achieve the objectives of the resolution recommended in resolution EB97.R7, a multisectoral approach should be adopted to include technical assistance to communities in which tobacco was the main source of income, and to encourage crop substitution and the development of alternative sources of income.

Professor GUMBI (South Africa) said her country remained committed to the control of tobacco. Major causes of concern were passive smoking, and smoking among teenagers. Emphasizing the need for firm global action, she expressed strong support for the resolutions recommended in resolutions EB97.R7 and EB97.R8; an international convention should protect the weaker countries. She commended WHO's restrictions on smoking in meetings and hoped that at the 1997 Health Assembly there would be non-smoking zones outside the meeting rooms as well.

Dr ABU HELIQA (United Arab Emirates) agreed with previous speakers that the tobacco industry was largely responsible for the problem. Particularly in the developing countries, tobacco was advertised on a huge scale. The experience of countries with successful tobacco control campaigns should be turned to account; hers had adopted a number of measures and was introducing an anti-tobacco law. She hoped WHO would be able to provide advice and support as those efforts continued.
Dr AL-MUHAILAN (Kuwait) observed that coordination and cooperation among the tobacco producers was very close. Resources were insufficient to resist the pressure of the international tobacco lobby. Young people in particular were the target. Kuwait had adopted certain measures to reduce or eliminate the use of tobacco, particularly in public places, and to prevent advertising. While industrial countries were challenging the interests of the tobacco companies, consumption in the developing countries was rising by 10% or more annually. Welcoming the measures already taken internationally, he stressed the need to continue efforts and expressed support for the two draft resolutions.

Dr DASHZEVEG (Mongolia) said that a law on tobacco control had recently come into force in Mongolia. It embraced a number of WHO recommendations and had drawn on the experience of certain other countries. With the transnational tobacco companies now concentrating on the developing countries, strict international rules should be drawn up to control sales of tobacco and tobacco products on the world market.

Dr CALMAN (United Kingdom of Great Britain and Northern Ireland) observed that the ill effects of tobacco were well recognized. He expressed full support for the resolution recommended in resolution EB97.R7 but, concerning the one recommended in resolution EB97.R8, felt that a framework convention was not currently the best approach. The Executive Board should consider the matter further and expand on the proposals.

Dr ADELAJA (Nigeria), summarizing Nigeria’s activities since 1989, drew particular attention to measures to determine the prevalence of smoking and provide information and health education, as well as to a decree on the control of tobacco use promulgated in 1990 and reviewed in 1995. She expressed support for the resolutions recommended by the Board.

Dr TIERNEY (Ireland) said that his country had adopted very strict legislation to reduce tobacco consumption, with tight restrictions on tobacco advertising and labelling; but advertising in imported publications aimed at the young, especially young women, was insidious. Ireland therefore strongly supported any move towards international restrictions on tobacco advertising and labelling, and he supported the resolutions recommended by the Board.

Mr AL-HABSÝ (Oman) said that international efforts to combat smoking should be matched by similar efforts at country level. Reporting on the measures adopted by Oman both nationally and in the region, he drew particular attention to legislation passed in January 1995 to limit tobacco consumption. He welcomed WHO’s activities on “tobacco or health” and expressed support for the two resolutions recommended by the Board.

Mr KALIMA (Malawi) observed that Malawi was a major tobacco producer; tobacco, a labour-intensive crop compared with soya or maize, provided a relatively good return, and accounted for 70% of the country’s exports. It was the only source of income for millions of rural people. The main beneficiaries, however, were the middlemen and multinational companies.

He welcomed the United Nations Economic and Social Council’s proposal for a study on tobacco and health. It should consider not only alternative crops but the development of secondary industries in countries dependent on tobacco, as well as sustainable exploitation of available natural resources. There should also be concerted efforts to stabilize commodity prices. Stagnation of the price of tea, coffee and other crops had done nothing to help Malawi’s economic stability. He supported the resolution recommended in resolution EB97.R7, but expressed reservations on that in resolution EB97.R8.

Miss HERNÁNDEZ (Cuba) said that, even though tobacco production was an important factor in Cuba’s economy, the Government had undertaken to combat smoking on a broad front. Outlining some of the measures already adopted, she drew particular attention to a programme for the prevention and control of smoking which took account of all the components of the WHO plan of action and relevant resolutions. She supported the development of a framework convention to strengthen international control of smoking.
Dr NAPALKOV (Assistant Director-General) thanked delegates for their support of the plan of action for 1996-2000 and the resolution recommended in resolution EB97.R7, and assured them that their comments had been noted.

Mr COLLISHAW (Tobacco or Health), replying to questions, said there were useful models in other parts of the United Nations system for a framework convention. UNEP, for example, managed a framework convention for the protection of the ozone layer, complemented by some draft protocols.

The international dimensions of the tobacco problem included smuggling; it had been estimated that about 300 thousand million cigarettes, 6% of world production or about one-third of cigarettes in international trade, were smuggled. Resulting tax losses were thought to amount to US$ 16 000 million. International tobacco advertising that escaped national restrictions was another problem that could be tackled at the international level, together with duty-free sales, tobacco pricing, taxation and price harmonization. Standardized reporting of sales and import and export of tobacco products would improve monitoring of the tobacco epidemic, as would standardized testing and reporting of toxic constituents. National programmes would benefit from the sharing of policy and programme information. The specific contents of a draft convention would of course be for Member States to determine, but they might wish to take into account the 14 Health Assembly resolutions on smoking or "tobacco or health" adopted between 1970 and 1995.

Mrs CARLSSON HÖPPERGER (Office of the Legal Counsel), replying to the delegate of Croatia, said that there was no legal objection to the Health Assembly's adopting a resolution on the technical aspects of tobacco control and at the same time initiating a convention pursuant to Article 19 of the Constitution. The difference between the two approaches was that a resolution was a recommendation to Member States with immediate effect, a convention's effect coming much later. On the other hand, a convention would be binding on signatory States, whereas a recommendation was not.

Repeating to a question by the CHAIRMAN, Mr ASAMOAH (Secretary) said that if there were no objections to the resolution recommended in resolution EB97.R7, it could be approved without a vote. Since objections had been raised to that recommended in resolution EB97.R8 there would be a vote.

The resolution recommended by the Executive Board in resolution EB97.R7 was approved.1

The CHAIRMAN invited the Committee to vote by show of hands on the resolution recommended in resolution EB97.R8, entitled "International framework convention for tobacco control".

The draft resolution recommended by the Executive Board in resolution EB97.R8 was approved by 71 votes to 5, with 10 abstentions.2

2. FIRST REPORT OF COMMITTEE B (Document A49/38)

Mr ASAMOAH (Secretary) noted that the report contained a draft resolution for approval by the Health Assembly under agenda item 20.3, entitled "Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution". In view of the fact that a contribution of US$ 1 million had been received from the Government of Congo during the course of the Assembly, the following wording, to become the fourth preambular paragraph, should be inserted:

Having been informed that the voting rights of Congo had been restored as a result of a payment received after the opening of the Forty-ninth World Health Assembly.

1 Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA49.16.

2 Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA49.17.
Dr KÖKÉNY (Hungary), Rapporteur, read out the draft first report of Committee B.

The report, as amended, was adopted.¹

Mr CLERC (France) said his delegation had not opposed adoption of the report but questioned the reference to an "expected income" in paragraph 3(1) of the draft resolution submitted for the approval of the Health Assembly under agenda item 20.1. France remained convinced that WHO's regular budget must be drawn up on the basis of a scale of assessments that was binding upon all countries without exception.

Mr AITKEN (Assistant Director-General) said the Director-General's view was similar to that expressed by the delegate of France. The matter could be reviewed when it was reported upon at the ninety-ninth session of the Executive Board.

3. SECOND REPORT OF COMMITTEE B (Document A49/40)

Dr KÖKÉNY (Hungary), Rapporteur, read out the draft second report of Committee B.

The report was adopted.²

Dr Shisana took the Chair.

4. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 30 of the Agenda


Professor SHAIKH (representative of the Executive Board) said that the Executive Board had reviewed the Director-General's report (document A49/22), which presented a summary of WHO "partnership" initiatives for health and development. The report noted that significant progress had been made in WHO's collaboration with the multilateral financial institutions, in particular the World Bank and the five regional development banks which were allocating increasing resources to social development, including health. New partnerships were also under way with major geopolitical and economic blocs, including the European Union, ASEAN, the South Asian Association for Regional Cooperation and OAU. WHO's support for African recovery and development had progressed considerably in 1995. The Executive Board had recommended two resolutions for adoption by the Health Assembly: one (contained in resolution EB97.R15) concerned WHO policy on collaboration with partners for health development and the other (contained in resolution EB97.R16) orientation of WHO policy in support of African recovery and development.

In pursuance of resolution 1995/56 of the United Nations Economic and Social Council, the Executive Board had reviewed thoroughly the question of strengthening coordination of emergency humanitarian assistance. It had concluded that WHO's strategy, based on partnership both outside and within the Organization, and its experience of coordination in emergencies, was of particular relevance. Unfortunately, only 5% of the resources allocated for that purpose were funded from the regular budget; activities relied almost entirely upon extrabudgetary resources, which had increased considerably in 1994-1995, reflecting the trust placed by donors in the Organization. The Executive Board had recommended that the attention of donor governments be drawn to the need to provide substantial extrabudgetary funding, in addition to their

¹ See page 209.
² See page 210.
generous donations for emergency response activities, to strengthen emergency preparedness and prevention programmes in Member States. The draft resolution contained in resolution EB97.R17 was submitted to the Health Assembly for adoption.

Dr NANTTEL (Canada) said that the development of collaboration with intergovernmental organizations was an important step in the reform permeating the United Nations system; a prime example of such collaboration was UNAIDS. Partnerships could not fail to raise awareness and respect for each partner’s role and capacities, and countries stood to gain a more integrated and rational approach to development, while partnerships with funding agencies offered opportunities for WHO to move away from the implementation component of its technical cooperation activities.

The report on partnership initiatives referred to the need for explicit orientation of the collaboration policy, and he understood that a document or discussion paper on such a policy would be produced in the near future. The Organization should develop a methodology for quantifying collaboration activities, so that Member States could assess the impact of collaboration, and to provide guidance. Such information would be useful, not only for WHO, but also for Member States, in influencing the policies of WHO’s "partners" on common goals.

The health and development situation in Africa warranted intensified coordinated action, and it was encouraging to see the quantity and variety of partnership arrangements emerging in support of such action.

The Canadian delegation supported the resolutions proposed on the item.

Ms LOBBEZOO (Netherlands) said that though the report on "partnership arrangements" referred to a number of meetings between WHO and other organizations, it failed to provide information on the outcome of those meetings. Her delegation wished to know precisely how and in which health fields WHO was cooperating with United Nations funds and programmes, the World Bank, other specialized agencies, the European Union and the development banks.

Referring to the information document on WHO’s response to the changing global economy (document A49/INF.DOC./3), she welcomed the attention given by WHO to matters concerning WTO. Noting that the Codex Alimentarius recommendations had assumed special significance under the new trade agreements, she expressed satisfaction that WHO was considering the potential impact of international recommendations on health and urged the Organization to continue with that approach.

She supported the resolution recommended in resolution EB97.R5 on the supply of controlled drugs for emergency care, in view of the importance of simplified regulatory procedures for the timely international supply of narcotic drugs and psychotropic substances in emergency situations.

Dr BOUFFORD (United States of America) said her delegation fully supported the resolutions submitted. It was pleased with WHO’s progress in planning and coordinating with other "partners" and would particularly like to see the development of stronger relations with the World Bank and other major international lending institutions which were increasing their support to countries in health and related sectors, where WHO’s leadership was crucial. The United States also supported the development of a broad range of appropriate and productive "partners" for WHO.

The work of the WHO Task Force on Health in Development had resulted in a series of important reports to chart a potential course for WHO in enhancing its "partnerships for health". That work should be central to the development of policies and strategy and of a true culture of collaboration. An enhanced partnership with the WHO collaborating centres was crucial to WHO’s ability to take advantage of global expertise, and the Planning Group of WHO Collaborating Centres on Occupational Health represented an excellent example of such partnership in action.

Turning to humanitarian and emergency assistance, she commended WHO’s effort, in cooperation with the two components of the Government of Bosnia and Herzegovina, to develop a strategy for reorientation and rehabilitation of the health system. That effort showed WHO functioning at its best in cooperation with others.

She urged that the strongest possible support should be given to WHO’s active participation in the United Nations System-wide Special Initiative on Africa as outlined in resolution EB97.R16. That activity was totally consistent with the priorities established by the Executive Board and the Health Assembly for the 1996-1997 biennium, with those recommended for 1998-1999, which called for special attention to countries
in greatest need, and with the Executive Board's efforts to strengthen country offices and to improve coordination within WHO for the development of integrated country programmes. WHO's global, regional and country-level participation in the Initiative should ensure that health occupied a central role in overall development plans, that countries themselves shaped the Initiative to meet their needs and that attention was paid to building a stable infrastructure for continued development in the health sector, meeting the needs of the health care delivery system as well as of the public health, nutrition and sanitation systems. She urged the Director-General to provide complete annual reports to the Health Assembly on the progress of the Special Initiative on Africa and, as needed, to advise the Health Assembly and/or the Executive Board on ways to strengthen WHO's role in that effort.

Mr SAKAI (Japan) welcomed WHO's "partnership initiatives" for health and development, noting that the Organization had strengthened its collaboration with different United Nations bodies and intergovernmental and nongovernmental organizations. A very positive partnership had been developed between WHO and the World Bank. He commended WHO's excellent work in that connection, including the brochure on WHO/World Bank partnership containing a recommendation on action for health and development. It would be useful to enhance further collaborative action with other institutions, along the lines of the strong leadership by WHO in supporting African recovery and development. He welcomed the work undertaken by the WHO working group on continental Africa which had helped to formulate policy and had produced important material, in particular for the United Nations System-wide Special Initiative on Africa.

The Government of Japan had been strengthening its support for African development and the improvement of the health of all African people. It had organized the Tokyo International Conference on African Development which had been attended by a number of heads of state. It supported the two resolutions recommended by the Executive Board in resolutions EB97.R15 and EB97.R16.

Dr KORTE (Germany) said that the recommendations of the WHO Expert Committee on Drug Dependence on a simplified regulatory procedure for the supply of narcotic drugs and psychotropic substances in emergency situations had been approved as a result of the experience gained in the Federal Republic of Germany and certain other States. Accordingly, Germany supported the resolution recommended in resolution EB97.R5 on the supply of controlled drugs for emergency care.

It would be necessary to elaborate guidelines for the controlled supply of drugs in emergency situations. In Germany, the regulatory procedures, which could be used as a basis for such guidelines, were as follows. Relief organizations were eligible to apply for an export permit, of unlimited duration, for certain controlled medicines for use in immediate disaster relief. They received the appropriate permit from the Federal Institute for Drugs and Medical Devices on condition that: for every consignment, an export permit was applied for - an import permit of the country of destination was not required; the export was immediately notified to the Federal Institute for Drugs and Medical Devices; receipt of the consignment in the disaster area was confirmed by the recipient and transmitted to the Federal Institute for Drugs and Medical Devices. The International Narcotics Control Board in Vienna had to be informed without delay of all individual cases. A more flexible arrangement existed for cases of extreme urgency occurring at weekends and on public holidays.

Mr HANSEN (Denmark) said that in relation to the initiatives for health and development, it was important to bridge the gap between relief and development assistance. The concept of development relief had, thus far, been largely neglected. However, there was a very clear need for the elaboration of such a concept. WHO should therefore work together with other United Nations bodies to achieve that. It was also important to stress the significance of coordination within the United Nations system. In relation to the coordination of emergency humanitarian assistance, it was essential for each United Nations body to accept the role played by the United Nations resident coordinator and also the invaluable contribution of the United Nations Department of Humanitarian Affairs.

Dr PAVLOV (Russian Federation) welcomed the draft resolutions relating to cooperation between the different United Nations institutions actively participating in the development of health systems. The adoption of such resolutions would undoubtedly help to strengthen the coordinating role played by WHO in its
cooperation with international "partners" in relation to the health of the population and the development of national health care systems. However, it was also essential to mobilize the necessary technical and financial resources.

The International Programme on the Health Effects of the Chernobyl Accident (IPHECA) was particularly important. Many governments had offered financial, scientific and technical assistance and support; without such support from all Member States, the Programme could not be successfully developed or implemented. The consequences of the Chernobyl accident continued to have a very adverse effect on the health of the population, which placed a heavy burden on health care services. The Russian Government and the Ministry of Health were doing all they could to alleviate the suffering of people affected by the disaster. However, the problems encountered were not only important at a local level; they went beyond the three countries geographically closest to the disaster (Russia, Belarus and Ukraine). The adoption of the draft resolution contained in document A49/31 would help to ensure that the victims of the Chernobyl accident were not forgotten; the resolution was particularly poignant in its tenth anniversary year. WHO continued to devote attention to the problem because undoubtedly the lessons and conclusions of Chernobyl were a legacy for all Member States of the Organization.

Mr KOVAL (Ukraine) expressed support for the draft resolution contained in document A49/31. The consequences of the Chernobyl disaster were many and varied. The effects on the health of the population would persist well beyond the end of the decade which had elapsed since the accident had occurred, and which had been commemorated at the end of April 1996 by the international community. The overall picture of the health effects presented by IPHECA was striking. Further, it was important that, within the follow-up proposed in the resolution, emphasis be placed on the health effects stemming from sources other than radiation, in particular the psychosocial and psychosomatic illnesses which had severely affected the populations concerned. He expressed gratitude to those Member States which had helped to implement IPHECA, and to WHO, and called for Member States to support the draft resolution in favour of maintaining the Programme.

Mr POINSOT (France) said that in relation to the strengthening of the coordination of emergency humanitarian assistance, it was important to emphasize the significance, within the United Nations system, of the coordination mechanism set up under the United Nations Department of Humanitarian Affairs. WHO played an active role in that mechanism and should be encouraged to continue its participation. With regard to document A49/22 Add.1 concerning the United Nations System-wide Special Initiative on Africa, he supported the proposal put forward by the Director-General in favour of the African continent. It was important to mobilize all the efforts of the international community in order to help Africa; in addition, WHO should play its part fully in implementing the initiative. Within the framework of resolution EB97.R16, he requested precise information on the exact scope of the health component of the Special Initiative.

Mrs DROBYSHEVSKAYA (Belarus) said that people had begun to forget about Chernobyl. Those who had not encountered the disaster at first hand considered that the problem was no longer as topical or acute as it had been. Unfortunately, that was not the case. She completely supported the measures set out in document A49/31 for collaboration between international organizations under the auspices of WHO, and continuation of IPHECA. Donor countries should be fully aware of the need to continue the Programme, and she was grateful to all the countries that provided support for it. A common understanding was essential if the Programme was to develop in the future.

Mr GRIFFITHS (United Nations Department of Humanitarian Affairs) informed the meeting that the interagency discussions on a coordinated follow-up to the provisions of resolution 1995/56 of the United Nations Economic and Social Council had led to the establishment of an inter-agency task force in October 1995. That task force, which he chaired, had decided that while generic policy and strategic issues should be debated in its forum, the tackling of problems at the operational level should be delegated to a series of informal consultations to be convened by the Department of Humanitarian Affairs. The Inter-Agency Standing Committee would decide on proposals emanating from such consultations.
The agencies would keep the task force informed of the progress of their consultations with their respective executive bodies. The role of the Department of Humanitarian Affairs was to ensure a coordinated follow-up to the resolution and to provide a series of formal and informal briefings to Member States.

WHO had played a major part in the debates of the Inter-Agency Standing Committee and those of its working group on follow-up to resolution 1995/56 of the United Nations Economic and Social Council. The Organization played an important normative role, and had more limited operational responsibility with regard to the handling of health problems arising in emergency situations. It also carried out technical assistance work in recovery and in emergency preparedness.

The Department of Humanitarian Affairs welcomed the initiative of WHO in drawing up memoranda of understanding with other United Nations organizations, especially UNICEF and UNHCR, and also with intergovernmental and nongovernmental organizations in order to facilitate collaboration, minimize overlap and delineate clearly the responsibilities and accountabilities which existed between the different organizations and agencies. Regrettably, WHO was experiencing difficulties with the funding of health sector activities through the consolidated appeals process, since WHO’s projects within that process were primarily normative. Such activities were important in terms of the effective management of the health sector. He welcomed measures taken by WHO to strengthen local capacity through preparedness and prevention activities, including development of national human resources and strengthening of regional and interregional emergency preparedness centres. Further, WHO was strengthening its capacity to provide technical guidance and monitoring and coordination of emergency health assistance. Such an important function should be coordinated with the appropriate bodies. Similarly, WHO was intending to play an increasing role in advocacy for health assistance to noncombatants and the effective care of injuries resulting from landmines and collective violence. Such work should be carried out in close cooperation with the United Nations Department of Humanitarian Affairs and other bodies concerned, including its own task force on assistance to internally displaced persons, and the International Committee of the Red Cross.

The recent adoption of the process of implementing resolution 1995/56 of the United Nations Economic and Social Council by other members of the Inter-Agency Standing Committee would greatly facilitate coherence in the dialogue with Member States and enhance the collective response of the United Nations system to emergency and humanitarian requirements arising from natural and man-made disasters.

The meeting rose at 12:50.
SIXTH MEETING
Thursday, 23 May 1996, at 14:30

Chairman: Dr O. SHISANA (South Africa)

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 30 of the Agenda (continued)


Mr DAY (United Nations International Drug Control Programme) drew attention to the close relation between drug abuse and other serious health problems, such as HIV/AIDS, hepatitis and other diseases, and to the wider social and economic effects of drug abuse, not least of which was its effect on the families. The growth of drug abuse in some developing countries posed a particularly acute problem among vulnerable groups. UNDCP was mobilizing all United Nations organizations concerned, particularly those for health, social and youth matters, to take drug abuse into account in their policies and programmes, and the Executive Heads had committed themselves to that approach at the first 1995 meeting of ACC. It was worth noting that as of 1 June 1996 the United Nations Office at Vienna would be implementing a new policy banning smoking on United Nations premises. In the specific matter of narcotic drugs and psychotropic substances, WHO was one of the most active participants in the reformulation of the United Nations system-wide action plan on drug control. The process developed for that ambitious exercise was at the forefront of new interagency approaches to planning in order to provide a more effective response to global problems. WHO had long been a major partner of UNDCP, each organization with its own specific mandate, although some overlapping was inevitable and indeed necessary. That overlap of responsibilities would be turned to account by taking utmost advantage of the expertise of both agencies to develop innovative cost-effective activities. An example, at the operational level was that, under their programme on substance abuse, work was nearing completion on a project in support of drug abuse prevention to be undertaken by grassroots nongovernmental organizations. Since traditional United Nations system modalities for technical cooperation were not always appropriate to that kind of activity, both organizations were seeking alternatives. Cooperation between them was entering a new phase following the joint programme framework for enhanced consultation on planning approved in April 1996. UNDCP appealed to WHO Member States to continue and to enhance their support for the prevention and control of drug abuse, for which the new machinery provided an unprecedented, coordinated and system-wide response.

Dr RIVERO (Uruguay) expressed firm support for the steps taken by WHO in response to the changing global economy. It could be seen that, despite the Organization’s financial difficulties, priority-setting had enabled it to undertake very useful studies on health economics and the links between health and trade. Document A49/INF.DOC./3 described the interesting work carried out by the WHO Task Force on Health Economics and the WHO coordinating group for WHO/WTO cooperation. She hoped that following the Board’s recommendation on programme budget priorities, the necessary resources would be reallocated to enable the work to be continued.

Mr HOU Zhenyi (China) stressed the importance of effective coordination with United Nations and other intergovernmental organizations in bringing about a speedier response to health problems, including

1 See document EB95/1995/REC/2, page 252.
emergencies. He hoped that WHO would play its full part in such coordination. The adverse effects of the Chernobyl accident, especially on the health of children, was a matter of grave concern. He accordingly supported the continued implementation of IPHECA, and the draft resolution contained in document A49/31.

Mr SENE (Special Adviser to the Secretary-General of the Second United Nations Conference on Human Settlements) stressed how important WHO’s work had been to the Conference (Habitat II). WHO and the United Nations Centre for Human Settlements (UNCHS) had been cooperating in preparing for Habitat II, to be held in Istanbul from 3 to 14 June 1996. Habitat II, which the United Nations Secretary-General had called the summit of the cities, would take as its theme the sustainable development of human settlements during the worldwide process of urbanization, as well as decent dwellings for all. The Director-General of the United Nations Office at Geneva had highlighted the importance of Habitat II; 150 countries and thousands of representatives of local authorities, mayors, parliamentarians, United Nations organizations, financial and professional institutions, nongovernmental and community organizations, women and youth groups, universities and research institutes would be represented, all of which had participated in the preparatory activities. A great many preparatory meetings had been held throughout the world, including one for ministers from the African region in Johannesburg, generously hosted by the city.

WHO had consistently offered its support and had declared 1996 to be the year in which World Health Day would be focused on the topics of cities and health. A vast network for the exchange of experience and cooperation was being woven between cities around the world, in accordance with the recommendations of Agenda 21 of the Rio Conference. Habitat II would concentrate, *inter alia*, on ways in which cities could be made more salubrious, safe and convivial. Those goals reflected WHO’s mission to ensure the physical and mental health of the world’s populations, and he hoped that all the world’s health authorities would be represented at Istanbul, where the Director-General of WHO would make a statement.

UNCHS shared the interest shown by WHO in the United Nations System-wide Special Initiative on Africa, designed to promote growth and development in a region which, despite its current difficulties, strove to participate in the construction of world peace, prosperity and stability.

Dr KHATIB (Organization of African Unity) thanked the Director-General of WHO for his efforts to breathe life into the cooperation agreement between the two organizations. WHO and OAU had worked together, *inter alia*, on issues relating to HIV/AIDS, the draft OAU health protocol - one of the important annexes to the treaty establishing the African Economic Community - the OAU staff clinic and its library. That cooperation had culminated in the adoption of various declarations and resolutions by the OAU Assembly of Heads of State and Government in 1992, 1993, 1994 and 1995. At the next OAU summit, a declaration on poliomyelitis eradication in Africa was to be discussed.

OAU was honoured to enjoy such close cooperation with WHO, which it hoped would be further strengthened, and offered its full support for WHO’s activities in Africa at a time of increasing need. His organization would always be prepared to collaborate with WHO on the betterment of health in Africa within the global strategy of health for all and welcomed the United Nations System-wide Special Initiative on Africa.

Mr OSMAN (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation and WHO had been collaborating since 1992 to harmonize basic first-aid techniques at the global level. Their efforts had culminated in a seminar on that subject in Lyon in April 1996, which had brought together 23 first-aid experts from all over the world to exchange experience with a view to establishing principles and approaches which could be applied universally and indicating areas where further research was required. The results of the seminar, which would be published jointly by WHO and the Federation, were only the first step in the process of strengthening the role of first-aid in the renewed health-for-all strategy.

First-aid remained the initial and most fundamental step in emergency health care: in accidents and emergency situations lives could be saved in the first few minutes or hours by neighbours or community volunteers. For nearly one and a half centuries local community volunteers had assisted the wounded and injured in wars, civil strife and other man-made and natural emergencies.

Responsibility for health improvement and maintenance had to be shared between communities, health service agencies, health professionals and other health and welfare-related groups. The Twenty-fourth
International Red Cross and Red Crescent Conference had confirmed the community-based approach for health care in the Federation's strategic workplan for the 1990s to reduce community vulnerability, particularly in poor areas, and had urged the national societies to ensure that first-aid training was based upon the priority health needs of vulnerable individuals, families and countries in relation to the disasters and emergencies which they faced in their everyday lives.

The new challenge for the international community was to improve health for sustainable human development according to the principles of primary health care. That meant improving local capacity to reduce the vulnerability by integrating community-based first-aid and emergency health services into the primary health network and promoting local and international "partnerships". Helping people to help themselves was an important aspect of that work.

National red cross and red crescent societies individually and through the International Federation were ready to participate actively in those areas and called upon their international partners to do likewise and to encourage governments to support their national societies in line with the relevant resolutions of the Twenty-sixth International Red Cross and Red Crescent Conference.

The Federation suggested that WHO might wish to consider taking "Community-based first-aid, helping people help themselves" as the theme for World Health Day 1997. It further suggested that reference centres should be created for the promotion of research and the systematic compilation and dissemination of scientific work on first-aid, and that partnerships at the international, regional and country levels should be coordinated to promote first-aid by building on existing networks and mechanisms and systematically monitoring progress at all levels. Lastly, the partnership between the Federation and WHO should be enhanced and developed for the benefit of all vulnerable groups.

The burden of global health problems including epidemics of diseases such as AIDS, tuberculosis and malaria on overstretched health resources was such that feasible low-cost methods must be sought. First-aid had adequately been demonstrated to be one such tool and should be used in the service of humanity.

Dr SAMBA (Regional Director for Africa), replying to earlier questions, said that the United Nations System-wide Special Initiative on Africa, which had been discussed among other topics at the recent interagency meeting in Nairobi, concerned all 53 African countries and made provision, inter alia, for health-sector reform, the objective being to improve health systems, notably through increased financing, equitable access to health services, and better management. It was also aimed at malnutrition, and at malaria, HIV/AIDS, tuberculosis, and any other diseases found at the local level during implementation. Population matters and questions related to differences between the sexes, including reproductive health, were also to be addressed by the Initiative.

Those priorities had been selected by a small committee from Health Assembly reports going back many years, reports on the major conferences in Cairo and Beijing and all relevant meetings of the United Nations system.

With regard to funding, a preliminary estimate of US$ 25 thousand million for 10 years had been set until a more realistic figure - which would almost certainly be higher - could be calculated. It remained unclear whether the reference was to additional funds or funds already available. Additional funding would certainly be needed, but readjustment of existing resources would also be required. Much more work remained to be done in that connection.

The United Nations Secretary-General and heads of agencies had emphasized in Nairobi that implementation would be the responsibility of African governments, although those governments would collaborate with multilateral and bilateral nongovernmental organizations. United Nations organizations were committed to collaboration at the country level but, as the Secretary-General himself had underlined, the role of the UNDP resident representative would not be coordination but "facilitation". The various agencies working on health matters, namely, WHO, UNFPA, UNICEF, UNDP and the World Bank would meet in July 1996 at the Regional Office in Brazzaville to work out the details.

Dr KAWAGUCHI (Division of Interagency Affairs), also responding to questions, said that, through WHO's "partnership initiatives", stronger links were being established between the Organization and others; in fact, with respect to the World Bank, a technical briefing had just been completed with the participation of senior World Bank representatives. Such partnership development permeated through country, regional and global levels, involving fully the regional offices and WHO Representatives. The development of those
committees initiatives, which included nongovernmental organizations, in addition to United Nations and other intergovernmental organizations, resulted in less duplication and more collaboration, with the full cooperation of governments. As to methodology and quantification, efforts would be made to provide meaningful data as partnerships developed.

Dr KREISEL (Office of Global and Integrated Environmental Health), welcoming the statements made at the previous meeting in support of the International Programme on the Health Effects of the Chernobyl Accident, said that the legacy of the nuclear catastrophe was by no means a matter of the past. Recent international conferences in which WHO had participated had made it clear that it was essential to maintain monitoring of the health consequences, particularly for highly exposed population groups, including those who had been children at the time of the accident and participants in clean-up operations. Attention should also be given to related psychological and psychosomatic disorders. WHO had a responsibility to continue to emphasize the humanitarian and scientific aspects of the accident, and everything possible would be done to raise the resources required to continue the Programme. He counted on Member States' support in the joint effort.

The CHAIRMAN, inviting the Committee to consider the four resolutions recommended by the Executive Board, asked for comments on that recommended in resolution EB97.R5, entitled "Supply of controlled drugs for emergency care".

Mr ASAMOAH (Secretary) said that following the adoption of resolution EB97.R5 by the Executive Board in January 1996, the United Nations Commission on Narcotic Drugs had adopted a similar resolution which made paragraph 2(1) of the text before the Committee redundant. It was therefore proposed that that paragraph be deleted and that paragraph 2(2) be amended to read:

2. REQUESTS the Director-General to prepare, in consultation with the relevant United Nations bodies involved in the international control of narcotic drugs and psychotropic substances, model guidelines to assist national authorities with simplified regulatory procedures for this purpose.

The resolution recommended by the Executive Board in resolution EB97.R5, as amended, was approved.

The CHAIRMAN invited the Committee to consider the resolution recommended in resolution EB97.R15, entitled "Collaboration within the United Nations system and with other intergovernmental organizations: WHO policy on collaboration with partners for health development".

The resolution recommended by the Executive Board in resolution EB97.R15 was approved.

The CHAIRMAN invited the Committee to consider the resolution recommended in resolution EB97.R16, entitled "Collaboration within the United Nations system and with other intergovernmental organizations: orientation of WHO policy in support of African recovery and development", as amended in document A49/22 Add.1, paragraph 11.

The resolution recommended by the Executive Board in resolution EB97.R16, as amended, was approved.

The CHAIRMAN invited the Committee to consider the resolution recommended in resolution EB97.R17, entitled "Collaboration within the United Nations system and with other intergovernmental organizations: strengthening of the coordination of emergency humanitarian assistance".

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA49.18.
2 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA49.19.
3 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA49.20.
The resolution recommended in resolution EB97.R17 was approved.¹

The CHAIRMAN invited the Committee to consider the draft resolution contained in paragraph 15 of document A49/31 on the International Programme on the Health Effects of the Chernobyl Accident.

The draft resolution was approved.²

Coordinated follow-up and implementation of plans of action of international conferences: Item 30.2 of the Agenda (Document A49/23)

The CHAIRMAN said that, in accordance with the provisions of resolution WHA47.14, paragraph 5, a draft resolution entitled "Prevention of violence: a public health priority", initiated and presented at the Health Assembly without prior review by the Executive Board, had been referred to the General Committee, which would make a recommendation thereon.

Professor SHAIKH (representative of the Executive Board) said that the Board had reviewed and noted an earlier version of the report of the Director-General, which had called attention to the need for a multisectoral view, with health as a central theme, for coordinating follow-up and implementation of the plans of action of the many recent international conferences. The Board's attention had been drawn to the consequences of violence and injury, a serious emerging public health problem, global awareness of which found reflection in the emphasis placed by international conferences, including the World Summit for Social Development (Copenhagen, 1995) and the Fourth World Conference on Women (Beijing, 1995), on the need for coordinated action. In a multisectoral response the health sector should play a leading role, determining the magnitude of the problem and the relation between preventable risk factors and injury and violence. The Organization should work with other international organizations and with Member States to create a violence-free environment.

Professor BADRAN (Egypt), after commending WHO's input to recent international conferences, stressed the importance of the health sector and hoped that the necessary support would be forthcoming to ensure that the activities emanating from those conferences were incorporated into national programmes and that WHO's leadership role, which had been particularly apparent at the Beijing Conference, would be equally so in follow-up action with others concerned.

Dr BOUFFORD (United States of America) also commended WHO, not only on its active participation at the Beijing Conference, where its unique potential to lead overall development efforts had been demonstrated, but also on its plans to identify United Nations agencies, foundations and other organizations active in the area of women's health and development in order to maximize follow-up of the implementation of recommendations formulated at the Conference.

Mr VAN REENEN (Netherlands) submitted that the information provided in the Director-General's report was too concise to be entirely satisfactory. For instance, the reference in the annex to the World Summit for Children's mentioned the work of the WHO/UNICEF Joint Committee on Health Policy in monitoring the Summit's mid- and end-of-decade goals, but provided no information about the nature and content of those goals. While extensive reporting on the follow-up of plans of action of international conferences was doubtless expensive, WHO should provide more concrete information in future, especially concerning the translation of the "platforms of action" into WHO priorities and programmes, as well as on problems encountered and the measures taken to remedy them.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA49.21.
² Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA49.22.
Dr HAMMAD (Adviser on Health and Development Policies), responding to the remarks by the previous speaker, said that more detailed information about the mid-decade goals was immediately available in reports of the WHO/UNICEF Joint Committee on Health Policy.

The implementation of "platforms of action" and plans emanating from international conferences was usually done by incorporating WHO's own programmes and priorities, as determined by the Health Assembly. That obviated the need for WHO to start again with each international conference and safeguarded continuity from one conference to another and in the Health Assembly's successive resolutions on priority programmes. The content of most "platforms of action" was subsumed in the targets and goals established in the Organization's Ninth General Programme of Work, and automatically fell within its mandate so that no additional resources were required.

Whereas the tendency in most organizations was to take follow-up action at the headquarters and regional levels, WHO would seek to streamline its activities and display its support for action at the country level.

The CHAIRMAN suggested that pending the General Committee's recommendation on the draft resolution on prevention of violence, the Committee might wish to take note of the report by the Director-General on item 30.2.

It was so agreed.

(For approval of draft resolution, see summary record of the eighth meeting, section 3.)

International Decade of the World's Indigenous People: Item 30.3 of the Agenda (Resolutions WHA47.27, WHA48.24 and EB97.R18; Document A49/24)

The CHAIRMAN said that, in accordance with the provisions of resolution WHA47.14, paragraph 5, a draft resolution entitled "International Decade of the World's Indigenous People", initiated and presented at the Health Assembly without prior review by the Executive Board, had been referred to the General Committee, which would make a recommendation thereon.

Professor SHAIKH (representative of the Executive Board) said that the Executive Board had noted the report of the Director-General on the International Decade of the World’s Indigenous People and adopted resolution EB97.R18. Follow-up action was described in document A49/24.

Dr GUERRA DE MACEDO (Brazil), as a sponsor of the draft resolution mentioned by the Chairman, expressed the hope that it would come before the Committee for discussion, especially as its purpose was to implement a United Nations General Assembly resolution and not to impose an additional burden on WHO's budget.

(For approval of draft resolution, see summary record of the eighth meeting, section 3.)

The meeting rose at 15:40.
SEVENTH MEETING
Friday, 24 May 1996, at 9:00

Chairman: Dr O. SHISANA (South Africa)

1. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 30 of the Agenda (continued)


IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4) (continued)

Global strategy for the prevention and control of AIDS (resolution WHA42.33)

Professor SHAIKH (representative of the Executive Board) said that the Global Programme on AIDS (GPA) had been disestablished on 31 December 1995 in accordance with Executive Board and Health Assembly resolutions endorsing the establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS), which was cosponsored by UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. Those organizations had all signed a Memorandum of Understanding. An Office of HIV/AIDS and Sexually Transmitted Diseases had been set up at WHO to maximize the Organization’s contribution to UNAIDS and to facilitate the integration of UNAIDS strategies and policies in WHO activities. HIV/AIDS and sexually transmitted disease units had been set up in each of the regional offices under the regular budget. All Member States had emphasized the importance of WHO’s technical leadership of the health aspects of the HIV/AIDS epidemic. A request had been made for health expertise to be reflected in the membership of the UNAIDS Programme Coordinating Board. The Board had also reviewed and noted the Director-General’s report on implementation of the global strategy for the prevention and control of AIDS.

The Executive Board had recommended a draft resolution for adoption in resolution EB97.R19.

Dr GUERRA DE MACEDO (Brazil) welcomed the establishment of UNAIDS. She proposed that paragraph 6(c) of the resolution recommended in resolution EB97.R19 be amended to read:

to strengthen surveillance of the pandemic and development and planning of, and resource mobilization for, national HIV/AIDS/STD programmes, in partnership with UNAIDS and its cosponsors,

and that the phrase "in close collaboration with ministries of health" be added at the end of paragraph 7(c).

Her delegation considered that the UNAIDS budget for 1996-1997 was insufficient to meet global needs. The Memorandum of Understanding between the cosponsors recognized that national governments were responsible for coordinating HIV/AIDS activities at country level. Since many countries relied on UNAIDS funds for programme implementation, it was important to know what percentage of the budget was directly transferred to individual governments and how funds were transferred.

Since UNAIDS acknowledged that sexually transmitted diseases (STDs) constituted a parallel epidemic, WHO must continue to support the STD component of its Office of HIV/AIDS and Sexually Transmitted

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1 Document WHA49/1996/REC/1, Annex 3.
Diseases by providing technical assistance to Member States and promoting interaction with other institutional programmes.

The Brazilian delegation would welcome clarification of the modus operandi of UNAIDS at country level, notably with regard to the functions of national theme groups on HIV/AIDS.

Dr AL-RAHMAN (Sudan) proposed that a fourth preambular paragraph be added to the resolution recommended in resolution EB97.R19, to read:

Noting with concern that the funds allocated so far by the UNAIDS programme to support countries in combating HIV/AIDS are significantly less than those allocated by GPA in the previous biennium;

He further suggested that paragraph 3 be deleted or redrafted in less emotional terms reflecting the true situation.

Questioning the use of "ENDORSES" as the verb governing paragraph 5(a), he proposed that the paragraph be reworded to request the United Nations Economic and Social Council to reconsider the formula of membership of the Programme Coordinating Board of UNAIDS to ensure more balanced representation of WHO regions.

With a view to discouraging dilution of efforts by referral to other ministries (such as ministries of social affairs), paragraph 6(a) should be amended to contain an appeal to Member States for continued strong political commitment to national AIDS prevention efforts and for ministries of health to be entrusted with a leading role in collaborating with UNAIDS and its cosponsors.

Dr JAYASURIYA (Sri Lanka) suggested that WHO Representatives should serve as country-level UNAIDS coordinators since they would be better qualified for the role than the UNDP resident representatives. He also endorsed the suggestion by the delegate of Sudan that ministries of health be encouraged to play a more prominent role in UNAIDS.

Dr EMIROGLU (Turkey) said that, sadly, AIDS was still a major global problem and the epidemiological data were not promising. The disease would not prove easy to control, especially in developing countries where it had reached endemic or epidemic proportions. She stressed the special importance within the framework of UNAIDS of measures to protect young people, involving the private sector, and promoting condom use.

The Turkish delegation favoured a multisectoral approach to prevention and hoped that UNAIDS would clarify the role of United Nations bodies at country level. Successful worldwide case studies should be properly reported with a view to sharing experience. WHO country offices and collaborating centres must be strengthened to enhance programme effectiveness and monitor cooperation between sectors.

Turkey supported the resolution recommended in resolution EB97.R19.

Dr KÖKÉNY (Hungary) supported the resolution recommended in resolution EB97.R19 as amended, particularly with regard to the strengthening of WHO's leading role in UNAIDS. It was greatly to be hoped that through cooperation with UNAIDS, central and eastern Europe would develop exemplary, cost-effective and comprehensive national AIDS control programmes with a view to diminishing AIDS-related morbidity, mortality, discrimination and suffering. The alternative was an epidemic perhaps on the scale of that in southern South-East Asia. Increased intravenous drug addiction and the growing need to protect health personnel were new challenges facing the central and eastern European countries.

Hungary wished to seize the opportunity of collaborating closely with UNAIDS. A multisectoral AIDS programme had been set up with government funds under the auspices of the national AIDS committee.

Dr SIDHOM (Tunisia) reminded the Committee of the discussions in the Executive Board and Health Assembly when UNAIDS had first been mooted, concern being expressed about the potentially negative impacts on programme implementation at country level of a transitional period between programmes, which must be kept as short as possible. That cause for concern remained.
Despite its social, economic and cultural ramifications, HIV/AIDS was primarily a health problem. Health personnel at all levels should thus be the driving force in the fight against the disease. WHO must maintain a leadership role in the Joint Programme, but it should not be diverted from its international responsibilities during the transitional period. Stronger provision should be made for participation at regional level and greater coordination and integration - especially at that level - with programmes such as those related to STDs, tuberculosis and visceral leishmaniasis.

Agreeing that ministries of health should assume leadership at national level, he joined in supporting the recommended resolution, as amended by the delegate of Sudan.

Dr PRATHAPA (Malaysia) commended the staff of the former GPA on their excellent work and pledged his country’s commitment to UNAIDS.

A prevention and control programme based on epidemiological evidence and ethical, moral and religious values had been initiated in Malaysia, and the involvement of nongovernmental organizations was being encouraged. An improved nationwide information management system was currently being assured. Collaboration with UNAIDS at country level was being expanded to include ASEAN and the Regional Office for the Western Pacific. Malaysia appreciated support received from WHO and looked forward to further improvements in information exchange and technical support through UNAIDS.

Dr DAULAIRE (United States of America) said that his Government strongly supported the resolution recommended in resolution EB97.R19 which commended the work of GPA and called for close collaboration between WHO and UNAIDS. The cosponsors of UNAIDS deserved high praise for their diligence, and its direction was to be commended on responsible and well-considered action during the first five months; the United States fully approved the current "governance" structure. As the Secretary of Health and Human Services had stressed, any breach in international solidarity would favour the virus. The United States thus fully backed UNAIDS, and remained committed to ensuring continued coordination between the Joint Programme and WHO.

Especially noteworthy were the underlying multisectoral vision and the explicit recognition that effective action to counter the AIDS pandemic required deep involvement of the health sector, albeit with a sharing of leadership at both national and global levels. The United States as major donor believed that a well defined and properly supported and implemented multilateral effort was essential for bilateral prevention and mitigation programmes and the attainment of the ultimate goal of eliminating the pandemic.

Most of the prevention and mitigation efforts to be carried out by the United Nations would be undertaken through the combined work of each of the six cosponsors. The Committee of Cosponsoring Organizations had a crucial role to play in ensuring consistency, coordination and support for UNAIDS activities and strategies. However, the organizational mandate of, and financial support from, each of the cosponsors had yet to be clearly defined. It was essential that each of them should allocate sufficient resources for the performance of its mandate, and that all possible extrabudgetary support - including the use of the global appeal - be explored.

Mr MOEINI (Islamic Republic of Iran) shared the concern which had been voiced regarding the low budget allocated to activities at country level, and fully agreed that ministries of health must assume a leading role. There was a need for clarification of the formula for distributing seats on the Programme Coordinating Board, since the UNAIDS system for dividing countries between regions seemed to differ from that of WHO and, surprisingly, fewer seats on the Board were allocated to the most vulnerable and densely populated regions of the world. The Iranian delegation thus supported the amendment proposed by the delegate of Sudan whereby the recommended resolution would call for reconsideration of the formula of membership of the Board. He further proposed that it be pointed out, in paragraph 5, that WHO would be an appropriate body in which to hold elections to the Programme Coordinating Board.

Professor BADRAN (Egypt) said there was no need to emphasize the scale of the HIV/AIDS pandemic and its disastrous consequences for human lives and development. Although the disease had social, economic, cultural and political ramifications, the magnitude of its impact on health could not be overestimated. WHO should therefore assume the leading role in the control effort. The importance of preventive measures must also be stressed, particularly in countries which had so far been blessed with low prevalence.
Egypt was especially concerned to promote blood safety since most HIV/AIDS cases in Egypt were connected with blood transfusion and renal dialysis. Blood safety was also an important measure against the hepatitis virus, particularly the new forms increasingly prevalent in developing countries. He called for more concerted action at both country and regional level and stressed the primary responsibility of national governments in the fight against AIDS. There must also be greater collaboration with the sponsors of other programmes.

He agreed with earlier speakers that WHO should be accorded the leading role in the initiative and that ministries of health should serve as the focus for all HIV/AIDS-related activities.

Mr SAKAI (Japan) observed that HIV/AIDS was spreading throughout the world, with an unprecedented impact on health and development in developed and developing countries alike. Given the gravity of the situation, its prevention and control should be considered a global priority. Japan was committed to enhancing its international contribution through multilateral and bilateral channels, and urged other Member States to participate further in the international response to the HIV/AIDS epidemic.

Although the Joint Programme was already under way, the importance of WHO’s technical leadership remained unchanged and must be emphasized. The manner of WHO’s collaboration with UNAIDS required further clarification. He asked how the Organization would maintain its activities in blood safety, reproductive health and tuberculosis control within the UNAIDS coordinating framework, and called for the preparation of a progress report, in close collaboration with UNAIDS, with a view to ensuring that WHO was fully involved in HIV/AIDS prevention and control.

Professor REINER (Croatia) supported the resolution recommended in resolution EB97.R19. It was evident from the Director-General’s report on UNAIDS that much had been achieved in terms of managerial and organizational activities and legal provisions, but even with 111 staff engaged on the project, not enough time had passed to permit more concrete results.

AIDS, shrouded in myths as if it were some mediaeval plague, could in fact be seen as just one more global disease. Therefore, the Director-General, his staff and the Executive Board must be urged to ensure that the Organization - whose mission it was to tackle disease - played the leading role in UNAIDS. He agreed with the remarks by the delegates of Sri Lanka and Tunisia and expressed surprise that the country coordinators for UNAIDS were representatives of UNDP and not WHO.

Dr CICOGNA (Italy), speaking on behalf of the European Union, said that its member countries were mindful that informal consultations were under way elsewhere in the United Nations system. They consequently proposed the deletion of paragraph 5(b) of the resolution recommended in resolution EB97.R19, and the addition of a new paragraph 6, to read:

ENCOURAGES Member States to complete the consultations on mechanisms for future elections to the Programme Coordinating Board as soon as possible.

The subsequent paragraphs would be renumbered accordingly.

Mr VAN REENEN (Netherlands), commending the report, nevertheless noted with disappointment that it contained very little mention of WHO’s own contribution to UNAIDS; WHO had established a liaison office which appeared to be more concerned with building up a separate WHO programme on AIDS than with channeling WHO’s efforts within UNAIDS as it was supposed to do. The technical contribution of WHO programmes on, for example, tuberculosis, blood safety, STDs, reproductive health and health promotion was extremely important for UNAIDS, and closer direct cooperation between UNAIDS and those programmes was called for.

The Netherlands therefore proposed two amendments to the recommended resolution. First, paragraph 7(b) should read:

to provide technical guidance to UNAIDS on WHO’s health policies, norms and strategies, and to facilitate direct cooperation between UNAIDS and the relevant WHO programmes and divisions;
Secondly, the second part of operative paragraph 7(b) would be reworded as a new paragraph 7(c) to read:

...to facilitate the incorporation of UNAIDS-specific policies, norms and strategies into the activities of WHO at global, regional and country levels...;

The words "where appropriate" had been deleted because the Netherlands held that no qualification was needed.

Regarding the transfer of the balance of funds from GPA to UNAIDS, he recalled that in April 1995 the Management Committee of the former GPA had recommended that a minimum of US$ 20 million of GPA's 1994-1995 income be carried forward to support UNAIDS activities during the first quarter of 1996. It had also recommended that the Programme's assets and the unobligated balance remaining after 31 December 1995 be transferred to UNAIDS, with the exception of an estimated sum of US$ 2.3 million to be retained by WHO to meet expenses related to the closure of GPA. Any unspent portion of the retained funds was to be transferred to UNAIDS.

The current situation was that WHO had transferred US$ 20 million to UNAIDS and was holding US$ 17 million in escrow to cover the cost of possible adverse rulings by the ILO Administrative Tribunal on appeals by former GPA staff against their dismissal after the closure of GPA. If the Tribunal were to establish the Organization's liability and to award damages to the claimants, were the costs to be met from the former GPA Trust Fund (extrabudgetary money) or from the regular budget? The letter sent by Dr Hu Ching-Li (Assistant Director-General) to the Governments of donors to GPA had indicated that it was WHO's established policy that the costs of litigation were to be met by the WHO programme for which the appellant had worked when the alleged action occurred. The position of the Netherlands was that such costs ought to be charged to the regular budget and not taken from voluntary contributions designated by donor countries for activities in the field of HIV/AIDS. WHO was responsible in its capacity as an employer for all employment issues, including litigation concerning hiring and firing procedures. The Netherlands did not seek a decision of the Health Assembly on the matter. It was a legal dispute to be sorted out between WHO and contributors to the former GPA Trust Fund. However, the Netherlands wished to place on record that it did not share the view put forward in Dr Hu's letter. The establishment of a policy or practice required either the explicit consent of the parties involved (the donors to GPA) or their acquiescence. The Netherlands had already challenged WHO's position in a written reply to Dr Hu's letter. By making an explicit statement to the same effect before the Health Assembly, it wished to prevent acquiescence on the part of the donors being invoked as legal grounds for charging the costs of the appeals to extrabudgetary funds.

The issue had wider implications for other extrabudgetary-funded programmes. The fact that in the present instance UNAIDS would benefit from the full transfer of the balance of the GPA Trust Fund was immaterial. The real issue was the relation between WHO and governments which provided extrabudgetary contributions to WHO programmes or special programmes in general. Pending the outcome of the legal dispute, the Netherlands called on WHO to transfer to UNAIDS as soon as possible the remainder of the unobligated balance, i.e. US$ 17 million.

Mr ÖRTENDAHL (Sweden) commended the Director-General and his staff for their support for UNAIDS. UNAIDS was a unique, international cooperative health venture and contributions from relevant WHO programmes and divisions were extremely important. His delegation supported the amendments proposed by the Netherlands to paragraph 7 of the recommended resolution.

Dr HEIKEL (Morocco) said it was clear from the report on UNAIDS that the programme was doing remarkable work. However, Morocco supported all the amendments proposed by Sudan. Controlling the spread of HIV/AIDS had many connotations for human rights, human development and ethics. HIV/AIDS, however, was a disease, a public health issue. WHO ought not to be simply a funding agency within the new Programme, since it was a technical agency with a great deal of proven expertise to share. It must maintain the leading role in UNAIDS in two major domains: surveillance and the management of HIV/AIDS patients; and coordination with other health-related activities such as programmes on reproductive health, tuberculosis, STDs, health promotion and the organization of health systems at the regional and country levels. At national level the ministries of public health had to continue to be the focal point of multisectoral strategies.
Dr SOMBIE (Burkina Faso) paid tribute to WHO for having set up an HIV/AIDS programme at the beginning of the epidemic to assist Member States, and thanked the international community for having set up UNAIDS. Nonetheless, there was cause for concern.

First, there was the relatively slow start to the Joint Programme. At the Forty-eighth World Health Assembly Burkina Faso had advocated a harmonious transition from GPA to UNAIDS. Yet since December 1995 no activity in Burkina Faso had been financed from the UNAIDS budget, even though the country’s programme of activities and the budget for 1996 had been approved by UNAIDS. The technical adviser for the UNAIDS theme group for Burkina Faso, Mali and Niger had not even been appointed. There had thus been a break in support for the national programme. In Burkina Faso, WHO headed the theme group but UNDP held the purse strings. The letter of agreement had been signed by the Government and by UNDP, whereas applications by the Government had to go through the head of the theme group, which was a lengthy process. To remedy delays, Burkina Faso suggested strengthening WHO’s managerial role in the programme, so that it was more than just a postbox between national authorities and UNAIDS. WHO was in direct contact with ministries of health and could, for example, recruit advisers or consultants.

Secondly, the leadership of WHO had not been clearly recognized within the UNAIDS programme, despite its undeniable experience and the continued presence of staff from the former GPA. UNAIDS could only benefit by giving WHO the leading role, as an available, reliable resource with appropriate health policies, norms and strategies.

Burkina Faso therefore suggested inserting a further paragraph in the resolution recommended in resolution EB97.R19, inviting UNAIDS to take account of the experience of WHO and to make it a co-sponsoring technical and managerial agency in the fight against HIV/AIDS, in accordance with resolution AFRO/RC45/R1 adopted by the Regional Committee for Africa.

Mr ISLAM (Bangladesh) noted with satisfaction that WHO, despite yielding some of its HIV/AIDS-related tasks to UNAIDS, would continue to play an independent role in prevention and control. The HIV/AIDS epidemic was expanding at an alarming rate, particularly in developing countries, and imposing a severe additional burden on their hard-pressed health services. Although Bangladesh had only a few known cases of AIDS, and although it had an active prevention programme, the situation could at any time become uncontrollable given the country’s limited resources, notwithstanding strong political will. His delegation therefore called on WHO to continue its efforts to develop a vaccine and to intensify its HIV/AIDS control programmes in developing countries. For its part, Bangladesh would pursue its national prevention efforts and would collaborate closely with UNAIDS and WHO.

Mr HOU Zhenyi (China) said that the HIV/AIDS situation was extremely critical and called for a public sense of urgency and responsibility. China hoped to see UNAIDS meet expectations and offer improved coordination, guidance and support in prevention and control at the country and global levels alike; it also hoped to see WHO play a key technical role in view of its network of technical cooperation and its successful experience. Special attention must be given to high-risk areas and developing countries. For its part, the Chinese Government attached great importance to the prevention and control of HIV/AIDS, the threat and prevalence of which were increasing. In 1995, the Chinese State Council had approved a recommendation on the subject. In order to intensify guidance, it had set up a permanent coordinating committee. China had established a UNAIDS coordinating working group, involving many departments, to formulate a national strategy and plan for information, health education and the control of HIV/AIDS in the period 1996-2000. The priorities for 1996 were to train health professionals, to conduct an epidemiological study and to monitor risk factors in blood transfusion. The Government wholeheartedly supported the work of HIV/AIDS prevention and control, in order to check the threat of the disease to the health of its people.

Mr RAI (Indonesia) said that all must acknowledge the importance of the Joint Programme, despite a certain slowing down of activities during the transition from GPA. However, WHO ought to play the leading role, since the control of HIV/AIDS was primarily a health matter. He endorsed the view expressed by previous speakers that a more balanced composition of the Programme Coordinating Board was desirable.

Professor GUIKAHUE (Côte d’Ivoire) welcomed the launching of a programme coordinated by the United Nations system as a whole, and congratulated its Executive Director on his appointment. Côte
d'Ivoire would strive to merit its selection as the headquarters for the West African subregion by making facilities available. Côte d'Ivoire approved the draft resolution under discussion, but considered that commitments should be more clearly spelt out; paragraph 6(b) should be far more explicit: the first part up to the word "prevention" was very important, but the remainder was rather vague. The Health Assembly must take a stand with regard to treatment. What commitment could it assume in ensuring that developing countries would have access to antiretroviral drugs? Prevention and treatment were equally important. He was afraid that in a few years time there would be two types of country represented at the Health Assembly: advanced countries which offered treatment and where the diseases had been checked; and developing countries which had to be content with prevention and treatment of opportunistic infections. Despite the fact that the world was now a "global village" and information on advances in science travelled fast, antiretroviral therapy was not yet possible in developing countries. He hoped for a commitment to rectify the situation without delay.

Dr PAVLOV (Russian Federation) joined in welcoming the report and the progress already made by UNAIDS. Many organizational, coordinating and administrative problems had been solved, and staff matters were being settled, as were matters at country level involving ministries and health institutions. Subregional offices were being set up and regional advisers appointed. All that would help to coordinate the process and would assist countries in implementing their national AIDS programmes. WHO must continue to support UNAIDS, in a leading and coordinating role. His delegation wished the Joint Programme every success.

Mrs TINCOPA (Peru) agreed with many of the statements made by previous speakers. Peru firmly supported the resolution recommended in resolution EB97.R19 and the proposed amendments, especially with regard to strengthening WHO's leading role in the prevention and control of HIV/AIDS. Cooperation and support were essential if many countries, including Peru, were to be able to maintain their programmes. The Peruvian Ministry of Health was currently improving its programme and extending it at national level. It needed technical cooperation and guidance, and counted on close cooperation with WHO and UNAIDS. Commending UNAIDS for its work, her delegation appealed for a continuation of the work of orientation, mobilization and coordination with health ministries in developing countries.

Dr BERGEVIN (Canada) endorsed the comments by the delegate of the United States of America. Canada strongly supported the recommended resolution as presented. It commended the work done by the Executive Director of UNAIDS and his staff, and noted with satisfaction the progress made in a mere five months. UNAIDS could serve as a model of collaboration within the United Nations and deserved the full support of Member States. From 7 to 11 July 1996, Canada would host the Eleventh International Conference on AIDS in Vancouver, and would facilitate participation from developing countries, thereby demonstrating its continued support for UNAIDS.

Professor LEOWSKI (Poland) expressed support for the recommended resolution with the amendments put forward by the Netherlands. In his country's experience, UNAIDS was already producing results. Poland's revised AIDS programme, which incorporated a more multisectoral approach along the lines of UNAIDS, had been fully endorsed by parliament for implementation by the Government as a whole, not just by the Ministry of Health. Though HIV/AIDS had particular significance for health, its implications were far broader. An agreement had been signed by UNDP, WHO and the Polish Government on the national programme. Poland had also succeeded in securing greater international cooperation on a bilateral basis with, inter alia, the Governments of France, Germany, and the United Kingdom of Great Britain and Northern Ireland.

Dr DANKOKO (Senegal) commended WHO on its unwavering support for national AIDS control efforts. In Senegal, AIDS control was increasingly involving those concerned with socioeconomic development; as an example, collaboration between public health specialists and religious leaders had resulted in significant increases in public awareness, including what had come to be known as "moral contraception". If those efforts continued, it was hoped that Senegal could keep the prevalence of AIDS at an acceptable level until the century's end. Irrespective of other sectors HIV/AIDS remained a public health problem, albeit with a multiplicity of socioeconomic determinants. His delegation would view with favour all proposals which
set ministries of health and WHO itself in the forefront of technical coordination. He endorsed the remarks by the delegate of Côte d'Ivoire regarding the importance of treatment as well as prevention.

Ms INGRAM (Australia) favoured WHO's close involvement with UNAIDS as a cosponsor and emphasized its role in providing expert technical advice; WHO must maintain a strong technical capability and ensure that adequate funding was available for crucial services such as blood security. It should continue to contribute to such measures in its own right, while more generally ensuring the integration of HIV/AIDS activities into appropriate WHO divisions, programmes and policies, and the mobilization of resources within the existing budget. Her delegation would welcome more detailed information on such integration. Like that of the Netherlands, the Australian delegation looked to WHO for advice on the transfer of remaining GPA funds to UNAIDS.

Dr AL-JEFRI (Saudi Arabia) voiced appreciation of the international efforts undertaken at various levels to combat HIV/AIDS. His delegation felt, however, that the transfer of responsibility for the programme had been too rapid, and had noticed no positive changes or developments in the intervening five months. On the contrary, it was afraid that some of the collaborating countries might have been adversely affected. He endorsed the amendments proposed by the Islamic Republic of Iran and Sudan to the recommended resolution.

Dr DLAMINI ZUMA (South Africa) expressed support for the recommended resolution and commended GPA on its past achievements. The response to HIV/AIDS must be multisectoral, and UNAIDS should be seen as a mechanism to coordinate the 10 years of experience accumulated by the different cosponsoring agencies, rather than an agency to deal exclusively with the problem. South Africa hoped that resource commitment by the cosponsors would increase, as the epidemic demanded, and called for a significant commitment by WHO to the incorporation of HIV/AIDS prevention and control activities in its programmes on blood safety, tuberculosis, sexually transmitted diseases, and health promotion, in which it should continue to play a leading role in providing technical guidance. Considering that UNAIDS had been operational for only five months she was encouraged by its management style, strategy and work plan. Management must be capable of a swift response to the needs of Member States, particularly those in Africa which were bearing the brunt of the epidemic, while the involvement of all Member States was crucial to the success of the Joint Programme. She hoped that UNAIDS would support and develop national capacities, especially for fund-raising. The 10 years of valuable experience accumulated at country level should be enhanced by the Joint Programme, not lost in the transition. South Africa had become a modest inaugural donor to the first UNAIDS core budget and supported one of the technical teams in Africa.

Dr TIERNEY (Ireland) expressed support for the recommended resolution and commended the Executive Board and the Director-General on their work in that regard. Stressing the need for a focused and targeted response to HIV/AIDS, he pointed out that a dilution of effort would not help. He therefore favoured the retention of the words "where appropriate" in paragraph 7(b) of the recommended resolution or any amendment thereof. That would also be consistent with the inclusion of "as appropriate" in paragraph 7(e)(ii). It was important to remember that the wording of the text was the product of careful consideration by the Executive Board.

Dr VASSALLO (Malta) urged WHO to pursue and intensify its work on what was a very serious health problem through its already significant input into UNAIDS. Malta stressed the importance of continuing to evaluate the strategies used against the disease and, if necessary, to introduce changes that might improve on the results achieved so far. His delegation strongly supported the recommended resolution with the amendments proposed by Ireland, Italy, and the Netherlands.

Ms CHRISTIANSEN (Denmark) said that given the general need for improved coordination within the United Nations, UNAIDS must be successful as an innovation in interagency cooperation. Denmark's allocation to UNAIDS would be considerably larger than its previous support for GPA. However, it would not hesitate to cut that contribution if the cosponsors failed to show a firm commitment to action. What was at stake was not coordination for coordination's sake, but the control of a pandemic. Regarding GPA, she
shared the concerns raised by the delegate of the Netherlands and supported calls to transfer to UNAIDS the remainder of the unobligated balances. She supported the Netherlands' amendments to the recommended resolution.

Mrs DHAR (India) submitted that the key features of WHO's role as a cosponsor of UNAIDS were: an expanded response to the epidemic; greater coordination within participating countries; integration of HIV/AIDS activities into national health systems; liaison with other United Nations partners; and resource mobilization to intensify control activities. Although ultimate responsibility for the coordination of HIV/AIDS control at country level lay with governments, UNAIDS activities should complement and support governmental, public and nongovernmental efforts. She gave a brief survey of HIV/AIDS control in her own country since 1987, emphasizing the conscious effort to review progress and to involve nongovernmental organizations in the strategy.

Given the growing menace of HIV/AIDS, it would be more appropriate to concentrate the scarce technical and financial resources of WHO and UNAIDS on research, information and prevention measures in the countries most seriously afflicted in the Third World, rather than spreading the resources thinly and including advanced countries which had means of their own to combat the disease. The composition of the Programme Coordinating Board should be adjusted accordingly to allow greater representation of Africa and Asia, the continents most ravaged by HIV/AIDS. Her delegation was confident that the experience acquired on those continents would prove valuable to WHO and UNAIDS in finding appropriate solutions to the HIV/AIDS problem.

Her delegation supported the recommended resolution, with the amendments proposed by the Islamic Republic of Iran and Sudan.

Ms HERNÁNDEZ (Cuba) submitted that the principal objective of UNAIDS at the country level should be to strengthen national capacities for planning, coordinating, implementing and monitoring the response to the AIDS problem by all bodies and institutions and to coordinate the support of the United Nations system to national programmes. Cuba had become involved in the new global strategy based upon the multisectoral approach, and a project of cooperation with UNAIDS had been developed. In Cuba the Ministry of Health was considered as the coordinating body representing State and Government, and WHO as the United Nations agency representing and coordinating the activities of UNAIDS.

The national theme group on HIV/AIDS in Cuba had requested her to bring to the attention of the Health Assembly a problem which had serious implications and which she knew other countries had also encountered, namely the non-receipt of funds from UNAIDS pledged in support of the national HIV/AIDS control programme. Apparently it had not yet been decided through which agency the funds should be transferred and administered.

Mr PÉREZ (Spain) welcomed the launching of the Joint Programme and the work of the Programme Coordinating Board. Spain would continue to provide support for national AIDS control measures, in coordination with UNAIDS and WHO, in order to cooperate with third parties, especially developing countries of similar cultural and linguistic identity. It was essential to have proper coordination between UNAIDS and the other United Nations agencies, and most particularly WHO, not only to obtain resources at country level, but also to ensure coordination between WHO's regional offices and UNAIDS in respect of AIDS control programmes. He gave an assurance of Spain's support in developing the programme for 1996-2000 with a clearly defined budget and adequate staff.

Dr JEANFRANÇOIS (France) said that her delegation fully supported the amendment proposed by the delegate of Italy on behalf of the European Union.

She observed that, while HIV/AIDS was a multifaceted and multisectoral matter, it was first and foremost a disease and consequently fell firmly within the purview of WHO. For that reason it was important that WHO should reaffirm its leadership role within UNAIDS.

She shared the views expressed by the delegates of the Netherlands and Denmark regarding the transfer of USS 17 million from GPA to UNAIDS, in accordance with the recommendations of the GPA Management Committee. France could not agree to voluntary contributions intended for AIDS prevention and control
activities being used to pay compensation to former GPA officials should they win their appeals before the ILO Administrative Tribunal.

Mr MUYLLE (Belgium) congratulated the entire UNAIDS team on the outstanding work already done. Its efficiency augured well for the future. He also paid tribute to all those involved in the former GPA. He supported the amendment to paragraph 7(b) of the recommended resolution proposed by the Netherlands, the effect of which would be to improve coordination and cooperation by reducing intermediaries to a minimum.

He did not wish to comment on the matter of the appeals brought by former GPA officials before the ILO Administrative Tribunal, nor on the issue of compensation. However, he could not agree with the view that compensation should be paid from the remainder of the Trust Fund. The decision of the GPA Management Committee should be respected, and WHO should therefore transfer without delay the amount of US$ 17 million remaining from the GPA Trust Fund to UNAIDS, with the proviso that part of the sum would be held in reserve in case of a legal ruling that any compensation should be paid from the Trust Fund and not from the regular budget of WHO.

Dr LOUA (Guinea) said that his country's apprehensions when UNAIDS began operations in January 1996 had been allayed. The theme group in Guinea was chaired by the WHO Representative. He called upon UNAIDS to strengthen the technical capacities of the country teams dealing with AIDS prevention and control. His delegation supported the recommended resolution with its various amendments.

Dr BAATH (Syrian Arab Republic) shared the concern of previous speakers that the funds allocated so far to the UNAIDS programme to help countries in combating HIV/AIDS were far less than those collected by GPA for the same purpose in previous years. Their concern should find expression in the recommended resolution. He therefore proposed the insertion in paragraph 6(a) after the word "efforts", of the phrase: "and give the ministries of health a leadership role in collaborating with UNAIDS and its cosponsors". Lastly, he called on the Director-General to play a larger role in ensuring the availability of safe blood products.

Mr EIDHAMMER (Norway) welcomed the new Joint Programme, not least because it brought together the major multilateral actors in a concerted global effort. Norway would support the Programme with substantial funding. He agreed with the United States delegate and others that the governance structures of UNAIDS should remain as they were. He pointed out that the formula for the membership of the Programme Coordinating Board was the product of lengthy and complicated negotiations between United Nations Member States and was an integral part of the general consensus to establish the new Programme. He did not believe that much would be gained from reopening the negotiations. There was now an urgent need to concentrate on implementation, not least to achieve tangible results at country level. Emphasizing the role of national governments at country level, he agreed with the delegate of Poland that, although ministries of health would naturally take a lead role, AIDS control was a matter for governments in their entirety.

The structure of UNAIDS at country level had been decided with the aim of bringing together all the agencies involved in combating AIDS, in close collaboration with governments. He pointed out that the Memorandum of Understanding between the multilateral agencies did not state that a United Nations coordinator should be the coordinator of the new programme as such, but merely that the resident coordinator should establish a United Nations theme group on HIV/AIDS and designate a chairperson from among the members. In most cases the chairperson was likely to be the WHO Representative.

Norway supported the recommended resolution with the amendments proposed by the Netherlands.

Dr BERGER (Switzerland) said her country, aware of the alarming progression of the HIV/AIDS epidemic and of its grave and far-reaching consequences, welcomed and supported the establishment of UNAIDS and commended WHO on its invaluable efforts in combating the disease. A global approach to the problem, covering all the various dimensions, was urgently needed. WHO should contribute to UNAIDS the competence and experience gained through GPA so as to ensure optimal collaboration. To that end, it was essential that UNAIDS headquarters remain in Geneva.
Switzerland supported the recommended resolution, together with the amendment proposed by Italy on behalf of the European Union concerning arrangements for the election of the Programme Coordinating Board and the proposal made by the delegate of the Netherlands on the transfer to UNAIDS of the unutilized balance from GPA.

Dr AL-JABER (Qatar) supported the recommended resolution. The membership of the Programme Coordinating Board of UNAIDS was not representative of the countries most seriously affected by HIV/AIDS, and it should be reformulated. WHO's role in the Joint Programme was small, and that of the regional offices, virtually nil. He therefore supported the amendment proposed by several delegations with a view to rectifying that imbalance - HIV/AIDS was, above all, a health matter. His country's experience had shown that action to prevent the disease had been abating over the past two years, while incidence was on the rise.

Dr SOLARI (Uruguay) supported the recommended resolution and had no strong feelings about the various amendments. Uruguay was deeply concerned, however, over the direction taken in recent years by the international community's response to the HIV/AIDS pandemic, especially at the local level. Two trends were discernable: a quest for ways of improving coordination among the various United Nations organizations, Member States and interested nongovernmental organizations; and a reduction of real support to national programmes, which weakened their capacity to check the spread of the disease and to organize proper care for HIV-infected people and those suffering from AIDS.

Mr OSMAN (United Republic of Tanzania) supported the recommended resolution with the amendments proposed by Sudan and supported by other delegations. WHO must buttress the response of Member States to HIV/AIDS and STDs through training and the maintenance of technical capabilities. The Organization should also collaborate in all aspects of resource mobilization to combat HIV/AIDS, including joint fund-raising efforts with the other cosponsors of UNAIDS and in strengthening the capability of WHO country offices to participate in appeals for funds at country level. Finally, WHO should play a leading role in prevention, care and surveillance in connection with HIV/AIDS and related health problems.

Mr BRIGGS (Jamaica) endorsed the emphasis placed by other speakers on the mission of WHO as a global body specifically set up to spearhead the assault on the world's health problems and to coordinate and support activities at the regional and national levels. Though HIV/AIDS presented multifaceted characteristics, and UNAIDS had the potential to tackle the problem, there was no doubt that WHO, by definition, must have a stronger leading role in directing HIV/AIDS control programmes and evaluating the results. Jamaica therefore supported the recommended resolution with the amendments that sought to strengthen WHO's leadership role in the Joint Programme, to place country-level coordination in the hands of the WHO Representatives and to include the WHO regional offices in the coordination and control structure.

Dr KYABAGGU (Uganda) said his country had been among the first to adopt an open policy on HIV/AIDS prevention and control and to take a multisectoral approach. One of the lessons it had learned was that, although HIV/AIDS was fundamentally a disease like any other tackled by the health sector, its effects were so diverse that all sectors had a role to play in prevention and control strategies and, above all, in dealing with the socioeconomic impact of the pandemic. Accordingly, the Ugandan Government saw UNAIDS as a step in the right direction. It was concerned, however, about the transition from GPA to UNAIDS and sought reassurance that national programmes would not be interrupted by any additional delays in the flow of resources. He supported the recommended resolution together with the proposed amendments.

Mr MESSAOUI (Algeria) said his country strongly supported UNAIDS and the recommended resolution before the Committee. As a member of the UNAIDS Programme Coordinating Board, Algeria had attended the preparatory meetings and wished to pay tribute to the parties involved. UNAIDS, bringing together several organizations of the United Nations system, was only five months old; it had not yet had time to demonstrate its utility and its work could not be judged properly. His delegation supported such
initiatives as the revitalization of the theme groups under the auspices of the United Nations resident coordinator, and the global appeal.

Mr SYKORA (Slovakia) commended the Executive Director and staff of UNAIDS for an excellent example of interagency cooperation and supported WHO’s involvement within the framework of the Memorandum of Understanding signed by the executive heads of the cosponsoring organizations. WHO should play a leading role in providing technical expertise. Slovakia supported the resolution recommended by the Executive Board, as amended by the Netherlands and by Italy on behalf of the European Union.

Dr TUMBA (Zaire) supported the recommended resolution, together with the proposed amendments, and acknowledged that constructive efforts had been made to realize UNAIDS. She agreed with the comments made by the delegate of Côte d’Ivoire and stressed that, as part of WHO’s technical leadership, the same facilities for prevention and for treatment with antiretroviral drugs must be made available to African and developed countries. Given the precarious political situation in the majority of African countries, the struggle against HIV/AIDS could not be restricted to preventive measures alone. The wars that pitted residents of African countries against one another often entailed massive migratory movements making people refugees and favouring the spread of problems linked to the disease. The symptomatic treatment of HIV-infected individuals in developing countries would thus be of great help in the struggle against the pandemic.

Mr KHAN (Pakistan) said his delegation was convinced that UNAIDS leadership would do much to facilitate the coordination of and the implementation of measures to combat HIV/AIDS. WHO must play a pivotal role in all aspects of the Programme. Pakistan shared other delegations’ concern that the funds allocated so far to support countries were inferior to those earmarked by GPA a year earlier. The Pakistan Government had assigned high priority to measures to control the spread of HIV/AIDS; in 1995-1996, its budgetary provisions had been 16 times higher than in 1993, and the Government hoped to maintain the same rate in coming years. Despite the country’s conservative norms, the Government had initiated a bold media campaign for education and action on HIV/AIDS. Most public hospitals had been provided with kits for blood screening. Legislation on safe blood transfusion both there and in private hospitals had nearly completed its passage through Parliament. He fully supported the recommended resolution and the amendments that sought to strengthen WHO’s role.

Dr DURHAM (New Zealand) congratulated UNAIDS on the progress made and strongly supported the resolution recommended by the Executive Board as amended by the Netherlands. Technical cooperation between UNAIDS and the WHO programmes and divisions concerned was essential to the effective control of the HIV/AIDS pandemic. She supported Australia’s call for more information and regular feedback on WHO’s activities relating to the control of HIV/AIDS and STDs in accordance with paragraph 7 (e) of the resolution.

Mr SALIH (Maldives) commended the measures taken against HIV/AIDS - a fearful long-term threat whose economic and social consequences were not yet fully apparent. Awareness programmes had been launched in his country long before the first AIDS case had been found, yet the disease was increasing steadily. The Maldives had been enthusiastic about the formation of UNAIDS, but was greatly disappointed with the slow pace of progress; support to its programme was urgently needed, yet UNAIDS had provided seven times less than GPA. HIV/AIDS was primarily a health issue, and WHO’s leadership in efforts to combat the disease must be enhanced and sustained.

Dr STAMPS (Zimbabwe) said the first cases of AIDS in his country had been found in 1985; in 1996 there were about 900 000 HIV-infected individuals. More and more were being cared for in health facilities and community health units. As a result, health workers were increasingly being exposed to HIV and were beginning to leave in search of work in developed countries. Three such cases of transmission had been confirmed, and prevalence among health workers was causing anxiety among non-infected patients. The international community should protect health workers, who faced risks linked, not to lifestyle, but to professional activity. Worldwide concern for protection of health workers should be mobilized; he urged the Health Assembly to adopt a resolution on the subject.
Dr FIKRI (United Arab Emirates) commended the work done by WHO and other organizations to stem the spread of HIV/AIDS. In his country, preventive activities had begun in 1985; a special budget had been allocated and a national programme and action plan had been elaborated, in cooperation with WHO and its Regional Office for the Eastern Mediterranean. UNAIDS must receive strong support so that a worldwide effort could be launched and national services for combating HIV/AIDS strengthened. His delegation supported the recommended resolution as amended by Sudan and the Syrian Arab Republic.

Dr SULAIMAN (Oman) said that UNAIDS must succeed, using the experience accumulated by WHO and individual countries. His delegation endorsed the comments of the representatives of Sudan, Syrian Arab Republic and Islamic Republic of Iran.

Mr KALIMA (Malawi) supported the recommended resolution as amended by Sudan. More help from the developed world was required in the form of funding and technical assistance for the effort to combat HIV/AIDS. Malawi, which favoured the strengthening of collaboration of WHO, UNAIDS and countries within the regional framework and the exchange of technical information to cope with the epidemic, was stepping up its nationwide HIV/AIDS awareness campaigns. His delegation endorsed the suggestion by the delegate of Zimbabwe concerning the protection of health workers: the resolution might include provision for the necessary materials.

Dr GUERRA DE MACEDO (Brazil) echoed the comments by the delegate of Côte d’Ivoire on the cost of treatment with antiretroviral drugs. The international community, including UNAIDS and WHO, should work with the pharmaceutical industry towards appropriate production levels and market costs for such drugs, while the Joint Programme should give priority to the overall problem of treatment costs, which represented a much larger burden for developing than developed countries.

Mrs RINKINEVA-HEIKKILÄ (Finland) said that from the very outset of the HIV/AIDS pandemic, her Government had adopted a multisectoral approach, with the direct involvement of the social sector. Whilst recognizing the primary responsibility of the health sector in combating the pandemic, Finland firmly believed in the need for broad cooperation and a multisectoral approach involving the United Nations system and the Bretton Woods institutions. She commended for their hard work and dedication the direction and staff of UNAIDS, which had received strong professional support from WHO. Finland supported the resolution recommended in resolution EB97.R19 with the amendments proposed by the Netherlands and other countries.

Dr RABESON (Madagascar) said that the WHO Representative in his country had presided ably over the theme group concerned with combating STDs and HIV/AIDS and had always supported the efforts of the Ministry of Health and others against those diseases. Seven ministerial departments were uniting their efforts with UNAIDS, its sponsoring agencies and others to coordinate the national programme. Madagascar subscribed to all the points made in the recommended resolution.

Dr DODD (United Nations Population Fund) said that his organization had been a full partner in the development of UNAIDS, and was continuing to play an active role through the Committee of Cosponsoring Organizations, the Programme Coordinating Board and other mechanisms. Theme groups had been set up in over 90 countries in less than five months: that was just one example of the commendable fashion in which UNAIDS was rapidly moving ahead. UNFPA was playing an active role in those groups and chairing a number of them. It had been seconding a staff member to UNAIDS since 1994, and was finalizing a financial contribution for 1996-1997 expected to total approximately US$ 1 million.

At country level, UNFPA’s support for HIV/AIDS prevention had been provisionally estimated at US$ 19 million in 1995, compared to US$ 14 million in 1994, and was continuing to increase.

In 1995, support had been provided in response to requests from 114 countries in four main areas: the supply and distribution of condoms; HIV/AIDS prevention training providers of reproductive health information and services; in-school and out-of-school education activities on HIV/AIDS prevention; and information, education and communication (IEC) activities on HIV/AIDS as part of population and reproductive health. In 1995, UNFPA had met requests from 53 countries for condom procurement, as
all six regions. That was all the more remarkable because the approved budget for the 1996-1997 biennium had been extrabudgetary. Furthermore, UNFPA had supported HIV/AIDS prevention activities for youth and adolescents in 68 countries. Finally, UNFPA had collaborated with over 50 nongovernmental organizations in country-level HIV/AIDS prevention. Even greater collaboration was expected in the future. Similar measures were also anticipated with UNAIDS and family and reproductive health programmes in areas of mutual concern; for example, in the prevention and management of reproductive tract infections, sexually transmitted diseases, and HIV/AIDS in the context of reproductive health programmes, particularly at the primary health care level. UNFPA was committed to supporting the vital work of UNAIDS at headquarters and country level, and also to continuing its support for national AIDS prevention and control within the theme group mechanism.

Mr BONEV (United Nations Development Programme) said that a representative of his organization had spoken on UNAIDS at the ninety-seventh session of the Executive Board in January 1996. He reiterated the complete commitment and support of UNDP for that Programme.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended WHO on its work in the area of HIV/AIDS prevention and care. The emergence and re-emergence of diseases was clearly highlighted in The world health report 1996. Undoubtedly HIV/AIDS was one of the most devastating diseases of the past two decades. The HIV/AIDS pandemic had received widespread attention from WHO, governments, nongovernmental organizations and the media. Millions of health care providers continued to be at the forefront of AIDS prevention and care. From modest villages in developing countries to urban settings in industrialized countries, health care providers faced the harsh realities of AIDS care on a daily basis. Without a vaccine or effective treatment health care providers, often working under difficult conditions, were the only available source of assistance and hope for people with AIDS.

For health care providers, AIDS care presented a certain risk of infection with HIV or, for example, tuberculosis. The risk was compounded by the fear of contagion and the social stigma associated with such illnesses. The voice of nurses worldwide, the International Council of Nurses (ICN) was primarily committed to quality of care for all people including those with HIV/AIDS; but it was also concerned about the impact of HIV/AIDS on health care providers. He wished, therefore, to call the Health Assembly's attention to the importance of: surveillance of the long-term impact of HIV/AIDS on the recruitment and retention of health care providers; monitoring the trend of HIV infection among health care providers; strengthening measures that reduced the risk of such infection, especially where resources were scarce; and access to adequate and continuous supplies and equipment to protect health care providers and their patients. ICN's concern was also reflected in its various position statements and actions it had undertaken, both on an individual basis and in collaboration with other organizations, most notably WHO, with which a joint declaration on AIDS had been adopted. Guidelines on reducing the impact of HIV/AIDS on nursing/midwifery personnel had been prepared and distributed in 112 countries worldwide, to WHO and to the International Confederation of Midwives. ICN would continue to collaborate with its members and with international organizations in monitoring the HIV/AIDS situation and in responding with appropriate actions to reduce the occupational risk of HIV/AIDS to health care providers and its transmission in the community.

On behalf of ICN, he urged that the resolution recommended in resolution EB97.R19 be amended to reflect the remarks by the delegates of Zimbabwe and Malawi.

Dr HU Ching-Li (Assistant Director-General) said that everyone without exception was concerned about the spread of HIV/AIDS. That was the primary reason why the United Nations had established UNAIDS with its six cosponsors. The cosponsors had already held several meetings in order to define their individual roles. Because HIV/AIDS was essentially a health issue, WHO must continue to play a leading role and to provide technical support to UNAIDS and to Member States through its network of regional offices and WHO Representatives. UNAIDS had been created on 1 January 1996. Even before that date, WHO's Global Policy Council and Management Development Committee had met on several occasions to consider what WHO's role should be, and offices responsible for HIV/AIDS and STDs had been established at headquarters and in all six regions. That was all the more remarkable because the approved budget for the 1996-1997 biennium had made no provision for an HIV/AIDS programme; the entire funding of GPA had been extrabudgetary.
In 1995, 25 staff members had been lent and US$ 1 million had been transferred to UNAIDS for preparatory work. As of 1 January 1996, any remaining funds donated to the Global Programme on AIDS were due for transfer to UNAIDS. However, certain funds had been retained to cover carry-over activities. For 1996-1997, WHO regular budget funding had been allocated for the creation of 10 posts at regional level to support UNAIDS activities; regular budget funding for the six regional offices would total US$ 2 million, while at country level it would total US$ 2.8 million. Despite current economic constraints, two professional and two secretarial posts had been created at WHO headquarters from the regular budget, at a cost of US$ 1.3 million. In addition, the Global Policy Council had decided that, for the 1998-1999 biennium, half of the 2% of the budget allocated to priorities would be devoted to HIV/AIDS, in particular at country level.

WHO had always considered HIV/AIDS as a priority and would continue to offer technical support to UNAIDS. Within WHO itself, some 18 programmes could usefully contribute to UNAIDS, in particular, in those on tuberculosis, blood safety, reproductive health, substance abuse, emerging and other communicable diseases surveillance and control, strengthening of health systems, nursing, essential drugs and drug management and policies.

The role to be played by WHO at country level was also important. Of the 95 UNAIDS theme groups established at country level, covering 112 countries, 77% were currently led by WHO Representatives.

Dr PIOT (Executive Director, UNAIDS) remarked that the discussion had reflected both the successes and failures encountered in establishing UNAIDS. The Programme was clearly not advancing rapidly enough and the rate of progress differed between individual countries. However, in the strategic plan approved by the governing body of UNAIDS, the Programme Coordinating Board, targets had been set for the middle of 1996, and all of them were likely to be reached at both global and country level. After the first four months of UNAIDS, 95 theme groups covering 112 countries had been established, compared with 36 countries at the end of 1995, and an operational framework had been developed for their joint action in support of national AIDS programmes. The primary aims of the theme groups were to improve coordination within the United Nations system and to strengthen national responses to the AIDS epidemic. The groups represented a new way of working within the United Nations system at country level, both in terms of a resolute choice for a multisectoral approach to the problems concerned and cooperation within the system as a whole. The mechanisms for channelling financial support to different countries had also been established. An agreement on that subject had been signed with UNDP and the theme groups had been informed accordingly. The agreement stipulated that UNDP should provide the necessary administrative support but that the chairman of the theme group had the authority to sign for the various funds. In addition, an agreement for administrative support with WHO existed at global level. Letters of agreement with national AIDS programmes had been drawn up for many countries and work plans for most countries had been approved. Furthermore, 32 out of the 42 planned country programme advisers had been selected. A co-ownership mechanism had been used involving the cosponsors and individual countries. A consultation process had been established, since it was necessary for all partners to feel that the commitment they were making was worthwhile. In addition, a framework had been developed for intercountry technical support teams. Such teams had been established, for example, in Côte d'Ivoire and South Africa.

In relation to technical cooperation mechanisms, progress was currently being made in many countries. UNAIDS basic philosophy was that it was a broker for technical cooperation based on the expertise available in each region or subregion. Considerable expertise was now available in the world and a major role for UNAIDS was to facilitate its sharing among countries.

To delegates who had requested clarification regarding the modus operandi of UNAIDS and its cosponsors at country level, he replied that documents giving details were available, and that they would be revised in the light of the programme's experience. The main objective was to strengthen national capabilities for responding to the epidemic through better coordination within the United Nations system. He wished to make it clear that it was not for UNAIDS to coordinate the response to the epidemic within countries themselves. A primary function of the theme groups was as a coordinating mechanism within the United Nations system, at country level. However, in most countries a representative of government participated as a full member or observer in the theme group. Coordination was not a goal in itself but a mechanism to ensure better utilization of resources and to avoid duplication. It was explicitly stipulated in the Memorandum of Understanding that the United Nations Resident Coordinator should designate a member, not necessarily the UNDP resident representative, to chair the theme group. So far, 77% of those chosen...
Nevertheless, harmonization of the activities of the cosponsors was a major challenge for UNAIDS. An early success was the setting-up of a joint WHO/UNESCO/UNICEF/UNFPA group to draw up a programme of technical cooperation in the area of education in schools - a most important area since 50% of those infected with HIV were young.

Several delegates had raised the question of the cost of treatment. Given the number of HIV-infected people in the world, currently estimated at around 20 million, it was clear that greater attention would have to be given to that aspect of the epidemic. UNAIDS was therefore giving a higher priority to treatment and technical cooperation in the area of education in schools - a most important area since 50% of those infected with HIV were young.

A key feature of UNAIDS work was the presence of a country programme adviser or national programme officer to support the activities of the theme groups, which were being encouraged to move from mere coordination to joint action. Those individuals had a difficult task, since they also constituted a bridge between the theme group and the national response to the national AIDS programme and hence they were selected with great care.

Several delegations had expressed concern that the AIDS epidemic was expanding while resources were declining. The total amount of funds to support AIDS activities had increased over the last five years. However, the focus of resource mobilization had shifted to country level; the process had begun even before the creation of UNAIDS and in every biennium there had been a decline in multilateral support to national AIDS programmes. That was still a matter of concern.

Concern had also been voiced that the UNAIDS budget was inadequate. For the current biennium it amounted to some US$ 120 million, which was small compared to the dimensions of the problem. However, UNAIDS was not primarily a funding agency; its functions had been defined as coordination, advocacy, technical cooperation and development of best practice. The donors had considered that UNAIDS should not give direct financial support to national AIDS programmes. However, it had been agreed that, in the short term, such a policy would have led to a major disruption of the national response in countries and funds had been made available. Of the total UNAIDS budget, 60% was destined for country support, US$ 12 million to national AIDS programmes and some US$ 7 million to technical cooperation activities. It must be stressed that HIV/AIDS was not a disease outbreak, as with the Ebola virus for example, but an epidemic that would last for a very long time and countries could not rely on external support over such a long period. It was therefore essential to develop long-term multisectoral and capacity-building strategies. UNAIDS had already had some initial success in strengthening capabilities to deal with resource mobilization.

Turning to collaboration between the cosponsors, he said that the Executive Boards of UNFPA and UNDP had met in April 1996 and had expressed strong support for UNAIDS. He expressed appreciation to WHO for its support for the establishment of UNAIDS in 1995 when UNAIDS had had no resources of its own. UNAIDS collaborated with WHO both at the country and regional levels. Agreements had already been signed with all the WHO regional offices: UNAIDS would provide US$ 300 000-500 000 for the biennium in support of technical cooperation activities; it would also finance the placing of staff in some regional offices. As Dr Hu Ching-li had indicated, at headquarters level there was excellent collaboration between UNAIDS and the WHO Global Programme on Tuberculosis and with Family and Reproductive Health. In some respects, cooperation on tuberculosis was now much better than at the time of GPA. Nevertheless, harmonization of the activities of the cosponsors was a major challenge for UNAIDS. An early success was the setting-up of a joint WHO/UNESCO/UNICEF/UNFPA group to draw up a programme of technical cooperation in the area of education in schools - a most important area since 50% of those infected with HIV were young.

Several delegates had raised the question of the cost of treatment. Given the number of HIV-infected people in the world, currently estimated at around 20 million, it was clear that greater attention would have to be given to that aspect of the epidemic. UNAIDS was therefore giving a higher priority to treatment and care than had been the case in the past. The gap between the poorest and the industrialized countries was far greater than in the area of prevention. The use of antiretroviral drugs constituted a serious economic problem and innovative solutions must be sought in the private as well as in the public sector. The health sector reforms under way in many countries provided an opportunity for the incorporation of AIDS care activities in health systems.
As the delegates of Zimbabwe and Malawi and the representative of the International Council of Nurses had pointed out, the protection of health professionals against HIV infection was a serious, but not a new problem. UNAIDS would work together with WHO in that regard.

He drew attention to some of the problems being encountered by UNAIDS. First, as a new entity, it was liable to meet with suspicion and resistance and it had to establish its methods of operation. Secondly, recruitment of suitable staff was always a slow business but it was essential to select the best staff. Thirdly, the difficult financial position of several cosponsors sometimes made coordination problematic.

In conclusion, he paid tribute to the devoted work of his colleagues at all levels and expressed confidence that he would be able to report significant progress at the next Health Assembly.

Dr BLAKE (Office of HIV/AIDS and Sexually Transmitted Diseases), responding to delegates' concern regarding the exact mechanisms for integrating HIV/AIDS activities within the mainstream of WHO programme activities (often referred to as "mainstreaming"), said that all programmes relevant to the epidemic were establishing substantive activities contributing to a joint response. The Office of HIV/AIDS and Sexually Transmitted Diseases was a focal point for that response, providing technical support to the coordinating process and liaising with UNAIDS. One of its main aims was to ensure that WHO had a defined role which could be characterized in terms of objectives, activities and targets within the normal programming structure of WHO and within the framework of the cosponsored arrangements for UNAIDS. She saw WHO as playing a leading part in ensuring the viability of UNAIDS. Interdivisional task forces had been set up on blood safety, sexually transmitted diseases, treatment and support for HIV/AIDS patients, and surveillance, and in the last two joint WHO/UNAIDS task forces had been established. Access to drugs would be a considerable challenge. A joint WHO/UNAIDS task force in the area of strengthening district health systems was under development and substantive collaborative programmes were being set up by the two organizations in such fields as school health, tuberculosis, reproductive health and blood safety.

She expressed the hope that UNAIDS headquarters would remain at its present location, while indicating that its proximity did not obviate the need for a correct management approach with regard to policies and procedures for a coordinated WHO response.

Turning to the question of treatment, she said that WHO was providing support to countries in respect of treatment of opportunistic infections, sexually transmitted diseases and carrying out studies on antiretroviral therapy. The costs of antiretroviral drugs were high and, when allocating funds for drug purchasing, countries would have to decide what proportion of general public health funds should be devoted to them. The quality of life of people living with HIV/AIDS depended on good health and social systems; essential drugs for prompt treatment of opportunistic infections, counselling and care should be guaranteed. In that context antiretroviral drugs should be seen as supportive drugs.

Mr AITKEN (Assistant Director-General), replying to questions concerning the transfer of funds between GPA and UNAIDS, recalled that when the former had ceased functioning, the Organization had been asked to make sure that a sum of at least US$ 20 million was transferred to the new programme. However, WHO was concerned that it might still face liabilities in respect of GPA, in particular due to the fact that the closing down operation had been carried out so rapidly and under such pressure. A total of US$ 26.3 million had now been transferred to UNAIDS. A further US$ 10 million had been retained by WHO to cover potential liabilities, for example, possible claims by former staff members. It being necessary to exercise such caution, since the closing down of a programme within the United Nations system was such a rare occurrence. Staff members' claims would normally be paid from the salary funds of the programme itself; if no such funds were available, they would have to be paid from another programme within WHO, and that might disrupt priority activities. The Office of the Legal Counsel and administrative staff were studying the situation to see how the matter could best be handled, and he assured governments that had written to WHO expressing concern in that regard that WHO would be communicating its considered view to them after the Health Assembly.

The CHAIRMAN took it that the Committee wished to take note of section IX, Global strategy for the prevention and control of AIDS (resolution WHA42.33), in the Director-General's report on implementation of resolutions (document A49/4).
It was so decided.

Mr ASAMOAH (Secretary) announced the setting-up of a drafting group to consider the amendments proposed to the resolution recommended in resolution EB97.R19. The group would comprise the delegates of Brazil, Burkina Faso, Côte d'Ivoire, Ireland, Islamic Republic of Iran, Italy, Netherlands, Sri Lanka, Sudan, Syrian Arab Republic, Tunisia, and Zimbabwe, and any others interested.

(For approval of draft resolution, see summary record of the eighth meeting, section 3.)

2. THIRD REPORT OF COMMITTEE B (Document A49/43)

Dr KÖKÉNY (Hungary), Rapporteur, read out the draft third report of the Committee.

Mr DEBRUS (Germany) stated that his delegation wished to be recorded as a sponsor of the resolution approved by the Committee on item 30.1 of the agenda - Collaboration within the United Nations system and with other intergovernmental organizations: International Programme on the Health Effects of the Chernobyl Accident (IPHECA).

The report was adopted.¹

The meeting rose at 12:55.

¹ See page 210.
EIGHTH MEETING
Friday, 24 May 1996, at 14:30

Chairman: Dr O. SHISANA (South Africa)

1. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 29 of the Agenda (Documents A49/21, A49/INF.DOC./4, A49/INF.DOC./5 and A49/INF.DOC./6)

The CHAIRMAN invited the Committee to consider the draft resolution proposed by the delegations of Belgium, Egypt, Germany, Greece, Italy, Jordan, Morocco, Norway, Russian Federation, United Kingdom of Great Britain and Northern Ireland, and United States of America, which read as follows:

The Forty-ninth 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 the Palestine Liberation Organization on 5 May 1996;

Emphasizing the need to accelerate the implementation of the Declaration of Principles and the subsequent Accord;

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, emphasizing that health development is best enhanced under conditions of peace and stability;

Expressing the hope that the Palestinian patients will be able to benefit from health facilities available in the health institutions of 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;

Having considered the report of the Director-General,¹

1. EXPRESSES the hope that the peace talks will lead to the establishment of a just, lasting and comprehensive peace in the Middle East;

¹ Document A49/21.
2. 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;

3. 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;

4. 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;

5. 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 Fiftieth World Health Assembly;

6. 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.

Mr FRIBERG (Sweden) expressed his delegation’s support for the draft resolution.

Ms KIZILDELI (Turkey) welcomed the spirit of cooperation between the Israeli and Palestinian delegations demonstrated by the submission of the joint resolution, which was a heartening sign for the future of the peace process in the Middle East. Her delegation supported the draft resolution. The Palestinian people, who were at the beginning of their nation-building process, needed the support of the international community to develop the capacities required to meet the needs of a modern society. She hoped that the efforts of WHO to secure health assistance would lead to a more comprehensive health development effort for the Palestinian people.

Mr POINSOT (France), Ms LOBBEZOO (Netherlands), Mr HANSEN (Denmark) and Dr DLAMINI ZUMA (South Africa) asked to be included as sponsors of the resolution.

Dr ZAHRAN (Egypt), presenting the draft resolution on behalf of the sponsoring nations, referred to some positive moments in the peace process, initiated by the Madrid Conference in 1991 and culminating in the signing of the agreement on self-rule between Israel and PLO in Washington D.C. in September 1993. The historic accord signed in Cairo on 4 May 1994 marked the date on which the health services had been transferred to the Palestinian authorities. He hoped that the negotiations which had just started between Israel
and the Palestine Liberation Organization (PLO) would lead to a lasting and comprehensive peace settlement in the Middle East.

The draft resolution represented a consensus arrived at after intensive negotiations during the past few days and he thanked the drafters for their flexibility and understanding. The resolution was based on two principles in the WHO Constitution, underscoring that the provision of health was an essential prerequisite of peace and security.

He outlined the main points in the resolution. He mentioned that a word had been omitted in the penultimate preambular paragraph: the word "Syrian" should be inserted between the words "occupied" and "Golan". He called on Member States to adopt the draft resolution by consensus and to participate in a speedy implementation of its provisions, in the hope that further positive steps would be taken to secure a stable peace settlement in the Middle East.

Mr LAMDAN (Israel) said he thought there might have been a misunderstanding; the text of the penultimate preambular paragraph which had been agreed contained no reference to "Syria", being modelled on the text adopted in 1995.

The CHAIRMAN asked the delegate of Egypt whether he wished to maintain his proposed wording.

Dr ZAHRAN (Egypt) said that while he was introducing the draft resolution, his attention had been drawn to the fact that a word was missing. However, he had no intention of complicating the process and if the sponsors agreed, he would not insist on that point. The Israeli delegate was right in stating that the same text had been adopted the previous year.

Mr LAMDAN (Israel) thanked his Egyptian colleague for avoiding a misunderstanding. He recommended to the Committee the text of the resolution which, as in the past two years, had been drafted in a joint effort by the Israeli and Palestinian delegations. The language used was virtually the same. He was not fully satisfied with the text - including the title - which still remained political. However, his delegation took a wider view of things: in a spirit of cooperation between PLO and Israel and in an effort to enable WHO to contribute to the peace process, the two sides had settled on that compromise text.

Regrettably, over the past few months in particular, the citizens of Israel had been subjected to repeated acts of gross terrorism. As a result, the Government of Israel had had no option but to place certain restrictions on the movement of Palestinians to and from the area now governed by the Palestinian Council. Nonetheless, Israel was doing everything in its power to assist the Palestinians in health matters. Good relations and cooperation had prevailed between Palestinians and Israelis over the past year, both in negotiations towards interim agreements and subsequent to the establishment of the Palestinian Health Authority.

He outlined the eight main areas of activity agreed upon by the two parties, as follows: creation of four joint professional committees; exchange of medical information; referral of Palestinian patients to Israeli hospitals for inpatient and outpatient care; the purchase of drugs and immunization material by the Palestinian Health Authority from the central stores of the Israeli Ministry of Health; training programmes, courses and study-days for Palestinian physicians in Israel; Middle East training programme on "top quality management" with participation of Israelis and Palestinians; a Middle East consortium on cancers, statistical information, diagnosis, treatment and research; and a joint Palestinian-Israeli project involving the construction of a modern tertiary hospital in the Gaza Strip.

He thanked the sponsors of the draft resolution and trusted that it would once again be adopted by consensus.

Dr ARAFAT (Palestine) said that the draft resolution reflected the positive political developments in the region, particularly in the peace process in which Israel and Palestine were engaged and which they were determined to advance despite all difficulties.

The draft resolution also reflected the current problems faced by the Ministry of Health of the Palestinian Authority and the people themselves, owing to the constraints imposed by Israel which adversely affected health services and were a considerable financial burden in all areas of the economy.
He reiterated his delegation's condemnation of all terrorist attacks against civilians. The limitations imposed on the Palestinian people were regrettable. Despite all those difficulties, the Palestinians were determined to work towards peace. Those working with them in the health field were also determined to restore and rebuild the Palestinian health institutions on the basis of WHO principles.

On behalf of the Palestinian people he thanked all donor and other countries for their support in the march towards peace; he also thanked the sponsors of the draft resolution and the Regional Director for the Eastern Mediterranean for their support and assistance.

He expressed appreciation for the positive spirit which had prevailed in the negotiations with the Israeli delegation and had enabled the parties to achieve results, and expressed the hope that the joint negotiations would continue in the same vein with a view to achieving the aims of the peace process and enabling the people to build a Palestinian State with its capital in East Jerusalem and join with Israel and other countries in achieving the aims of WHO, particularly health for all by the year 2000.

Mr Zackheos (Cyprus) said that his delegation wished to become a sponsor of the draft resolution. Cyprus had decided to build two medical centres in the Palestinian territories costing over US$ 2 million and had signed an agreement setting up a Middle East cancer consortium.

Mr Coundoureas (Greece) said that his delegation was pleased to sponsor the draft resolution, in particular because it was supported by both Israel and Palestine. It reflected the desire of the people of the region for practical and realistic measures in the sensitive area of public health.

His Government would continue to provide full financial and other support to the region: it had recently decided to make a further contribution to a newly established WHO programme for the Gaza Strip and Palestine totalling some US$ 500,000, as well as scientific and technical support and assistance.

Ms Schiefermair (Austria) said that her delegation wished to cosponsor the draft resolution.

Dr Yin Dakui (China) observed that major upsets over the years had harmed the health of the Palestinians in the occupied Arab countries and had affected the health of other countries in the region including Israel. The Chinese delegation was concerned about that situation. As Palestine and Israel had now signed an agreement on the autonomy of the West Bank, he called on the international community to increase efforts to promote the peace process in the Middle East and help its people to overcome the obstacles which would undoubtedly arise in the implementation of the agreement. During the transitional period, the international community, including WHO, should continue to give the Palestinian and Arab peoples of the region the necessary financial help and technical assistance to enable them to improve and develop their health infrastructure and human resources, as well as their capacity to devise and implement health programmes and projects with a view to attaining health for all by the year 2000.

The Chinese Government and people would make every effort, in cooperation with WHO, to improve the health situation of Arab and Palestinian people in that region and fully supported the draft resolution.

Mr Chaudhry (Pakistan) expressed strong support for the draft resolution. The Middle East was in great need of assistance, and the world community must help the peace efforts by strengthening capacities and meeting the basic needs of the Arab population. WHO was to be commended for its efforts in assisting them, as were the sponsors for their part in the process.

Mrs Rinkineva-Heikkilä (Finland) commended the parties involved on the direct approach which they had adopted in drafting the resolution. Her delegation supported that resolution and wished to be included as a sponsor.

Mr Abdesselem (Tunisia) and Mrs Schleder-Leuck (Luxembourg) said that their delegations also supported the draft resolution and wished to be sponsors.

Dr Szatmári (Hungary) fully supported the draft resolution particularly since peace was the most important prerequisite for health.
Mr BOYER (United States of America) said that the United States was pleased to be a sponsor of the draft resolution and to see consensus on the text. It was particularly significant that a consensus had been achieved for the third consecutive year on a subject which in the past had been one of great difficulty for all. The draft resolution benefited both the peace process and the Health Assembly, which was now virtually free of political confrontation and could henceforth concentrate on health concerns. The Palestinian authority and Israel could for their part continue to use the Health Assembly as a forum for talks as part of the process of reaching agreement in many more important areas.

The United States delegation continued to be concerned about the title of the agenda item and expressed the hope that the negotiating parties would in the future be able to resolve that persistent problem. It looked forward to full agreement on all aspects of the issue at the Fiftieth World Health Assembly.

Dr PAVLOV (Russian Federation) said, as a sponsor of the draft resolution, that he hoped it would serve not only to consolidate peace in the Middle East, of which the Russian Federation had always stressed the importance, but also to fulfil the rights of the population to health and medical assistance. It was also important to achieve rapid progress in other aspects of the Arab-Israeli negotiations within that framework. During the fiftieth session of the General Assembly of the United Nations, the Russian Federation had voted in favour of the relevant resolution. It welcomed the approval of the current draft resolution as part of the process.

The draft resolution was approved.¹

Mr MOEINI (Islamic Republic of Iran) said that, although his delegation had joined the consensus on the resolution, that should not be construed as its recognition of Israel.

2. WHO REFORM AND RESPONSE TO GLOBAL CHANGE: Item 21 of the Agenda (continued)

Progress report on reform: Item 21.1 of the Agenda (continued from the second meeting)

The CHAIRMAN invited the Committee to consider the following draft resolution proposed by the delegations of Australia, Canada, Denmark, Finland, France, Ireland, Netherlands, New Zealand, Sweden and the United Kingdom of Great Britain and Northern Ireland:

The Forty-ninth World Health Assembly,
Recalling resolution WHA48.15 of the Forty-eighth World Health Assembly;
Having considered the report by the Director-General in document A49/11;
Having also considered resolution EB97.R2 of the Executive Board on implementation of recommendations on the WHO response to global change;
Recalling resolution EB92.R2 of the Executive Board, which underlined the importance of technical competence, career development and rotation of staff;
Recognizing the challenges faced by the Organization in adapting to changing global needs;
Determined that WHO reform should permeate the Organization at all levels and in all regions, and that it should constitute an integral part of WHO’s management culture;
Convinced that WHO’s staff are its most important resource, and that an effective personnel policy is essential to the effective implementation of reform,

1. NOTES the progress achieved;

2. REQUESTS the Director-General:

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA49.24.
(1) to ensure that urgent steps are taken to develop and implement a new personnel policy for WHO incorporating the recommendations of EB97.R2 and compatible with the United Nations common system, and to submit that policy to the ninety-ninth session of the Executive Board for consideration;
(2) to ensure that the work begun by the development team on personnel policy is followed up, that proposals are developed for putting the recommendations into practice, and that concrete outcomes are achieved;
(3) to continue to report regularly to the Executive Board on achievements made and any obstacles encountered during the implementation of WHO reform;
(4) to report to the Fiftieth World Health Assembly on progress made in implementation of reform throughout WHO;

3. REQUESTS the Regional Directors to report regularly to the Executive Board on progress in, and any obstacles encountered to, the implementation of reforms in their region;

4. REQUESTS the Executive Board to continue to monitor closely and encourage progress in reform and advise the Director-General on measures to overcome any obstacles encountered.

The draft resolution was approved.¹

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 30 of the Agenda (continued)

Coordinated follow-up and implementation of plans of action of international conferences: Item 30.2 of the Agenda (Document A49/23) (continued from the sixth meeting)

The CHAIRMAN recalled that a draft resolution on "Prevention of violence: a public health priority", proposed by the delegations of Australia, Barbados, Botswana, Cyprus, Jamaica, Kenya, Malawi, Mauritius, Mozambique, Namibia, New Zealand, Saint Kitts and Nevis, Seychelles, Sierra Leone, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe had been referred to the General Committee. She invited the Committee to consider the following revised version of that resolution, as amended by the delegation of South Africa, in which deletions were marked and additions underlined:

The Forty-ninth World Health Assembly,
Noting with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children;
Endorsing the call made in the Declaration of the World Summit for Social Development for the introduction and implementation of specific policies and programmes of public health and social services to prevent violence in society and mitigate its effect;
Endorsing the recommendations made at the International Conference on Population and Development and the Fourth World Conference on Women urgently to tackle the problem of violence against women and girls and to understand its health consequences;
Recalling the United Nations Declaration on the elimination of violence against women;
Noting the call made by the scientific community in the Melbourne Declaration adopted at the third international conference on injury prevention and control (1996) for increased international cooperation in ensuring the safety of the citizens of the world;
Recognizing the serious immediate and future long-term implications for health, and psychological and social development that violence represents for individuals, families, communities and countries;

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA49.23.
Recognizing the growing consequences of violence for health care services everywhere and its
detrimental effect on scarce health care resources for countries and communities;

Recognizing that the health sector is frequently at the forefront of contacts with victims of
violence and has a unique technical capacity and benefits from a special position in the community to
help those at risk;

Recognizing that WHO, the major agency for coordination of international work in
public health, has the responsibility to provide leadership and guidance to Member States in developing
public health programmes to prevent self inflicted violence and violence against others, all forms of
violence in society;

1. DECLARES that violence is a leading worldwide public health problem;

2. URGES Member States to assess the problem of violence on their own territory and to
communicate to WHO their information about this problem and their approach to it;

3. REQUESTS the Director-General, within available resources to initiate public health activities
to address the problem of violence that will:

(1) characterize different types of violence, define their magnitude and assess the causes and
the public health consequences of violence;

(2) assess the types and effectiveness of measures and programmes to prevent violence and
mitigate its effects, with particular attention to community-based initiatives;

(3) promote activities to tackle this problem at both international and country level including
steps to:

(a) improve the recognition, reporting and management of the consequences of violence;

(b) promote greater intersectoral involvement in the prevention and management of
violence;

(c) promote research on violence as a priority for public health research;

(d) prepare and disseminate recommendations for violence prevention programmes in
nations, States and communities around the world;

(4) ensure the coordinated and active participation of appropriate WHO technical programmes;

(5) strengthen the Organization's collaboration with governments, local authorities and other
organizations of the United Nations system in the planning, implementation and monitoring of
programmes of violence prevention and mitigation;

(6) present a progress report to the ninety-ninth session of the Executive Board.

4. FURTHER REQUESTS the Director-General to present a report to the ninety-ninth session of
the Executive Board describing the progress made so far and to present a plan of action for progress
towards a science-based public health approach to violence prevention.

Mr ASAMOAH (Secretary) said additional sponsors of the resolution were Belarus, Cameroon,
Honduras, Lesotho, Norway, Sweden and Trinidad and Tobago.

Mr FRIBERG (Sweden) proposed adding to paragraph 3(1) the words: "using also a gender perspective
in the analysis;".

There were no comments.

The CHAIRMAN invited the Committee to approve the revised draft resolution as thus further
amended.

The revised draft resolution, as thus further amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA49.25.
Mr VAN REENEN (Netherlands) explained, in accordance with Rule 77 of the Rules of Procedure of the Health Assembly, that his delegation had initially intended to submit an amendment, but having encountered some opposition and in order not to jeopardize the adoption of the resolution by the Health Assembly, had decided not to do so. He nevertheless wished to put on record that his interpretation of paragraph 3(5) was that strengthened collaboration with other organizations of the United Nations system would include the special mechanisms of the Human Rights Commission, such as the special rapporteurs and working groups, as well as treaty bodies in the field of human rights. He trusted that the Director-General, in presenting a report to the Executive Board as requested in paragraph 4, would cover collaboration with such mechanisms.

International Decade of the World's Indigenous People: Item 30.3 of the Agenda (Resolutions WHA47.27 and WHA48.42) (continued from the sixth meeting)

The CHAIRMAN drew the Committee's attention to the draft resolution proposed by the delegations of Australia, Brazil, Chile, Cook Islands, Denmark, New Zealand, Peru, Philippines, South Africa, United States of America and Uruguay, which read as follows:

The Forty-ninth 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 resolution WHA47.27 of the Forty-seventh World Health Assembly, and resolution WHA48.24 of the Forty-eighth World Health Assembly;
Further recalling the United Nations General Assembly resolution 50/157, which adopted the programme 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", and in this regard, 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 partnership with indigenous people;
Mindful of the health initiative for indigenous people undertaken by the Pan American Health Organization;
Noting document A49/24;
Welcoming the appointment by the Director-General of a focal point for the International Decade of the World's Indigenous People,
REQUESTS the Director-General:
(1) to strengthen the focal point for the International Decade of the World's Indigenous People; and,
(2) to submit to the ninety-ninth session of the Executive Board a comprehensive programme of action for the Decade, developed in consultation with national governments and organizations of indigenous people, to be undertaken by the World Health Organization at both headquarters and regional levels, with a view to achieving the health objectives of the Decade.

Mr ASAMOAH (Secretary) said that Argentina, Canada, Cyprus, Mexico and Nicaragua wished to join the list of sponsors.

Mrs DHAR (India) said that the concept of indigenous people as a special category was somewhat unclear. If it meant tribal or aboriginal people, there were no such people in India, all Indians being considered indigenous.

Dr TRUJILLO (United States of America), speaking as the Director of the American Indian Alaskan Native Programme providing health care for American Indians who were Alaskan natives, said that the United States fully supported the draft resolution. In his country there were certain tribes, or indigenous peoples, that were designated as sovereign nations and treated as such. The draft resolution implicitly acknowledged
the specificity of indigenous populations and the fact that some countries indeed recognized the indigenous populations within their borders as being different entities politically and culturally; its purpose was to ensure that they were not left outside the mainstream of health care programmes.

The draft resolution was approved.¹

Health assistance to specific countries: Item 30.5 of the Agenda (Document A49/26)

The CHAIRMAN drew attention to the following draft resolution, proposed by the delegations of Algeria, Bahrain, Bangladesh, Cyprus, Egypt, Greece, India, Iran (Islamic Republic of), Jamaica, Jordan, Kuwait, Lebanon, Lesotho, Madagascar, Morocco, Oman, Qatar, Saudi Arabia, Seychelles, South Africa, Syrian Arab Republic, Tunisia, United Arab Emirates, and Yemen:

The Forty-ninth World Health Assembly,

Recalling and confirming the previous resolutions of the Health Assembly on health assistance to specific countries, the most recent being resolution WHA48.31, which includes reference to earlier resolutions WHA44.37 (Health and medical assistance to Lebanon); WHA44.38 (Health assistance to refugees and displaced persons in Cyprus); WHA44.39 (Assistance to Lesotho and Swaziland); WHA44.40 (Reconstruction and development of the health sector in Namibia); and WHA44.43 (Health and medical assistance to Somalia);

Noting that an increasing number of countries and areas are stricken by natural and man-made disasters and the subsequent numerous reports submitted for discussion during the Health Assembly;

Taking note of United Nations General Assembly resolution 46/182, on "Strengthening of the coordination of humanitarian assistance of the United Nations";

Recalling resolution WHA35.1 on method of work of the Health Assembly, which draws attention to the desirability of a full discussion at regional level of all matters dealing with specific countries before such items are referred to the Health Assembly, and the recent decision on this matter by the Regional Committee for the Eastern Mediterranean (resolution EM/RC39/R.11),

1. EXPRESSES its appreciation to the Director-General for his continued efforts to strengthen the Organization's capacity to respond promptly and efficiently to country-specific emergencies;

2. URGES the Director-General to continue to give high priority to countries mentioned in the above resolutions and to coordinate these and other WHO efforts in emergency preparedness and humanitarian assistance with the humanitarian affairs programmes of the United Nations system, including mobilization of extrabudgetary resources;

3. CALLS UPON the Director-General to report to the Fiftieth World Health Assembly on the implementation of this resolution.

Ms KIZILDELI (Turkey) said that her delegation shared the widely held view that the scarce resources of WHO should be used efficiently and directed to real priorities and emergencies. She therefore urged the Director-General to continue to give high priority to the provision of assistance and extrabudgetary resources to Lebanon, Lesotho, Swaziland, Namibia and Somalia, but felt that the direction was not justified for Cyprus. With a per capita income of US$ 13 000, the Greek Cypriot community's requirements for health assistance were not the same as the others mentioned in the draft resolution. The Turkish delegation would not block the draft resolution as it believed in the necessity of providing assistance to the other countries mentioned in the resolution, but this should not be taken as Turkey's agreement to the inclusion of Cyprus in the list. It believed that assistance, were it to be provided, should be administered with the consent of, and in collaboration with, both communities on the island.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA49.26.
Mr ZACKHEOS (Cyprus) pointed out that there was a refugee problem in Cyprus. The Turkish Cypriots had their own share of health assistance provided by WHO, confirmed in the report of the Director-General to the previous Health Assembly in paragraph 17 of document A48/38. Although some people in the occupied area had received medical care in government hospitals and clinics, the Turkish army and the illegal regime in the area had prevented most people from seeking medical assistance in the free areas of the Republic, open to all Cypriots. Also, the Government of Cyprus, together with the Greek Cypriots, had subsidized the Turkish Cypriot community with free electricity and, until recently, reduced-cost gas.

The draft resolution was approved.¹

**Joint United Nations Programme on HIV/AIDS (UNAIDS): Item 30.4 of the Agenda (Resolution EB97.R19; Documents A49/4 section IX, and A49/25) (continued from the seventh meeting)**

At the CHAIRMAN’s invitation, Mr ASAMOAH (Secretary), having listed the names of the members of the drafting group that had met to consider the amendments proposed to the resolution recommended in resolution EB97.R19, read out the following amended version of the draft resolution:

The Forty-ninth World Health Assembly,

Having considered the Director-General’s reports on the implementation of the global strategy for the prevention and control of AIDS and on progress towards establishing the Joint United Nations Programme on HIV/AIDS (UNAIDS);

Recalling resolutions WHA40.26, WHA41.24, WHA42.33, WHA42.34, WHA43.10, WHA45.35 and WHA48.30, and United Nations General Assembly resolution 46/203 on HIV/AIDS, which has emerged as a major public health problem;

Noting the comments and resolutions of the regional committees on HIV/AIDS and the establishment of the Joint United Nations Programme on HIV/AIDS;

Noting that new resource mobilization mechanisms need to be developed to support countries in combating HIV/AIDS,

1. NOTES with concern that the impact of the HIV/AIDS epidemic - with parallel and related epidemics of sexually transmitted diseases - is expanding and being intensified, resulting both in increasing morbidity and mortality, particularly in developing countries, and in repercussions on the functioning of health services;

2. ACKNOWLEDGES with appreciation the essential leadership role played by WHO, through its Global Programme on AIDS since its inception, in the mobilization, guidance and coordination of activities for the prevention of HIV/AIDS, care and support of "persons living with HIV/AIDS", and promotion and coordination of research activities;

3. RECOGNIZES the dedication and exceptional contribution of the staff of the Global Programme on AIDS to the response to the HIV/AIDS epidemic, globally and within countries, and to the epidemics of sexually transmitted diseases, and expresses appreciation of this work;

4. NOTES with satisfaction that, pursuant to resolution WHA48.30, the Memorandum of Understanding has been concluded for the establishment of the Joint United Nations Programme on HIV/AIDS;

5. ENDORSES:
   (a) the formula drawn up by the United Nations Economic and Social Council for the membership of the Programme Coordinating Board of UNAIDS;

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA49.28.
(b) the proposal that further consultation should be conducted on mechanisms for future elections of Member States to the Programme Coordinating Board;
(c) the functions of the Programme Coordinating Board described in the report of the Director-General;

6. URGES Member States:
(a) to continue to show strong political commitment to national AIDS prevention efforts and give the ministries of health a leading role in collaborating with UNAIDS and its cosponsors;
(b) to ensure expansion of the national response to HIV/AIDS and sexually transmitted diseases in both prevention and care, and surveillance of related health problems;
(c) to ensure that maximum protection measures for health workers are promoted and sustained in all work situations;
(d) to strengthen surveillance of the pandemic and development and planning of, and resource mobilization for, national HIV/AIDS/STD programmes in partnership with UNAIDS and its cosponsors;
(e) to provide support to UNAIDS governance by participating actively in the work of the Programme Coordinating Board;

7. REQUESTS the Director-General:
(a) to ensure support for Member States in their response to HIV/AIDS and sexually transmitted diseases through maintenance of a strong technical capability within WHO to respond to related health issues;
(b) to provide technical guidance to UNAIDS on WHO's health policies, norms and strategies, and to facilitate cooperation between UNAIDS and the relevant WHO programmes and divisions;
(c) to facilitate the incorporation of UNAIDS specific policies, norms and strategies into the activities of WHO at global, regional and country level, where appropriate;
(d) to collaborate in all aspects of resource mobilization for HIV/AIDS activities, including (i) participation in joint fund-raising activity with UNAIDS and its other cosponsors; and (ii) strengthening of the capability of WHO country offices to participate in appeals for funds at the country level to combat HIV/AIDS in close collaboration with ministries of health;
(e) to ensure that the Health Assembly receives the reports prepared by UNAIDS on its activities on a regular basis;
(f) to keep the Executive Board and the Health Assembly informed about the development and implementation of an overall strategy for WHO's activities relating to HIV/AIDS and sexually transmitted diseases, including: (i) support to Member States; (ii) integration of activities into WHO programmes at all levels of the Organization, as appropriate; (iii) support provided by WHO to UNAIDS; and (iv) collaboration between WHO and UNAIDS as outlined in paragraph 7(d).

The CHAIRMAN invited the Committee to consider the draft resolution containing the amendments proposed by the drafting group.

Mr AITKEN (Assistant Director-General), in response to a query from Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) as to whether it might not be advisable to separate the two, not necessarily related, goals of strengthened surveillance and resource mobilization mentioned in paragraph 6(d), said that since the final particle "national HIV/AIDS/STD programmes ... its cosponsors" applied to both ideas, it would be difficult to redraft the text at that stage, especially since the meaning was clear.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) accepted that position.
The resolution recommended by the Executive Board in resolution EB97.R19, as amended, was approved.¹

4. EXPERT COMMITTEES AND STUDY GROUPS: MODIFICATION OF THE REGULATIONS FOR EXPERT ADVISORY PANELS AND COMMITTEES: Item 31 of the Agenda (Decision EB97(5))

Professor SHAIKH (representative of the Executive Board) said that the Board recommended to the Health Assembly that it modify Regulation 4.23 of the Regulations for Expert Advisory Panels and Committees to provide that expert committee recommendations be annexed to the Director-General’s report to the Board on meetings of expert committees and study groups, rather than the texts of the reports themselves, in order to simplify the procedures and enable the Director-General to report more promptly to the Board. The text of the proposed modification appeared in decision EB97(5).

Mr KÖKÉNY (Hungary), Rapporteur, read out the following draft resolution:

The Forty-ninth World Health Assembly

DECIDES to amend the Regulations for Expert Advisory Panels and Committees so that regulation 4.23 reads as follows:

4.23 The Director-General shall submit to the Executive Board a report on meetings of expert committees held since the previous session of the Board. It shall contain his observations on the implications of the expert committee reports and his recommendations on the follow-up action to be taken, and the texts of the recommendations of the expert committee shall be annexed. The Executive Board shall consider the report submitted by the Director-General and address its comments to it.

The draft resolution was approved.²

The meeting rose at 16:25.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA49.27.
² Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA49.29.
1. FOURTH REPORT OF COMMITTEE B

Dr KÖKÉNY (Hungary), Rapporteur, read out the draft fourth report of Committee B, contained in document A49/44.

The request by Dr BERNARD (United States of America) and Professor BADRAN (Egypt) that their countries be added to the list of sponsors of the resolution entitled "Prevention of violence: public health priority" was noted.

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 211.
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 WHA49/1996/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA49/1996/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

[A49/39 - 22 May 1996]

1. The Committee on Credentials met on 21 May 1996. Delegates of the following Member States were present: Austria, Botswana, Cape Verde, Federated States of Micronesia, Islamic Republic of Iran, Jamaica, Kenya, Malta, Myanmar, Syrian Arab Republic.

2. The Committee elected the following officers: Dr P. Abela-Hyzler (Malta) - Chairman; Mrs W.G. Manyeneng (Botswana) - Vice-Chairman; Dr Ohn Kyaw (Myanmar) - 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 delegate of the Islamic Republic of Iran expressed his Government’s reservation regarding the inclusion of Israel in the list of formal credentials.

6. 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: Bolivia, Central African Republic, Côte d'Ivoire, Kyrgyzstan, Latvia, Nicaragua, Portugal, Uzbekistan.

1 Approved by the Health Assembly at its fourth plenary meeting.
States whose credentials it was recommended should be recognized as valid (see paragraph 4 above)

Afghanistan; Albania; Algeria; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Denmark; Djibouti; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran, Islamic Republic of; Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Lao People's Democratic Republic; Lebanon; Lesotho; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Micronesia, Federated States of; Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Peru; Philippines; Poland; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; The Former Yugoslav Republic of Macedonia; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Vanuatu; Venezuela; Viet Nam; Yemen; Zaire; Zambia; Zimbabwe.

Second report

[A49/46 - 25 May 1996]

1. The Committee on Credentials met on 24 May 1996, under the Chairmanship of Dr P. Abela-Hyzler (Malta). Mrs W.G. Manyeneng (Botswana) was Vice-Chairperson, and Dr Ohn Kyaw (Myanmar) was Rapporteur. Delegates of the following Member States were present: Austria, Botswana, Federated States of Micronesia, Iran (Islamic Republic of), Jamaica, Malta, Myanmar, Syrian Arab Republic.

2. The Committee examined the formal credentials of the delegates of Kyrgyzstan, Latvia, Nicaragua, and Portugal, 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 examined the formal credentials of Dominica, which were found to be in conformity with the Rules of Procedure, and the Committee therefore proposes that the Health Assembly recognize their validity, thus enabling the delegation of Dominica to participate with full rights in the World Health Assembly.

4. The Committee also examined the notifications from Nauru and Paraguay, 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 therefore recommends to the World Health Assembly that the delegates of Nauru and Paraguay be provisionally seated with all rights in the Assembly pending the arrival of their formal credentials.

1 Approved by the Health Assembly at its sixth plenary meeting.
COMMITTEE ON NOMINATIONS

First report

The Committee on Nominations, consisting of delegates of the following Member States: Albania, Algeria, Bahrain, Benin, Bolivia, China, Cyprus, Democratic People's Republic of Korea, Djibouti, Ethiopia, Finland, France, Lesotho, Mauritius, Mexico, Nepal, Panama, Republic of Korea, Russian Federation, Saint Lucia, Samoa, Senegal, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, and Uruguay met on 20 May 1996. Mr K. Lee (Republic of Korea) 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 Dr A. J. Mazza (Argentina) for the Office of President of the Forty-ninth World Health Assembly.

Second report

At its first meeting, held on 20 May 1996, 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 S. Mba Bekale (Gabon), Mr A.B.S. Al-Khayareen (Qatar), Dr M. Vitkova (Bulgaria), Mr A.H.M. Fowzie (Sri Lanka), Mrs S.H. Tiy (Fiji);

Committee A: Chairman - Professor B. Sangster (Netherlands);

Committee B: Chairman - Dr O. Shisana (South Africa).

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: Australia, Canada, China, Croatia, Cuba, Ecuador, France, Lebanon, Mali, Nigeria, Oman, Russian Federation, Thailand, United Kingdom of Great Britain and Northern Ireland, United States of America, Zaire, Zambia.

Third report

At its first meeting, held on 20 May 1996, 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:

1 Approved by the Health Assembly at its second plenary meeting.
2 See summary records of the first meetings of Committees A and B (pp. 7 and 103).
Committee A: Vice-Chairmen: Dr A.M. Alfaro de Gamero (El Salvador) and Dr M.M. Dayrit (Philippines); Rapporteur: Dr J. Singay (Bhutan)

Committee B: Vice-Chairmen: Dr A.Y. Al-Saif (Kuwait) and Professor A.K. Shamsuddin Siddiquey (Bangladesh); Rapporteur: Dr M. Kökény (Hungary).

GENERAL COMMITTEE

Report¹

[A49/41 - 23 May 1996]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting held on 22 May 1996, 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: Angola, Benin, Botswana, Burkina Faso, Honduras, Indonesia, Japan, Poland, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland.

In the General Committee’s opinion these 10 Members would provide, if elected, a balanced distribution on the Board as a whole.

COMMITTEE A

First report²

[A49/42 - 23 May 1996]

On the proposal of the Committee on Nominations,³ Dr A.M. Alfaro de Gamero (El Salvador) and Dr M.M. Dayrit (Philippines) were elected Vice-Chairmen, and Dr J. Singay (Bhutan) Rapporteur.

Committee A held its first three meetings on 21 and 22 May 1996 under the chairmanship of Professor B. Sangster (Netherlands) and its fourth meeting on 22 May 1996 under the chairmanship of Dr A.M. Alfaro de Gamero (El Salvador).

¹ See document WHA49/1996/REC/2, verbatim record of the fifth plenary meeting, section 5.
² Approved by the Health Assembly at its fifth plenary meeting.
³ See the third report of the Committee on Nominations, above.
It was decided to recommend to the Forty-ninth World Health Assembly the adoption of a resolution relating to the following agenda item:

17. Implementation of resolutions (report by the Director-General)
   Strengthening nursing and midwifery [WHA49.1].

Second report

[A49/45 - 25 May 1996]

Committee A held its fifth meeting on 23 May 1996 under the chairmanship of Professor B. Sangster (Netherlands), its sixth meeting on 23 May 1996 under the chairmanship of Dr M.M. Dayrit (Philippines) and its seventh and eighth meetings on 24 May 1996 under the chairmanship of Professor B. Sangster (Netherlands).

It was decided to recommend to the Forty-ninth World Health Assembly the adoption of resolutions relating to the following agenda items:

18. Communicable disease prevention and control
   18.1 Smallpox eradication - destruction of variola virus stocks [WHA49.10]
   18.2 New, emerging and re-emerging infectious diseases: special programme on malaria [WHA49.11]

17. Implementation of resolutions (report by the Director-General)
   WHO global strategy for occupational health for all [WHA49.12]
   Prevention and control of iodine deficiency disorders [WHA49.13]
   Revised drug strategy [WHA49.14]
   Infant and young child nutrition [WHA49.15]

COMMITTEE B
First report

[A49/38 - 22 May 1996]

Committee B held its first meeting on 21 May 1996 under the chairmanship of Dr O. Shisana (South Africa). On the proposal of the Committee on Nominations, Dr A.Y. Al-Saif (Kuwait) and Professor A.K. Shamsuddin Siddiquey (Bangladesh) were elected Vice-Chairmen and Dr M. Kökény (Hungary) Rapporteur.

The second meeting of Committee B was also held on 21 May 1996 under the chairmanship of Dr O. Shisana (South Africa) and of Professor A.K. Shamsuddin Siddiquey (Bangladesh).

1 Approved by the Health Assembly at its sixth plenary meeting. See also summary record of the ninth meeting of Committee A, section 1, and decision WHA49(11).
2 Approved by the Health Assembly at its fifth plenary meeting.
3 See the third report of the Committee on Nominations, above.
It was decided to recommend to the Forty-ninth World Health Assembly the adoption of resolutions relating to the following agenda items:

20. Financial matters
   20.1 Financial report on the accounts of WHO for the financial period 1994-1995, report of the External Auditor, and comments thereon of the Administration, Budget and Finance Committee [WHA49.2]
   20.2 Status of collection of assessed contributions [WHA49.3]
   20.3 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA49.4]
   20.4 Arrears of contributions of South Africa [WHA49.5]

Second report

[49/40 - 23 May 1996]

Committee B held its third and fourth meetings on 22 May 1996 under the chairmanship of Dr O. Shisana (South Africa).

It was decided to recommend to the Forty-ninth World Health Assembly the adoption of resolutions and a decision relating to the following agenda items:

21. WHO reform and response to global change
   21.4 Reassignment of Member States to regions [WHA49.6]
   21.5 Report of the ad hoc group [WHA49.7]
25. Real Estate Fund [WHA49.8]
26. Personnel matters: employment and participation of women in the work of WHO [WHA49.9]
27. United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee [WHA49(9)]

Third report

[49/43 - 24 May 1996]

Committee B held its fifth and sixth meetings on 23 May 1996 under the chairmanship of Dr A.Y. Al-Saif (Kuwait) and Dr O. Shisana (South Africa).

It was decided to recommend to the Forty-ninth World Health Assembly the adoption of resolutions relating to the following agenda items:

17. Implementation of resolutions (progress reports by the Director-General)
   Tobacco or health
   - Tobacco or health programme [WHA49.16]
   - International framework convention for tobacco control [WHA49.17]

1 Approved by the Health Assembly at its fifth plenary meeting.
2 Approved by the Health Assembly at its sixth plenary meeting.
30. Collaboration within the United Nations system and with other intergovernmental organizations

30.1 General matters
- Collaboration within the United Nations system and with other intergovernmental organizations: Supply of controlled drugs for emergency care [WHA49.18]
- Collaboration within the United Nations system and with other intergovernmental organizations: WHO policy on collaboration with partners for health development [WHA49.19]
- Collaboration within the United Nations system and with other intergovernmental organizations: Orientation of WHO policy in support of African recovery and development [WHA49.20]
- Collaboration within the United Nations system and with other intergovernmental organizations: Strengthening of the coordination of emergency humanitarian assistance [WHA49.21]
- Collaboration within the United Nations system and with other intergovernmental organizations: International Programme on the Health Effects of the Chernobyl Accident (IPHECA) [WHA49.22]

Fourth report¹

[A49/44 - 25 May 1996]

Committee B held its seventh and eighth meetings on 24 May 1996 under the chairmanship of Dr O. Shisana (South Africa).

It was decided to recommend to the Forty-ninth World Health Assembly the adoption of resolutions relating to the following agenda items:

21. WHO reform and response to global change
   21.1 WHO reform and response to change: Progress report on reform [WHA49.23]

29. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine [WHA49.24]

30. Collaboration within the United Nations system and with other intergovernmental organizations
   30.2 Coordinated follow-up and implementation of plans of action of international conferences [WHA49.25]
   30.3 International Decade of the World's Indigenous People (resolutions WHA47.27 and WHA48.24) [WHA49.26]
   30.4 Joint United Nations Programme on HIV/AIDS (resolution WHA48.30) [WHA49.27]
   30.5 Collaboration within the United Nations system and with other intergovernmental organizations: Health assistance to specific countries [WHA49.28]

31. Expert committees and study groups: modification of the Regulations [WHA49.29]

¹ Approved by the Health Assembly at its sixth plenary meeting.
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