## TENTH MEETING

**Tuesday, 27 May 2003, at 14:45**

**Chairman:** Dr J. LARIVIÈRE (Canada)

**1. TECHNICAL AND HEALTH MATTERS:** Item 14 of the Agenda (continued)

**Intellectual property rights, innovation and public health:** Item 14.9 of the Agenda (Document A56/17) (continued from the ninth meeting)

Ms BREMER (Norway), speaking as chairman of the informal drafting group set up to discuss the draft resolution on intellectual property rights, innovation and public health, said that consensus had been reached on most of the outstanding points. Two issues, raised by China and the United States of America respectively, remained to be resolved.

The CHAIRMAN thanked the delegate of Norway and other participants in the drafting group for their efforts to achieve consensus. He asked if the delegations concerned were in a position to approve the draft resolution.

Dr ZEPEDA BERMUDEZ (Brazil) proposed, with a view to consensus, that paragraph 1(2) of the draft resolution should be amended to read: "to consider, whenever necessary, adapting national legislation in order to use to the full flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)". The rest of the sentence could be deleted, since the issue of paragraph 6 of the Doha Declaration was covered in paragraph 1(3).

Dr STEIGER (United States of America) said that his delegation could accept the amendment proposed by Brazil.

Mr SHEN Yongxiang (China) noted that the drafting group had been unable to reach consensus on his country's proposal for paragraph 1(1), even though it was consistent with the Doha Declaration. Many members had endorsed China's position, and only a few had opposed it. However, in the interests of consensus, his delegation was prepared to approve the draft resolution with paragraph 1(1) left as it stood.

The CHAIRMAN said that, if he saw no objection, he would take it that the Committee wished to approve the draft resolution as amended.

**The draft resolution, as amended, was approved.**[1]

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA56.27.

2. **PROGRAMME BUDGET:** Item 12 of the Agenda (continued)

**Proposed programme budget for 2004-2005:** Item 12.1 of the Agenda (Documents PB/2004-2005, A56/5,[1] A56/6, A56/51, A56/51 Corr.1 and A56/INF.DOC./1) (continued from the second meeting)
**Miscellaneous income 2002-2003:** Item 12.2 of the Agenda (Document A56/7) (continued from the second meeting)

**FINANCIAL MATTERS:** Item 16 of the Agenda (continued)

**Assessments for 2004-2005:** Item 16.6 of the Agenda (Documents A56/35, A56/51, A56/51 Corr.1, and A56/INF.DOC./3) (continued from the second meeting)

The CHAIRMAN drew the Committee's attention to three draft resolutions relating to the proposed programme budget. The first was an appropriation resolution for the financial period 2004-2005, as proposed by the Director-General, which read:

The Fifty-sixth World Health Assembly,

1. RESOLVES to appropriate for the financial period 2004-2005 an amount of US$ 960 111 000 under the regular budget as follows:

| Appropriation Section | Purpose of appropriation | Amount |
|---|---|---|
| | | US$ |
| 1. | Communicable diseases | 93 025 000 |
| 2. | Noncommunicable diseases and mental health | 69 616 000 |
| 3. | Family and community health | 60 340 000 |
| 4. | Sustainable development and healthy environments | 81 802 000 |
| 5. | Health technology and pharmaceuticals | 49 728 000 |
| 6. | Evidence and information for health | 175 451 000 |
| 7. | External relations and governing bodies | 44 055 000 |
| 8. | General management | 139 294 000 |
| 9. | Director-General, Regional Directors and independent functions | 21 670 000 |
| 10. | WHO's presence in countries | 111 130 000 |
| 11. | Miscellaneous | 34 000 000 |
| | Effective working budget | 880 111 000 |
| 12. | Transfer to Tax Equalization Fund | 80 000 000 |
| | **Total** | 960 111 000 |

2. RESOLVES to finance the regular budget for the financial period 2004-2005 as follows:

| Source of financing | Amount |
|---|---|
| | US$ |
| Miscellaneous Income | 21 636 000 |
| Regular budget net assessments on Members (see also paragraph 5 below) | 863 100 890 |
| Net transfer to the Tax Equalization Fund | 75 374 110 |
| **Total** | 960 111 000 |

[1] See document WHA56/2003/REC/1, Annex 2.

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2004-2005; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations approved under paragraph 3 shall be available for the payment of obligations incurred during the financial period 1 January 2004 to 31 December 2005 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 2004-2005 to sections 1 to 11;

(3) in establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization; the total amount of such tax reimbursements is estimated at US$ 4 625 890;

4. DECIDES:

(1) that notwithstanding the provisions of Financial Regulation 5.1, an amount of US$ 12 364 000 shall be financed directly by the Miscellaneous Income account to provide an adjustment scheme for the benefit of those Member States that will experience an increase in the rate of assessment between that applicable for the financial period 2000-2001 and for the financial period 2004-2005 and notify the Organization that they wish to benefit from the adjustment scheme;[1]

(2) that the amount required to meet payments under the financial incentive scheme for 2004 and for 2005 in accordance with Financial Regulation 6.5, estimated at US$ 1 000 000, shall be financed directly by the Miscellaneous Income account;

(3) that the level of the Working Capital Fund shall remain at US$ 31 000 000 as decided previously under resolution WHA52.20;

5. REQUESTS the Director-General to provide budget information on staffing and categories of expenditure resulting from the operational planning for 2004-2005 to the Executive Board at its 113th session;

6. NOTES that the expenditure in the programme budget for 2004-2005 to be financed from sources other than the regular budget is estimated at US$ 1 824 500 000, leading to a total effective budget under all sources of funds of US$ 2 704 611 000.

The second draft resolution, on scale of assessments for the financial period 2004-2005, as proposed by the Director-General, read:

The Fifty-sixth World Health Assembly,

1. DECIDES to accept henceforth the latest available United Nations scale of assessment for assessed contributions of Member States, with a maximum assessment rate of 22% and a

[1] See resolution WHA56.34.

minimum assessment rate of 0.001%, taking into account differences in membership between WHO and the United Nations;

2. DECIDES that the scale of assessments for the years 2004 and 2005 shall be as follows:

| (1) Members and Associate Members | (2) WHO scale 2004-2005 % |
|---|---|
| Afghanistan | 0.00890 |
| Albania | 0.00300 |
| Algeria | 0.06890 |
| Andorra | 0.00390 |
| Angola | 0.00200 |
| Antigua and Barbuda | 0.00200 |
| Argentina | 1.13050 |
| Armenia | 0.00200 |
| Australia | 1.60090 |
| Austria | 0.93180 |
| Azerbaijan | 0.00390 |
| Bahamas | 0.01180 |
| Bahrain | 0.01770 |
| Bangladesh | 0.00980 |
| Barbados | 0.00890 |
| Belarus | 0.01870 |
| Belgium | 1.11090 |
| Belize | 0.00100 |
| Benin | 0.00200 |
| Bhutan | 0.00100 |
| Bolivia | 0.00790 |
| Bosnia and Herzegovina | 0.00390 |
| Botswana | 0.00980 |
| Brazil | 2.35160 |
| Brunei Darussalam | 0.03250 |
| Bulgaria | 0.01280 |
| Burkina Faso | 0.00200 |
| Burundi | 0.00100 |
| Cambodia | 0.00200 |
| Cameroon | 0.00890 |
| Canada | 2.51690 |
| Cape Verde | 0.00100 |
| Central African Republic | 0.00100 |
| Chad | 0.00100 |
| Chile | 0.20860 |
| China | 1.50740 |
| Colombia | 0.19780 |
| Comoros | 0.00100 |
| Congo | 0.00100 |

| (1) Members and Associate Members | (2) WHO scale 2004-2005 % |
|---|---|
| Cook Islands[a] | 0.00100 |
| Costa Rica | 0.01970 |
| Côte d'Ivoire | 0.00890 |
| Croatia | 0.03840 |
| Cuba | 0.02950 |
| Cyprus | 0.03740 |
| Czech Republic | 0.19970 |
| Democratic People's Republic of Korea | 0.00890 |
| Democratic Republic of the Congo | 0.00390 |
| Denmark | 0.73700 |
| Djibouti | 0.00100 |
| Dominica | 0.00100 |
| Dominican Republic | 0.02260 |
| Ecuador | 0.02460 |
| Egypt | 0.07970 |
| El Salvador | 0.01770 |
| Equatorial Guinea | 0.00100 |
| Eritrea | 0.00100 |
| Estonia | 0.00980 |
| Ethiopia | 0.00390 |
| Fiji | 0.00390 |
| Finland | 0.51360 |
| France | 6.36210 |
| Gabon | 0.01380 |
| Gambia | 0.00100 |
| Georgia | 0.00490 |
| Germany | 9.61200 |
| Ghana | 0.00490 |
| Greece | 0.53030 |
| Grenada | 0.00100 |
| Guatemala | 0.02660 |
| Guinea | 0.00300 |
| Guinea-Bissau | 0.00100 |
| Guyana | 0.00100 |
| Haiti | 0.00200 |
| Honduras | 0.00490 |
| Hungary | 0.11810 |
| Iceland | 0.03250 |
| India | 0.33550 |
| Indonesia | 0.19680 |
| Iran (Islamic Republic of) | 0.26760 |
| Iraq | 0.13380 |
| Ireland | 0.28930 |
| Israel | 0.40830 |

[a] Not a Member of the United Nations.

| (1) Members and Associate Members | (2) WHO scale 2004-2005 % |
|---|---|
| Italy | 4.98340 |
| Jamaica | 0.00390 |
| Japan | 19.20220 |
| Jordan | 0.00790 |
| Kazakhstan | 0.02750 |
| Kenya | 0.00790 |
| Kiribati | 0.00100 |
| Kuwait | 0.14460 |
| Kyrgyzstan | 0.00100 |
| Lao People's Democratic Republic | 0.00100 |
| Latvia | 0.00980 |
| Lebanon | 0.01180 |
| Lesotho | 0.00100 |
| Liberia | 0.00100 |
| Libyan Arab Jamahiriya | 0.06590 |
| Lithuania | 0.01670 |
| Luxembourg | 0.07870 |
| Madagascar | 0.00300 |
| Malawi | 0.00200 |
| Malaysia | 0.23120 |
| Maldives | 0.00100 |
| Mali | 0.00200 |
| Malta | 0.01480 |
| Marshall Islands | 0.00100 |
| Mauritania | 0.00100 |
| Mauritius | 0.01080 |
| Mexico | 1.06850 |
| Micronesia (Federated States of) | 0.00100 |
| Monaco | 0.00390 |
| Mongolia | 0.00100 |
| Morocco | 0.04330 |
| Mozambique | 0.00100 |
| Myanmar | 0.00980 |
| Namibia | 0.00690 |
| Nauru | 0.00100 |
| Nepal | 0.00390 |
| Netherlands | 1.71010 |
| New Zealand | 0.23710 |
| Nicaragua | 0.00100 |
| Niger | 0.00100 |
| Nigeria | 0.06690 |
| Niue[a] | 0.00100 |
| Norway | 0.63560 |
| Oman | 0.06000 |

[a] Not a Member of the United Nations.

| (1) Members and Associate Members | (2) WHO scale 2004-2005 |
|---|---|
| | % |
| Pakistan | 0.06000 |
| Palau | 0.00100 |
| Panama | 0.01770 |
| Papua New Guinea | 0.00590 |
| Paraguay | 0.01570 |
| Peru | 0.11610 |
| Philippines | 0.09840 |
| Poland | 0.37190 |
| Portugal | 0.45460 |
| Puerto Rico[a,b] | 0.00100 |
| Qatar | 0.03340 |
| Republic of Korea | 1.82130 |
| Republic of Moldova | 0.00200 |
| Romania | 0.05710 |
| Russian Federation | 1.18070 |
| Rwanda | 0.00100 |
| Saint Kitts and Nevis | 0.00100 |
| Saint Lucia | 0.00200 |
| Saint Vincent and the Grenadines | 0.00100 |
| Samoa | 0.00100 |
| San Marino | 0.00200 |
| Sao Tome and Principe | 0.00100 |
| Saudi Arabia | 0.54510 |
| Senegal | 0.00490 |
| Serbia and Montenegro | 0.01970 |
| Seychelles | 0.00200 |
| Sierra Leone | 0.00100 |
| Singapore | 0.38670 |
| Slovakia | 0.04230 |
| Slovenia | 0.07970 |
| Solomon Islands | 0.00100 |
| Somalia | 0.00100 |
| South Africa | 0.40140 |
| Spain | 2.47830 |
| Sri Lanka | 0.01570 |
| Sudan | 0.00590 |
| Suriname | 0.00200 |
| Swaziland | 0.00200 |
| Sweden | 1.01030 |
| Switzerland | 1.25350 |
| Syrian Arab Republic | 0.07870 |
| Tajikistan | 0.00100 |
| Thailand | 0.28930 |

[a] Not a Member of the United Nations.

[b] Associate Member of WHO.

| (1) Members and Associate Members | (2) WHO scale 2004-2005 |
|---|---|
| | % |
| The former Yugoslav Republic of Macedonia | 0.00590 |
| Timor-Leste | 0.00100 |
| Togo | 0.00100 |
| Tokelau[a,b] | 0.00100 |
| Tonga | 0.00100 |
| Trinidad and Tobago | 0.01570 |
| Tunisia | 0.02950 |
| Turkey | 0.43290 |
| Turkmenistan | 0.00300 |
| Tuvalu | 0.00100 |
| Uganda | 0.00490 |
| Ukraine | 0.05210 |
| United Arab Emirates | 0.19870 |
| United Kingdom of Great Britain and Northern Ireland | 5.44700 |
| United Republic of Tanzania | 0.00390 |
| United States of America | 22.00000 |
| Uruguay | 0.07870 |
| Uzbekistan | 0.01080 |
| Vanuatu | 0.00100 |
| Venezuela | 0.20470 |
| Viet Nam | 0.01570 |
| Yemen | 0.00590 |
| Zambia | 0.00200 |
| Zimbabwe | 0.00790 |

The third draft resolution, entitled "Adjustment mechanism", as proposed by the Director-General, read:

> The Fifty-sixth World Health Assembly,
>
> DECIDES:
> (1) to establish an adjustment mechanism that shall be available to compensate those Member States that will experience an increase in their rate of assessment due to the change in the WHO scale of assessments for 2004-2005 and for 2006-2007 as compared with the WHO scale of assessment for 2000-2001;
> (2) that the compensation shall be available to Member States that notify the Director-General before the beginning of the year concerned that they wish to benefit from this mechanism;
> (3) that the maximum available to each Member State referred to in paragraph 1 shall be limited to the amount corresponding to the increase resulting from a change in the

[a] Not a Member of the United Nations.

[b] Associate Member of WHO.

WHO scale of assessment between 2000-2001 and 2004-2005 and between 2000-2001 and 2006-2007 applied to the sum of US$ 858 475 000;

(4) that the amount calculated in accordance with paragraph 3 shall be limited to a maximum of 60% of the increase in 2004, a maximum of 40% of the increase in 2005, a maximum of 40% of the increase in 2006, and a maximum of 30% of the increase in 2007;

(5) that the amounts calculated in accordance with paragraphs 3 and 4 shall be applied as a credit to Member States' accounts on 1 January of the year to which the credit relates;

(6) that a further transfer to the adjustment mechanism from Miscellaneous Income of US$ 8 655 000 shall be incorporated in the appropriation resolution for the biennium 2006-2007.

The DIRECTOR-GENERAL said that, following the informal consultations held over the past week, it appeared that most delegations were prepared to support a regular budget level of US$ 880 million, on the understanding that country programmes would be protected from any reduction. The regular budget would thus grow in real terms for the first time in many years, and the increase of US$ 25 million was one which WHO undoubtedly needed.

As for the financing of the regular budget, it had not proved possible to reach agreement on certain aspects, although a number of principles had been accepted. It had been agreed that countries should be helped to adjust to the impact of the latest United Nations scale of assessments, by setting aside a certain sum from Miscellaneous Income, although not so much as unduly to affect the level of the programme. Member States should be free to choose whether to avail themselves of the adjustment mechanism, which would be phased out after a certain period of time.

The main point at issue had been the length of time for which the adjustment mechanism should remain in place. Some delegations had considered that it should be phased out over three bienniums, which would cost some US$ 27 million, while others had considered that it should finish after one biennium, costing some US$ 12 million. Naturally, the longer the period chosen, the greater the amount of miscellaneous income which would be unavailable for financing programme activities. On the other hand, WHO had to recognize the impact of the latest United Nations scale on many countries, and their desire for an adjustment mechanism. If consensus could be reached on those issues, there would also be consensus on the principle that WHO would follow the United Nations scale in future bienniums, and that the matter would only be subject to discussion if the maximum or minimum assessment should change at any time.

Member States would undoubtedly prefer to approve the programme budget and scale of assessments by consensus than to put the matter to the vote. She had therefore proposed a compromise solution of a two-biennium phase-out period at a cost of US$ 21 million. If those who had favoured a one-biennium period were able to join a consensus on that solution, WHO would be able to adopt the principle of the United Nations scale immediately, at a cost of an additional US$ 9 million of the Organization's income over the next biennium. She pointed out to those Member States that had supported a three-biennium period that a growth in the WHO budget would be achieved in real terms and that only about a quarter of the sum they had envisaged for the adjustment mechanism would be lacking.

She invited delegations to approve by consensus the three draft resolutions, which outlined the details of her proposal. Such a consensus would demonstrate a strong and united front by the global community against disease and in favour of a healthier world.

Mr TOPPING (Legal Counsel) said that he had been asked to give a legal opinion on what was meant by "DECIDES to accept henceforth" in paragraph 1 of the draft resolution entitled "Scale of assessments for the financial period 2004-2005". Use of the word "henceforth" meant that the Health Assembly was adopting a policy that would remain in effect until a future Health Assembly took a different decision. Each Health Assembly was sovereign, and could decide on policy as it saw fit.

Mr SHEN Yongxiang (China) said that the three draft resolutions just introduced were extremely important for the future work of WHO. Pending instructions from his Government about the position China should adopt, he proposed that consideration of the resolutions be deferred to a later stage.

Dr SUWIT WIBULPOLPRASERT (Thailand), speaking on behalf of the Group of 77, said that he could accept the three draft resolutions in a spirit of consensus. The Group's understanding was that the adjustment mechanism was intended to benefit developing countries, and he expressed the hope that the developed countries would be sympathetic to the proposal. Thailand had voluntarily opted out of the adjustment scheme.

The Group of 77 was committed to achieving as high a budget as possible, so that more programmes for developing countries could be introduced. He requested that a list of countries that had taken advantage of the scheme should be compiled and submitted to the Fifty-seventh World Health Assembly, so that Member States could be sure that the budget would not fall below the US$ 880 million which had been agreed. It might be necessary to draw up a list of countries eligible for the adjustment mechanism in order to maintain the budget at the agreed level.

Mr VOIGTLÄNDER (Germany) expressed appreciation of the efforts to find a solution to the budget problem. Germany would welcome a consensus. However, it was only fair that delegations should be given a detailed breakdown of the financial implications for each country of approval of the draft resolution on scale of assessments, and he requested that that information should be provided before a decision was taken. The working group had been provided with a dozen different sets of projected contributions for each Member State, based on the various solutions proposed, which had led to some confusion. It should not be difficult to provide projected contributions based on the solution that was being recommended.

Mr AITKEN (Chef de Cabinet) said that the information requested by the delegate of Germany was not normally issued before the scale of assessments was adopted. However, the information was available, and would be distributed before the draft resolutions were approved.

The CHAIRMAN suggested that, as proposed by China, the Committee should suspend consideration of the draft resolutions on the proposed programme budget, scale of assessments and adjustment mechanism until later in the meeting.

**It was so agreed.**

(For resumption of discussion and approval of resolutions, see section 4.)

## 3. TECHNICAL AND HEALTH MATTERS: Item 14 of the Agenda (resumed)

**Revision of the International Health Regulations:** Item 14.16 of the Agenda (Documents A56/25, A56/25 Add.1 and A56/48) (continued from the ninth meeting)

Dr RAHANTANIRINA (Madagascar) said that the revision of the International Health Regulations would allow Member States to ensure the best possible protection against the spread of diseases between countries. In Madagascar, the Ministry of Health, in conjunction with WHO, had set up a national decision-making group to monitor all the available information about threats of emerging diseases and epidemic outbreaks occurring in the country. Madagascar had not yet had any cases of severe acute respiratory syndrome (SARS), but was remaining vigilant and complying with all the measures prescribed by WHO. The main difficulty was still the lack of adequate telecommunications

for rapid contact with outlying health care facilities. The Ministry of Health was working hard on that problem. She supported the draft resolution in document A56/25 Add.1.

Ms DUNLOP (Australia) said that the revision of the International Health Regulations was timely and important. Australia had been participating as a "collaborating country" in the revision process, and was working closely with the review team. The SARS outbreak had demonstrated the need for compatibility between domestic and international regulatory and policy frameworks in communicable disease control. She strongly endorsed the draft resolution contained in resolution EB111.R13. The additional paragraphs to that resolution proposed by the Director-General in document A56/25 Add.1 set out some important aspects of preparedness and timely responses to public health emergencies. Those elements were consistent with her country's approach and were crucial to a comprehensive strategy. However, in view of the amendments to those paragraphs proposed by some delegations, she suggested that, if it were not possible to reach consensus on the points in question, the Committee should revert to the original resolution contained in resolution EB111.R13 and refer the detailed points of procedure to the intergovernmental working group. That would leave the way clear to approve an important resolution.

Mr FURGAL (Russian Federation) welcomed the report in document A56/25. The International Health Regulations were an important international instrument for preventing public health emergencies caused by the global spread of infections, not least in the context of new risks and threats such as SARS. Clearly, if the Regulations were to be effective in practice, Member States must be able and willing to comply with them. Thus, in addition to developing the Regulations, WHO faced the no less important task of ensuring national preparedness for collective action. The guidelines being prepared by the Organization on the design and implementation of early warning systems played a key role in that respect. Broad participation in the consultation process and in the intergovernmental working group would be equally important. His delegation supported the draft resolutions presented to the Committee.

Dr FALL (Senegal) thanked WHO for the support it had given his country in connection with the revision of the International Health Regulations. In the light of Senegal's experience of applying them, he strongly endorsed the draft resolution.

Dr MILIOS (Greece), speaking on behalf of the European Union, the acceding countries Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic and Slovenia and the associated countries, Bulgaria, Romania and Turkey, said that the International Health Regulations had proved successful in providing a bulwark against the international spread of infectious diseases. However, the considerable growth in international travel and trade called for increased epidemiological surveillance and control of communicable diseases. New criteria had to be taken into account in order to respond effectively to health threats. The European Union consequently supported the work of revising the International Health Regulations, and fully endorsed the draft resolution contained in resolution EB111.R13. It also welcomed the invitation to the European Commission to participate in the intergovernmental working group to draft the new text for the revised Regulations. The outbreak of SARS had shown the need for the revision process to be accelerated and for an international response. The European Union supported the amendments proposed in document A56/25 Add.1 to take account of the outbreak.

Mr HETLAND (Norway), also speaking on behalf of Denmark, Finland, Iceland and Sweden, said that a revision of the International Health Regulations was overdue. He joined the representative of Greece, on behalf of the European Union, in supporting the draft resolution in document A56/25 Add.1. He welcomed the draft resolution on SARS in document A56/48, but would have preferred a reference in the latter text to the language used in the revision of the Regulations, which included the term "public health emergency of international concern". That phrase was one of the most

important linkages between SARS and the International Health Regulations. He acknowledged the link between the Regulations and WHO's outbreak alert and response activities which were intended to ensure that epidemic outbreaks were contained at the lowest possible cost in human, social and economic terms. The Regulations should encompass all Member States, and be developed through a process of negotiations built on consensus. The key elements of a successful outcome would be willingness on the part of all Member States to negotiate and participate in the revision process; a clear and limited mandate; national and international capacity building to enable smooth implementation of the revised text; and sufficient financial resources.

The intergovernmental negotiations would have to deal with the obligation of Member States to report promptly on specific indicators; the conditions set for international verification of events; the legal framework for responses, so that disease outbreaks with potential international implications could be controlled without unnecessary interference with international trade, transport and travel, and with due respect for individual rights, privacy and confidentiality; and procedures for the resolution of disputes. The effectiveness of the revised Regulations would ultimately depend on the compliance of Member States and on their ability to work within the legal framework. He looked forward to participating in the intergovernmental working group proposed in resolution EB111.R13.

Mr NAIK (India) said that in his country the group of experts considering the revision of the International Health Regulations had made a number of recommendations. The legal status of measures to prevent the spread of yellow fever should not be weakened. Time limits for notifying public health emergencies of international concern must be realistic, in other words more than 24 hours. National sensitivities should be taken into account in the process of notification. A mechanism was needed to address conflicts in the notification of diseases, especially in the event of a conflict between national and international interests. WHO's recommendations should be treated by WTO as scientific evidence for the purpose of resolving conflicts relating to health and trade matters. The importance of existing quarantine procedures should not be undermined. The guidelines on hygiene and sanitation in aviation and shipping should be updated and disseminated as a matter of urgency. The Regulations should deal with health problems resulting from food and animal husbandry.

India had taken effective measures against SARS, and appreciated WHO's guidance in that regard.

Dr CALDERÓN (Bolivia) welcomed the timely inclusion of the subject in the Committee's agenda. The purpose of the revision was evidently to optimize epidemiological monitoring systems in the light of increasing migration and trade, which facilitated the spread of disease. The adoption of appropriate legal requirements would encourage monitoring at the country level. The International Health Regulations should be revised as soon as possible; Bolivia wished to participate in the proposed intergovernmental working group.

Dr KHAZAL (United Arab Emirates) stressed the importance of developing criteria for identifying health emergencies, in the context of outbreak alert and response activities. She supported the draft resolution in document A56/25 Add.1. Intensified control of infectious disease at the national level was the primary means of containing the spread of infection worldwide. It was also important to strengthen basic national health-care capabilities in support of disease monitoring systems. The SARS outbreak had highlighted the need to develop an early warning system through national and international cooperation. She urged Member States to respond favourably to the invitation of the Health Assembly to participate in the intergovernmental working group.

Mr FERNÁNDEZ ALCÁZAR (Brazil) said that the emergence of SARS had highlighted the urgency of revising the International Health Regulations, which were outdated and inadequate. Brazil's Ministry of Health was participating actively in the revision process in respect of public health emergencies of international significance, and health regulations for ports, airports, and other

modes of transport. For that purpose, it had been collaborating actively with WHO, PAHO and other forums such as MERCOSUR. He supported the draft resolution.

Dr LEWIS-FULLER (Jamaica) commended the decisive and forthright response by WHO to the SARS epidemic, which had also demonstrated the need to review the International Health Regulations. Regrettably, the documents before the Committee made no mention of animal health in relation to the resurgence and emergence of diseases; zoonoses such as bovine spongiform encephalopathy and hantavirus infection underlined the importance of collaborating closely with professionals and researchers in other disciplines such as animal health, veterinary science and agriculture. On that basis, she suggested that the draft resolution contained in document A56/25 Add.1 be amended by inserting a new paragraph in the preamble, that would read: "Recognizing the part played by animals in the transmission and pathogenesis of some diseases which occur in humans". In paragraph 3, a new subparagraph (3) should be added, that would read: "to ensure collaboration with veterinary, agricultural and other relevant agencies involved in animal care, in research, planning and implementing preventive and control measures, when appropriate". In addition, the phrase "having included technical input from relevant disciplines and agencies, in particular, those involved in the veterinary field, animal care and relevant agricultural professionals", should be added to paragraph 5(1).

Dr CHIRWA (Zambia) said that his country had participated in the revision of the International Health Regulations, and had made several recommendations which had been incorporated into the draft resolutions. He emphasized the need for WHO to facilitate both the national and the international health emergency responses, in the light especially of the SARS outbreak. His delegation strongly supported the draft resolution in document A56/25 Add.1.

Dr UPUNDA (United Republic of Tanzania), expressing his country's support of the draft resolution, said that the revised International Health Regulations provided a good basis not only for establishing such regulations in respect of known epidemics, such as SARS, but also for tracking infectious diseases in general. He requested WHO to help to consolidate integrated disease surveillance so that any such problem could be pinpointed in good time.

Dr PARIRENYATWA (Zimbabwe) expressed full agreement with the process of revision of the International Health Regulations in the context of WHO's outbreak alert and response activities, the inclusion of criteria to define a public health emergency, and a description of the basic minimum capabilities and capacities needed by Member States to operate their national systems for disease surveillance and response. Zimbabwe had designated a focal point for the International Health Regulations, having in 1995 established a port health authority at international airports and frontier posts in order to suppress and limit transmission of infectious diseases across its borders. Zimbabwe had always reported outbreaks promptly, and had worked closely with WHO to contain outbreaks of cholera and malaria and to prepare for such threats as haemorrhagic fever, SARS, zoonotic diseases and foot-and-mouth disease. WHO's contribution in that respect was therefore greatly appreciated.

Mr HAIGH (European Commission) said that the speed at which the SARS outbreak had spread and its human and economic impact was a striking reminder that infectious diseases remained a threat. Trade and travel meant that the international community needed to work together to respond to major threats to public health if current freedom of movement were to continue; those were the principles that the revision of the International Health Regulations was attempting to address.

During the SARS crisis, all nations had had the support of WHO. The European Commission and the European Union Member States had cooperated closely with WHO, enabling Union initiatives to be based principally on the global guidance WHO had provided. The Health Assembly provided an excellent opportunity for reviewing how that experience could be used to reinforce international surveillance and support mechanisms to respond to health emergencies. Government institutes and

authorities in the European Union were networked to provide the backbone of European cooperation on the prevention and control of communicable diseases during outbreaks with a Community dimension; that network had taken a leading role in providing Member States and the Commission with advice, information and suggestions for both immediate and longer-term actions.

At a meeting in Brussels (6 May 2003) which the Director-General had attended, health ministers of the European Union had discussed SARS, agreeing on the need for further action within the Union itself under the network, continued cooperation with WHO, and assistance to affected areas. The Commission would report back to the ministers in June 2003 on achievements and what had yet to be done.

Although the European Union was fortunate in having robust methods of surveillance of communicable diseases, it had nevertheless been surprised by the SARS outbreak and lacked validated diagnostic tests, vaccines and antiviral agents, for example; nor did it have all the answers to reassure the travelling public, either in the SARS crisis or for a similar future situation.

The ministers had asked the Commission to consider developing a general preparedness plan for future combat against infectious disease outbreaks, and the Commission intended to propose the creation of a European centre on communicable diseases in order better to coordinate the expertise of Member States and provide improved institutional synergy in support of international endeavours. The link with the International Health Regulations was clear, and such a centre would have a coordinating role in the context of the revised Regulations.

The Commission looked forward to continuing its constructive collaboration with WHO and fully participating in the intergovernmental working group in order to facilitate the timely revision and subsequent implementation of the Regulations.

Dr HEYMANN (Executive Director) thanked Member States for their comments and support for the revision of the International Health Regulations, gratifyingly seen as a proactive set of regulations that could be implemented through WHO's Global Outbreak Alert and Response Network. Much had been learned from the 30 or more major public health events that occurred each year and were managed under that network, including the current response to SARS. In the coming year, WHO would work with Member States to include the lessons learned in the revision of the International Health Regulations in order to make them useful for global surveillance and response in the twenty-first century. He looked forward to continued work over the coming two years in regional consensus meetings, followed by the intergovernmental working group on the revision process. Discussions would also be continued with WTO and other trade-related organizations, and with FAO and the Office International des Epizooties for issues related to animal health. WHO would also continue to support countries in strengthening their national surveillance, prevention and control activities for naturally occurring public health events.

The CHAIRMAN drew attention to the resolution in document A56/25 Add.1 and invited the Secretary to give particulars of the amendments proposed.

Dr ISLAM (Secretary) said that Jamaica's proposed amendment for a preambular paragraph would be inserted after the second preambular paragraph to read: "Recognizing the part played by animals in the transmission and pathogenesis of some diseases which occur in humans;".

The CHAIRMAN said that, in the absence of any objections, he took it that Jamaica's amendment could be included in the resolution. He asked whether the United States of America still wished to delete all the proposals made in document A56/25 Add.1 that were at variance with the initial text proposed by the Executive Board. That proposal initially referred to the last preambular paragraph, whereas several additional amendments had since been made to the resolution. The preference of the United States had been noted, but he wondered whether it could agree to keep the text proposed by the Secretariat.

Mr HOHMAN (United States of America) said that a number of other countries also supported the adoption of the resolution recommended by the Executive Board, in its original form. However, he would not stand in the way of consensus.

The CHAIRMAN said that he therefore took it that the last preambular paragraph could remain in the resolution.

Dr ISLAM (Secretary) read out Jamaica's proposal to add a third subparagraph to paragraph 3:

"(3) to ensure collaboration with veterinary, agricultural and other relevant agencies involved in animal care and research, planning and implementing preventive and control measures when appropriate;"

The CHAIRMAN said that, in the absence of any objections, that amendment would be included in the text to be considered as a whole.

Dr ISLAM (Secretary) read China's proposal with regard to paragraph 4(1), accommodating the country's recommendation to divide it into two parts:

"(1) to take into account the reports from sources other than official notifications, to validate these reports according to established epidemiological principles;
"(2) to alert, when necessary and after informing the government concerned, the international community to the presence of a public health threat that may constitute a serious threat to neighbouring countries or to international health based on the outline and procedures that are jointly developed with Member States."

The CHAIRMAN said that, in the absence of any objections, that amendment could be accepted.

Mr AITKEN (Chef de Cabinet) read out the amendment, submitted by China in writing, that would become new paragraph 4(3): "to collaborate with national authorities in assessing the severity of the threat and the adequacy of control measures and, when necessary, in conducting on-the-spot studies by a WHO team with the purpose of ensuring that appropriate control measures are being employed". The change would mean that the conducting of on-the-spot studies would refer to "collaboration" rather than to "informing" which had been in the text of paragraph 4(2) in the version that appeared in document A56/25 Add.1, in other words the request would be to collaborate in conducting on-the-spot studies rather than to inform on conducting on-the-spot studies. The activity of the Organization would nevertheless continue in terms of doing the on-the-spot studies.

Dr TAHA ARIF (Malaysia), asking for clarification about the impact for countries, said that the version proposed in document A56/25 Add.1 meant that WHO had the right to enter any country when necessary, even without the consent of that country, whereas in the proposed amendment such consent was necessary.

The DIRECTOR-GENERAL, recognizing that several delegations wanted to know what the change of language implied, said that WHO would collaborate with national authorities in any case and be more effective for so doing. Everybody was aware, however, that there was a global public health interest that went beyond collaboration with the national authorities of any single Member State. There was a fine balance. She considered that, if the Director-General saw that it was necessary, given the epidemiological situation, after collaboration with the Member State, that on-the-spot studies by a WHO team should be undertaken, then it should be agreed that such studies should take place – but they would be done in collaboration with the national authorities. If that were not the meaning, she

could imagine that many delegations would be concerned about the proposed amendment. It was important to be clear on what that collaboration meant.

Dr TAHA ARIF (Malaysia) said that he was satisfied with that explanation.

The CHAIRMAN took it that the Committee was ready to accept the new paragraph 4(3) proposed by China.

Dr ISLAM (Secretary) read out Jamaica's proposed addition to the end of paragraph 5(1):

"... having included technical input from relevant disciplines and agencies, in particular those involved in the veterinary field, animal care, and relevant agricultural professionals".

Mr HOHMAN (United States of America) suggested replacing "in particular" in that proposal by "including".

The CHAIRMAN suggested that, in the absence of any objection, Jamaica's amendment to paragraph 5(1), as amended by the United States of America, could be accepted. With all those amendments, he invited the Committee to approve the draft resolution as a whole.

**The draft resolution, as amended, was approved.**[1]

**SARS**

The CHAIRMAN invited the delegate of Thailand to introduce a draft resolution on the related issue of SARS.

Dr WANCHAI SATTAYAWUTHIPONG (Thailand) reported that an informal working group, with delegates from 37 Member States participating, had considered the draft resolution on SARS in document A56/48, and had prepared a revised text in response to recommendations made at special meetings of health ministers in Asia and the European Union and Asian aviation authorities in April and May 2003 and in view of the related resolution just approved. The text read:

> The Fifty-sixth World Health Assembly,
>
> Having considered the report on the emergence of severe acute respiratory syndrome (SARS) and the international response;[2]
>
> Recalling resolutions WHA48.13 on new, emerging and re-emerging infectious diseases, WHA54.14 on global health security – epidemic alert and responses, EB111.R13 on revision of the International Health Regulations, and EB111.R6 on the prevention and control of influenza pandemics and annual epidemics;
>
> Deeply concerned that SARS, as the first severe infectious disease to emerge in the twenty-first century, poses a serious threat to global health security, the livelihood of populations, the functioning of health systems, and the stability and growth of economies;
>
> Deeply appreciative of the dedication in responding to SARS of health care workers in all countries, including WHO staff member, Dr Carlo Urbani, who in late February 2003 first brought SARS to the attention of the international community, and died of SARS on 29 March 2003;

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA56.28.

[2] Document A56/48.

Recognizing the need for Member States to take individual and collective actions to implement effective measures to contain the spread of SARS;

Acknowledging that the control of SARS requires intensive regional and global collaboration, effective strategies and additional resources at local, national, regional and international levels;

Appreciating the crucial role of WHO in a worldwide campaign to control and contain the spread of SARS;

Acknowledging the great effort made by affected countries, including those with limited resources, and other Member States in containing SARS;

Acknowledging the willingness of the scientific community, facilitated by WHO, to collaborate urgently, which led to the exceptionally rapid progress in the understanding of a new disease;

Noting, however, that much about the causative agent and the clinical and epidemiological features of SARS remains to be elucidated, and that the future course of the outbreak cannot as yet be predicted;

Noting that national and international experiences with SARS contribute lessons that can improve preparedness for responding to, and mitigating the public health, economic, and social consequences of the next emerging infectious disease, the next influenza pandemic, and the possible use of a biological agent to cause harm;

Seeking to apply the spirit of several regional and international efforts in fighting the SARS epidemic, including the ASEAN +3[1] Ministers of Health Special Meeting on Severe Acute Respiratory Syndrome (SARS) (Kuala Lumpur, 26 April 2003), the Special ASEAN-China Leaders Meeting on the Severe Acute Respiratory Syndrome (SARS) (Bangkok, 29 April 2003), Emergency Meeting of SAARC Health Ministers on the SARS Epidemic (Malé, 29 April 2003), ASEAN +3 Aviation Forum on the Prevention and Containment of SARS (Manila, 15-16 May 2003), and the Extraordinary Council of European Union Health Ministers Meeting (Brussels, 6 May 2003),

1. URGES Members States:

(1) to commit fully to controlling SARS and other emerging and re-emerging infectious diseases, through political leadership, the provision of adequate resources, including through international cooperation, intensified multisectoral collaboration and public information;

(2) to apply WHO recommended guidelines on surveillance, including case definitions, case management and international travel;[2]

(3) to report cases promptly and transparently and to provide requested information to WHO;

(4) to enhance collaboration with WHO and other international and regional organizations in order to support epidemiological and laboratory surveillance systems, and to foster effective and rapid responses to contain the disease;

(5) to strengthen, to the extent possible, capacity for SARS surveillance and control by developing or enhancing existing national programmes for communicable disease control;

(6) to ensure that those with operational responsibilities can be contacted by telephone or through electronic communications at all times;

(7) to continue to collaborate with and, when appropriate, provide assistance to WHO's Global Outbreak Alert and Response Network as the operational arm of the global response;

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[1] China, Japan, and the Republic of Korea.

[2] Travel to and from areas affected by SARS, in-flight management of suspected SARS cases who develop symptoms while on board, including aircraft disinfection techniques.

(8) to request the support of WHO when appropriate, and particularly when control measures employed are ineffective in halting the spread of disease;
(9) to use their experience with SARS preparedness and response to strengthen epidemiological and laboratory capacity as part of preparedness plans for responding to the next emerging infection, the next influenza pandemic, and the possible deliberate use of a biological agent to cause harm;
(10) to exchange information and experience on epidemics and the prevention and control of emerging and re-emerging infectious diseases in a timely manner, including among countries sharing land borders;[1]
(11) to mitigate the adverse impact of the SARS epidemic on the health of the population, health systems and socioeconomic development;

2. REQUESTS the Director-General:
(1) to further mobilize and sustain global efforts to control the SARS epidemic;
(2) to update and standardize guidelines on international travel, in particular those related to aviation, through enhanced collaboration with other international and regional organizations;
(3) to update guidelines on surveillance, including case definitions, clinical and laboratory diagnosis, and management, and on effective preventive measures;
(4) to review and update, on the basis of epidemiological data and information provided by Member States, the classification of "areas with recent local transmission", through close interactive consultation with the Member States concerned, and in a manner that safeguards the health of populations while minimizing public misunderstanding and negative socioeconomic impact;
(5) to mobilize global scientific research to improve understanding of the disease and to develop control tools such as diagnostic tests, drugs and vaccines that are accessible to and affordable by Member States, especially developing countries and countries with economies in transition;
(6) to collaborate with Member States in their efforts to mobilize financial and human resources and technical support in order to develop or enhance national, regional and global systems for epidemiological surveillance and to ensure effective responses to emerging and re-emerging diseases, including SARS;
(7) to respond appropriately to all requests for WHO's support for surveillance, prevention, and control of SARS in conformity with the WHO Constitution;
(8) to strengthen the functions of WHO's Global Outbreak Alert and Response Network;
(9) to strengthen the global network of WHO collaborating centres in order to carry out research and training on the management of emerging and re-emerging diseases, including SARS;
(10) to take into account evidence, experiences, knowledge and lessons acquired during the SARS response when revising the International Health Regulations;
(11) to report to the Fifty-seventh World Health Assembly through the Executive Board at its 113th session on progress made in the implementation of this resolution.

The text had been widely endorsed by Member States in its treatment of the technical aspects of SARS prevention and control.

[1] WHO regards any country with an international airport, or sharing a border with an area having recent local transmission of SARS, as being at risk of imported cases.

The CHAIRMAN asked whether the Committee was ready to approve the draft resolution before it.

**The draft resolution was approved.**[1]

Dr FUKUDA (Japan) said that the resolution just approved was an important step forward for the international community in its collective fight against SARS, which was a global rather than local or regional issue, as his country's Senior Vice-Minister for Health had recently stated. Member States, the Director-General and her staff should work together to tackle SARS and other emerging infectious diseases, bearing in mind both that new resolution and WHO's constitutional objective of "the attainment by all peoples of the highest possible level of health". Japan remained committed to fighting SARS.

Dr CICOGNA (Italy) expressed appreciation for the generous and brave response of all health care workers and professionals engaged in the fight against SARS. He paid tribute, in particular, to Carlo Urbani, the Italian epidemiologist and infectious disease specialist who had worked for WHO in Hanoi and first brought SARS to the attention of the international community before dying of the disease at the age of 46. He and other health care workers constantly in the front line against dangerous health threats had earned gratitude and admiration.

**The Committee applauded.**

Mr SHA Zukang (China) expressed satisfaction that the SARS resolution had been approved, in view of the threat it posed to the health and lives of people everywhere. SARS should not be complicated by irrelevant non-health issues. In the current situation, it was necessary and timely for the Health Assembly to adopt a resolution on the issue, and his delegation had, in a cooperative spirit, participated actively in the drafting process. Most Member States had participated in a professional, responsible and constructive manner, and it was regrettable that a few countries had attempted to use the drafting process to advance their own political purposes, which they had failed to fulfil by other means. That tendency to politicize technical issues had to stop.

Although WHO was important to and had done much to help China, it could not be more important than State sovereignty, territorial integrity and sovereign dignity. His Government attached importance to the health issue of SARS, but would not compromise on State sovereignty and territorial integrity. If a political confrontation were to arise, China would have no choice but to stand firm.

His delegation had not blocked consensus, but it was not satisfied with the resolution as worded. WHO had no role comparable to that of the Security Council and was composed of sovereign States only. His delegation understood paragraph 2(7) to mean that, before responding to requests for WHO's assistance, the Director-General had to obtain the consent of the government of the Member State concerned.

Mr HOHMAN (United States of America) said that his delegation had been pleased to join the consensus for approval of the resolution, which had reaffirmed WHO's worldwide mandate to respond to health crises wherever they occurred. For the United States, the important element of the resolution was the paragraph just referred to by the delegate of China, namely the text asking the Director-General to respond to all requests on behalf of WHO, as a worldwide organization with a global mandate.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA56.29.

Ms HOCHSTETTER (Guatemala) said that her delegation fully supported the resolution, having accepted the wording of paragraph 2(7) in the interests of consensus. However, it considered the reference to the WHO Constitution unnecessary, as all the actions of the Director-General were undertaken in accordance with it. The Constitution clearly enshrined the principle of the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being. Thus WHO's objective was that all peoples should attain that standard of health. To that end, its functions included promoting cooperation among scientific and professional groups which contributed to the advancement of health; providing information, counsel and assistance in the field of health; assisting in developing an informed public opinion among all peoples on matters of health; and generally, taking all necessary steps to attain the objective of the Organization.

It was essential to prevent and control the spread of SARS. Her delegation was confident that WHO and its Director-General would act in accordance with the Constitution, responding appropriately to all requests for support in the areas of monitoring, prevention and control of SARS. Political matters extraneous to health should not prevent the peoples of the world from receiving direct assistance from WHO whenever it was urgently needed.

Dr NÚÑEZ (Dominican Republic) welcomed the approval of the resolution. Paragraph 2(7) covered the issue of direct cooperation between WHO and all the peoples of the world, as called for in Article 2(*e*) of the WHO Constitution: "to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories".

Mrs BU FIGUEROA (Honduras) said that her delegation fully supported the resolution, which met the concerns of all countries and covered the points made by the Director-General in her address. The Ministry of Health of her country, with technical support from WHO, had taken the necessary measures to protect the country from SARS, but sympathized with countries that were affected by it. Honduras was also profoundly concerned that Taiwan, despite the efforts being expended by its Government to halt the disease, was not able to benefit from the specific response of WHO. No country should be excluded from the services of WHO. It was therefore an international obligation to secure for Taiwan a voice in the Health Assembly.

Mr GONZÁLEZ SANZ (Costa Rica) thanked all Member States whose goodwill had enabled consensus to be achieved. It was vital that WHO should respond to all requests for help, without political distinctions or priorities, so that everyone could be guaranteed full enjoyment of the right to health.

Mrs GONZÁLEZ NAVARRO (Cuba) welcomed the approval of the resolutions on SARS and the International Health Regulations, but expressed concern that topics that had been resolved on the first day of the Committee's work were still being reintroduced, in a confusing manner, into a debate that was supposed to be about SARS and the International Health Regulations. She called on Member States to remain focused on questions of health.

Mr BARREIRO PERROTA (Paraguay) said that it was a moral imperative and a question of international solidarity to provide assistance to countries affected by SARS. He called on Member States to make a political commitment to whatever measures WHO might take in order to improve public health.

**WHO's contribution to the follow-up of the United Nations General Assembly special session on HIV/AIDS:** Item 14.4 of the Agenda (Resolution EB111.R4; Documents A56/12 and A56/12 Appendix Rev.1[1]) (continued from the fifth meeting)

The CHAIRMAN drew attention to a draft resolution on the global health-sector strategy for HIV/AIDS, proposed by the Executive Board and subsequently amended by the delegations of Canada, China, Cuba, Finland, India, Jamaica, Thailand, United Kingdom of Great Britain and Northern Ireland and United States of America. It read:

The Fifty-sixth World Health Assembly,

Having considered the draft global health-sector strategy for HIV/AIDS;[2]

Mindful of WHO's role, as a cosponsor of UNAIDS, in ensuring that the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS (June 2001) is followed up;

Deeply concerned about the unprecedented burden the HIV/AIDS epidemic is placing on the health sector, and acknowledging the central role of that sector in providing an expanded, multisectoral response;

Conscious of the opportunities and challenges presented by the availability of new resources to Member States through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and from the World Bank, bilateral agencies, foundations and other donors;

Acutely aware of the need to strengthen health-sector capacity in order: (a) to absorb and manage resources; (b) to improve planning, prioritization, development of human resources, programme management, integration and implementation of key interventions, mobilization of nongovernmental organizations, and assurance of service quality **and sustainability (Finland)**; and (c) to support research as part of national responses;

Equally conscious of the need simultaneously to expand activities in prevention, treatment, care, support, surveillance, monitoring and evaluation, as essential and mutually supportive elements of a strengthened overall response to the HIV/AIDS epidemic;

Aware of the corresponding increase in demand by Member States for technical support, normative guidance and strategic information in order to make optimal use of resources and to maximize the impact of interventions;

Recalling that resolution WHA53.14 requested the Director-General, *inter alia*, to develop a global health-sector strategy for HIV/AIDS and sexually transmitted infections,

1. TAKES NOTE of the global health-sector strategy for HIV/AIDS;

2. EXHORTS Member States, as a matter of urgency:

(1) to adopt and implement the strategy as appropriate to national circumstances as part of national, multisectoral responses to the HIV/AIDS epidemic;

(2) to strengthen existing, or to establish new, structures, and to mobilize and engage all concerned parties, within and beyond the health sector, in order to implement the strategy through the health and other concerned sectors and to monitor and evaluate its effectiveness;

(3) to take all necessary steps, **including the mobilization of resources, (India)** to fulfil their obligations under the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS, **including (United States of**

[1] See document WHA56/2003/REC/1, Annex 5.

[2] Document A56/12, Annex.

**America) those related to access to care and treatment; (Canada) and efforts to prevent HIV infection; (United Kingdom of Great Britain and Northern Ireland)**

**(4) to strengthen measures of cooperation, both bilaterally and multilaterally, (Cuba) and support to fight the HIV/AIDS epidemic whether directly among themselves, or through WHO or other competent international and regional institutions; (Cuba)**

**(5) to place public health interests above trade interests, to recognize the difficulties faced by developing countries in effective use of compulsory licensing in accordance with the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), and to ease, when necessary, patent requirements in order to meet the needs of developing countries for drugs against HIV/AIDS; (China)**

3. REQUESTS the Director-General:

(1) to provide support to Member States, on request, in implementing the strategy and evaluating its impact and effectiveness;

(2) to cooperate with those Member States that request technical support in the preparation of their submissions to the Global Fund to Fight AIDS, Tuberculosis and Malaria;

**(3) to take the necessary steps to assure that offers of bilateral and multilateral (Australia) collaboration and support submitted by one or more Member States with regard to fighting the HIV/AIDS epidemic are widely disseminated and promoted among the rest of the Member States, and periodically to assess the impact of this proceeding at the Health Assembly; (Cuba)**

**(4) to support, (United States of America) mobilize, and facilitate (Jamaica) efforts of Member States and all other concerned parties to achieve the goal of providing in a poverty-focused manner, equitably and to those most vulnerable (United Kingdom of Great Britain and Northern Ireland), effective (Thailand) antiretroviral treatment within the context of strengthening national health systems (United Kingdom of Great Britain and Northern Ireland), while maintaining a proper balance of investment between prevention, care, and treatment (Thailand), and bearing in mind WHO's target of reaching (United States of America) at least three million people with HIV in developing countries by 2005;**[1]

**(5) further to mobilize Member States and all parties in support of actions taken by countries with an AIDS epidemic, especially developing countries, to obtain affordable and accessible drugs to combat HIV/AIDS; (China)**

**(6) to report to the Fifty-seventh World Health Assembly through the Executive Board at its 113th session on progress made in the implementation of this resolution. (Canada and United States of America)**

He drew attention to the portions of text that had been added as a result of the amendments.

Mr HOHMAN (United States of America), supported by Mrs GONZÁLEZ NAVARRO (Cuba), suggested that paragraph 2(4) should begin "to strengthen measures of cooperation and support".

Mr CHEN Xianyi (China) suggested that in paragraph 2(5) the phrase "to reaffirm that public health interests are paramount in both pharmaceutical and health policies," should replace "to place public health interests above trade interests".

[1] Document A56/12.

Mr HOHMAN (United States of America) suggested replacing the last part of paragraph 2(5), following "(Doha Declaration)" by "and when necessary to use the flexibilities in the TRIPS Agreement in order to meet the needs of developing countries for drugs against HIV/AIDS".

Mr CHEN Xianyi (China) said that he was willing to accept that amendment.

Dr HOLCK (Secretary) read paragraph 2(5) in the version currently proposed:

"to reaffirm that public health interests are paramount in both pharmaceutical and health policies, to recognize the difficulties faced by developing countries in effective use of compulsory licensing in accordance with the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), and when necessary to use the flexibilities in the TRIPS Agreement in order to meet the need of developing countries for drugs against HIV/AIDS;".

**The draft resolution, as amended, was approved.**[1]

**Traditional medicine:** Item 14.10 of the Agenda (Resolution EB111.R12; Document A56/18) (continued from the eighth meeting, section 2)

The CHAIRMAN drew attention to a draft resolution on traditional medicine, proposed by the Executive Board in resolution EB111.R12 and amended by the delegations of Cameroon, Democratic Republic of the Congo, Denmark, Germany, Indonesia, Jamaica, Nicaragua, Senegal and Thailand, which read:

The Fifty-sixth World Health Assembly,

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43 and WHA54.11;

Noting that the terms "complementary", "alternative", "nonconventional" **or "folk" (Thailand)** medicine are used to cover many types of **nonconventional health care (Thailand)** which involve varying levels of training and efficacy;

Noting that the term "traditional medicine" covers a wide variety of therapies and practices which vary greatly from country to country and from region to region;

Being aware that traditional, complementary, or alternative medicine has many positive features, and that traditional medicine and its practitioners play an important role in treating chronic illnesses, and improving the quality of life of those suffering from minor illness or from certain incurable diseases;

Recognizing that traditional medicinal knowledge is the property of communities and nations where that knowledge originated, and should be fully respected;

Noting that the major challenges to the use of traditional medicine include the lack of organized networks of traditional practitioners, and of sound evidence of the safety, efficacy and quality of traditional medicine; and the need for measures to ensure proper use of traditional medicine and to protect and preserve the traditional knowledge and natural resources necessary for its sustainable application, and for training and licensing of traditional practitioners;

Noting further that many Member States have taken action to support the proper use of traditional medicine in their health systems,

1. TAKES NOTE of WHO's strategy for traditional medicine, and its four main objectives of framing policy, enhancing safety, efficacy and quality, ensuring access, and promoting rational use;

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA56.30.

2. URGES Member States, **in accordance with established national legislation and mechanisms (Germany)**:

(1) to adapt, adopt and implement, where appropriate, WHO's traditional medicine strategy as a basis for national traditional medicine programmes or work plans;

(2) where appropriate, to **formulate (Thailand)** and implement national policies and regulations on traditional and complementary and alternative medicine in support of the proper use of traditional medicine, and its integration into national health-care systems, depending on the circumstances in their countries;

(3) to recognize the role of **traditional medicine as part of one of the components (Senegal)** of primary health care services, particularly in low-income countries, and in accordance with national circumstances;

(4) to set up or expand and strengthen existing national drug-safety monitoring systems to monitor herbal medicines **and other traditional practices (Democratic Republic of the Congo);**

(5) to provide **adequate (Senegal)** support for research on traditional remedies;

(6) to take measures to protect, preserve **and to improve if necessary (Democratic Republic of the Congo)** traditional medical knowledge and medicinal plant resources for sustainable development of traditional medicine, **depending on the circumstances in each country; such measures might include, where appropriate (Denmark)** the intellectual property rights of traditional practitioners **over traditional medicine formulas and texts (Thailand),** as provided for under national legislation consistent with international obligations, **and the development of a *sui generis* protection system (Indonesia);**

(7) to **promote and support, if necessary (Cameroon)** and in accordance with national circumstances, provision of training and, if necessary, retraining of traditional **medicine (Cameroon)** practitioners, and of a system for the qualification, accreditation or licensing of traditional **medicine (Cameroon)** practitioners;

(8) to **provide reliable information (Thailand)** on traditional medicine and complementary and alternative medicine **to (Thailand)** consumers and providers **in order to promote their sound use (Thailand);**

**(9) where appropriate, to ensure safety, efficacy and quality of herbal medicines by determining standards for, or issuing monographs on, herbal raw materials and traditional medicine formulas (Thailand);**

**(10) to encourage the inclusion of herbal medicines in national essential drug lists, with a focus on a country's demonstrated public health needs (Thailand);**

**(11) to promote traditional medicine education in medical schools (Thailand);**

3. REQUESTS the Director-General:

(1) to facilitate the efforts of interested Member States to **formulate (Thailand)** national policies and regulations on traditional and complementary and alternative medicine, and to promote exchange of information and collaboration on national policy and regulation of traditional medicine among Member States;

(2) to provide technical support for development of methodology, **to monitor or ensure product quality, efficacy and safety, (Jamaica)** preparation of guidelines, and promotion of exchange of information;

***OR***

(2) to provide technical support for **the (Nicaragua)** definition of **indicators for those diseases treated by traditional medicine and which are classified as unspecified diseases (Nicaragua);**

(3) to seek, together with WHO collaborating centres, evidence-based information on the quality, safety, **efficacy (Thailand)** and cost-effectiveness of traditional therapies so as to provide guidance to Member States on the definition of products to be included in

national directives and proposals on traditional-medicine policy as used in national health systems;

**(4) to organize regional training courses on quality control of traditional medicines; (Thailand)**

(5) to collaborate with other organizations of the United Nations system and nongovernmental organizations in various areas related to traditional medicine, including research, protection of traditional medical knowledge and conservation of medicinal plants resources;

(6) to promote the important role of WHO collaborating centres on traditional medicine in implementing WHO's traditional medicine strategy, particularly in strengthening research and training of human resources;

(7) to allocate sufficient resources to traditional medicine at global, regional and country levels of the Organization;

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

Professor SZCZERBAŃ (Poland), referring to paragraph 2(3) and supported by Dr SZATMÁRI (Hungary), said that referring to traditional medicine as part of one of the components of primary health care would modify the well-defined concept of "primary health care". He suggested that the original wording, "to recognize the role of certain traditional practitioners as one of the important resources of primary health care services, ...," be retained.

Mr CHEN Xianyi (China) agreed that, although the amendment proposed by Senegal to paragraph 2(3) was appropriate to some cultures, in the present situation it would be preferable to revert to the original text.

Mr DIOUF (Senegal) said that, in the interests of consensus, he would withdraw his delegation's amendment to paragraph 2(3).

Dr THORNE (United Kingdom of Great Britain and Northern Ireland), referring to paragraph 2(6), suggested that, in order to make it clear that the "*sui generis* protection system" would be a national system, the last part of the paragraph should be modified to read "... and the development of national *sui generis* protection systems, as appropriate".

Mr HOHMAN (United States of America) said that since discussions were already under way within WIPO on intellectual property rights related to traditional medicine and traditional practitioners, the last part could be amplified to read: "... and engaging WIPO in discussions of the development of national *sui generis* protection systems, as appropriate".

Mr SARWONO (Indonesia) agreed with the amendment proposed by the United States of America.

Mr CHEN Xianyi (China) proposed insertion of the word "national" between "determining" and "standards" in paragraph 2(9).

Ms DUNLOP (Australia) proposed addition of the words "where appropriate" after "to encourage" in paragraph 2(10).

Mr HOHMAN (United States of America) suggested the addition of the words "and on verified quality, safety and efficacy of herbal medicines" at the end of that paragraph.

Ms DUNLOP (Australia) proposed the addition of the words "where appropriate" after "promote" in paragraph 2(11).

The CHAIRMAN pointed out that both texts for paragraph 3(2) could be included. In response to a query from Professor AKOSA (Ghana), he suggested that the comma after the word "methodology" in the first alternative should be removed.

After a lengthy discussion on the alternative paragraph 3(2), in which Mr CHEN Xianyi (China), Mr HOHMAN (United States of America), Dr SZATMÁRI (Hungary), Dr CHIRWA (Zambia), Mr CHAKALISA (Botswana), Professor AKOSA (Ghana), Mr ROKOVADA (Fiji), Dr LARUELLE (Belgium), Dr MAHJOUR (Morocco), Dr PARIRENYATWA (Zimbabwe) and the CHAIRMAN took part, a consolidated amended text was suggested by Dr MAHJOUR (Morocco), which read as follows: "to provide technical support to Member States in defining indications for treatment of diseases and conditions by means of traditional medicine".

Referring to paragraph 3(4), Dr SZATMÁRI (Hungary) proposed addition of the words "where appropriate" after "regional training courses".

**The draft resolution, as amended, was approved.**[1]

## 4. PROGRAMME BUDGET: Item 12 of the Agenda (resumed)

## FINANCIAL MATTERS: Item 16 of the Agenda (resumed)

The CHAIRMAN announced that the three draft resolutions would be considered together and that the Chinese delegation had joined the consensus on all three texts.

**The three draft resolutions were approved.**[2]

Dr CHRISTIANSEN (Norway) said that the working group on the programme budget had held a rich debate, making for a better understanding of positions and constraints. All delegates had negotiated in good faith and had displayed willingness to explore any possibility of reaching consensus on the budget level and scale of assessments. Their efforts had been driven by a common will to provide the Director-General with the resources required in order to pursue WHO's mission.

Delegates had been willing to consider a budget level for 2004-2005 higher than that initially accepted by their governments. Agreement had been reached on basing the scale of assessments on the criteria and scale of assessments adopted by the United Nations General Assembly and on considering the establishment of an adjustment mechanism to support Member States whose rates of assessment would increase. A consensus on a package composed of those elements had, however, proved to be elusive. The main sticking point had been the duration of the period of transition for returning to the United Nations scale of assessments without any relief or adjustment. Some delegates had asked for no less than three bienniums, whereas others could accept not more than one biennium. He was pleased to note that delegates had had the courage to reach the consensus that had eluded the working group because, in the coming years, WHO would need the strength and authority that only unity and consensus among Member States could bring.

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[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA56.31.

[2] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolutions WHA56.32, WHA56.33 and WHA56.34.

Mr LONG Zhou (China) thanked the Committee for having deferred consideration of the draft resolutions while his Government decided whether to accept them. The three resolutions did not resolve all concerns, especially with regard to appropriations. His Government had always held that the United Nations scale of assessments should not automatically be applied to the specialized agencies. Although that principle was acknowledged in the relevant General Assembly resolution, it was not reflected in the resolution just adopted by the Health Assembly. In a spirit of compromise and cooperation and in order to support the work of WHO, his delegation had not blocked the approval by consensus of the three resolutions, but that did not signify that it had weakened or abandoned its position on appropriations.

Mr BRODRICK (Australia) said that, in the discussion on the budget and scale of assessments, his Government had unambiguously supported a zero nominal growth budget financed by a scale of assessments based on that of the United Nations, with no relief or adjustment mechanism. It had joined the consensus on the package just adopted with some difficulty, because it disagreed with the budget level and the adjustment mechanism, particularly the extension of that mechanism into the 2006-2007 biennium. It therefore reserved the right to avail itself of its entitlement to take advantage of the relief mechanism.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) said that, as her Government was a strong supporter of the Organization's work, it had accepted the consensus on the package of resolutions. Nevertheless, throughout the negotiations, her delegation had made it clear that the relief provided in 2002-2003 should not be extended to 2004-2005 or beyond. WHO's resources should be used to fund its programmes, not for relief for certain developed and developing countries. Her Government had agreed to forego the US$ 3.5 million in relief due to it in 2002-2003, in the expectation that the relief scheme would end in the current biennium and that the WHO scale would thereafter be based on the United Nations scale. As the G77 group of countries had insisted on continuation of an adjustment mechanism to 2007, her Government reserved the right to apply for the relief due to it.

Ms BLACKWOOD (United States of America) expressed satisfaction that the resolutions on the regular budget for 2004-2005, a scale of assessments based on the United Nations scale and an adjustment mechanism had been approved by consensus, since that had always been WHO practice. Her delegation sincerely regretted that the budget did not allocate the maximum possible resources to the programme work of WHO but provided a selective credit to Member States for the next four years. It had nevertheless joined the spirit of consensus.

Mr MACPHEE (Canada) welcomed the Committee's decision to recommend that the Health Assembly accept the latest United Nations scale of assessments for WHO Member States for 2004-2005, consistent with a longstanding practice that had served WHO well for over 40 years. Notwithstanding his country's commitment to zero nominal growth, in a spirit of compromise, his delegation had joined the consensus on the proposed budget increase for 2004-2005 but urged WHO to ensure progress toward a more modern, effective organization, delivering full value-for-money and the highest standards of budget discipline and efficiency. There remained considerable scope for freeing resources through internal reallocation and priority setting.

His delegation had reluctantly accepted the consensus on the proposed adjustment mechanism but remained concerned about the ad hoc arrangement on principle and, notably, mitigatory relief beyond the 2004-2005 biennium. The adjustment mechanism was contrary to the very basis of the scale of assessments, which reflected "capacity to pay", and to the appropriation resolution, which requested an unacceptably high level of resources. That ad hoc arrangement would pose difficulties for WHO in the future and should not be taken as a precedent for other organizations within the United Nations system.

Mr MINAGAWA (Japan), noting that his country favoured zero nominal growth in the budget, nevertheless acknowledged that the package of proposals put forward had been based on long, intensive discussion. Respecting that process, his delegation had joined the consensus.

Mr SEADAT (Islamic Republic of Iran) said that the starting point for developing countries, which could face sharp increases in their contributions under the new scale of assessments, had been United Nations General Assembly resolution 55/5/C, which implied that the scale would not automatically apply to the specialized agencies of the United Nations. His delegation had, however, made concessions for the sake of consensus.

Ms KONGSVIK (Norway) stated that, although her country would be eligible to apply for relief under the adjustment scheme, it did not intend to avail itself of that right. It urged other Member States in the same position to waive the right or to exercise it to a minimum, in order to have the least impact on the level of the programme budget.

Dr ABDALLA (Sudan) said that he had some reservations about the resolutions, particularly with regard to the extension of relief for four years, since it would mainly be developed countries that benefited. In a spirit of consensus, however, his delegation had, waived its objections. He echoed the delegate of Norway in urging developed countries eligible for relief to voluntarily waive their right to it so that the money would be available for programmes.

Mrs BENAVIDES COTES (Colombia) said that the approval of the resolutions by consensus, after much work on the part of the working groups and concessions by Member States facing different economic situations and complex fiscal realities, reflected the spirit of solidarity and cooperation that should be the backdrop to the adoption of resolutions by the Health Assembly. Reiterating her concern regarding the increase in her country's contribution, she nevertheless expressed the hope that the relief criterion would enable developing countries, in particular, to honour their commitments to the Organization, so that it could continue to discharge the tasks with which it had been entrusted.

**The meeting rose at 18:25.**

## ELEVENTH MEETING

**Wednesday, 28 May 2003, at 09:00**

**Chairman:** Dr J. LARIVIÈRE (Canada)

### 1. FOURTH REPORT OF COMMITTEE A (Document A56/66)

Mrs JANKÁSKOVÁ (Czech Republic), Rapporteur, read out the draft fourth report of Committee A.

**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 09:45.**

[1] See page 342.

## COMMITTEE B

## FIRST MEETING

**Thursday, 22 May 2003, at 14:55**

**Chairman:** Mr L. ROKOVADA (Fiji)

### 1. OPENING OF THE COMMITTEE: Item 15 of the Agenda (Document A56/54)

The CHAIRMAN, welcoming participants, reminded the Committee that representatives of the Executive Board voiced the Board's views and explained the rationale behind recommendations for the Health Assembly's consideration. He drew attention to the third report of the Committee on Nominations (document A56/54),[1] in which Dr R. Constantiniu (Romania) and Mr So Se Pyong (Democratic People's Republic of Korea) were nominated for the offices of Vice-Chairmen of Committee B, and Mrs C. Velásquez de Visbal (Venezuela) was nominated as Rapporteur.

**Decision:** Committee B elected Dr R. Constantiniu (Romania) and Mr So Se Pyong (Democratic People's Republic of Korea) as Vice-Chairmen and Mrs C. Velásquez de Visbal (Venezuela) as Rapporteur.[2]

### 2. ORGANIZATION OF WORK

The CHAIRMAN drew attention to document EB111/2003/REC/1, which contained the resolutions and decisions adopted by the Board in January 2003 and to which frequent reference would be made. He suggested that the Committee should meet from 09:00 to 12:30, and from 14:30 to 17:30, and he urged speakers to restrict the length of their contributions to no more than three or four minutes.

**It was so agreed.**

Referring to agenda item 16.2, Appointment of the External Auditor, the CHAIRMAN said that he had been informed that some difficulties had been experienced at the last such election, and proposed that there should be no generalized distribution of campaign material in support of any candidate in the Health Assembly room.

**It was so decided.**

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[1] See page 339.

[2] Decision WHA56(4).

## 3. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 19 of the Agenda (Documents A56/44, A56/INF.DOC./4, A56/INF.DOC./5 and Corr.1, and A56/INF.DOC./6)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegations of Algeria, Bangladesh, Cuba, Egypt, Indonesia, Libyan Arab Jamahiriya, Malaysia, Mauritania, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Tunisia and United Arab Emirates, which read as follows:

The Fifty-sixth 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;

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

Recalling with appreciation the report of the Director-General[1] on the health conditions of and assistance to the Arab population in the occupied Arab territories, including Palestine;

Expressing its deep concern at the deterioration of the health conditions as a result of the Israeli military acts against the Palestinian people since 28 September 2000, acts such as firing on civilians, deliberate extra-judicial killing, which caused hundreds of deaths and tens of thousands of injuries among Palestinians, including a large number of children; imposition of siege on Palestinian areas, thus preventing medicines and food from reaching towns, villages and refugee camps, obstruction of the circulation of ambulances, injuring a number of ambulance crew members and denial of access of injured people to hospitals and health institutions, thus condemning them to death;

Expressing its grave concern at the continued acts of aggression which have caused large-scale death and injury among Palestinians, thus increasing the toll of casualties which have so far reached thousands killed and tens of thousands wounded since 28 September 2000;

Expressing its grave concern at the grave violations by the Israeli occupation authorities in the occupied Palestinian territories of international humanitarian law and international public law, as well as their adverse effects on public health;

Stressing the integrity of the entire occupied Palestinian territory and the importance of guaranteeing the freedom of movement of persons, medical products and goods within the Palestinian territory, including the removal of restrictions on the movement into and from East Jerusalem and the freedom of movement to and from the Palestinian territories, particularly for the wounded and sick;

Bearing in mind the adverse effects of the continued closure of the Palestinian territory on the health sector, particularly the children who have been prevented from receiving vaccination for over 20 months, leading to high risk of infectious diseases and epidemics among children, whereas vaccination and immunization against infectious diseases constitute a basic right of every child in the world;

Noting with deep anxiety and concern the deterioration resulting from the excessive use of force by the Israeli occupation forces against civilians, including medical teams and its negative impact on health programmes, especially on mother-and-child related programmes, vaccination, reproductive health, family planning, epidemic control, school health, control of drinking-water safety, insect control, mental health and health education;

Expressing its deep concern at the serious deterioration of the economic situation in the Palestinian territory which has become a serious threat to the Palestinian health system,

[1] Document A56/44.

aggravated by the withholding by Israel of funds due to the Palestinian Authority, including health insurance income;

Affirming that the risks menacing public health are increasing as a result of the Israeli military incursions in the occupied Palestinian territories, imposition of closures and curfews on various areas, the refusal by Israel to honour the payment of taxes due to the Palestinian National Authority, the need to secure the resources necessary for assuring basic needs, prevention of every access to places such as education premises, markets and medical clinics, the decrease in the level of vaccinations, the complications imposed on patients suffering from chronic diseases such as cardiovascular conditions, cancer or kidney problems;

Affirming that the Israeli occupation prevents access of the Palestinian people to basic services, including health services;

Affirming that the current situation in the occupied Palestinian territories undermines efforts to maintain public health and endangers people's security; and furthermore that its consequences will certainly have an adverse effect on public health;

Affirming the need to increase health support and assistance for Palestinian populations in the regions under the control of the Palestinian Authority and for the Arab populations in the occupied territories, including Palestinians and the population in the occupied Syrian Golan;

Reaffirming the right of Palestinian patients and medical staff to benefit from health facilities available in the Palestinian Health Institutions in occupied East Jerusalem;

Affirming the need to provide international protection for the Palestinian people and health assistance to the Arab populations in the occupied territories, including the occupied Syrian Golan;

Having considered the reports on health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine, particularly the Director-General's report,[1]

1. RECOGNIZES that the Israeli occupation is a serious health problem because of the serious threat it poses to the health and lives of Palestinian citizens;

2. STRONGLY CONDEMNS the persistence of the Israeli acts of aggression against Palestinian towns and camps, which have resulted so far in the death and injury of thousands of Palestinian civilians, including women and children;

3. STRONGLY CONDEMNS firing on ambulances and paramedical personnel by the Israel army of occupation, preventing ambulances and cars of the International Committee of the Red Cross from reaching the wounded and the dead to transport them to hospitals, thus leaving the wounded bleeding to death in the streets;

4. AFFIRMS the need to support the efforts of the Palestinian Ministry of Health to continue to provide emergency services, deliver health and disease prevention programmes, receive further casualties in the future and deal with thousands of cases suffering from physical and mental disabilities;

5. CALLS on Israel to release all the funds due to the Palestinian Authority, including health insurance dues;

6. URGES Member States, intergovernmental, nongovernmental and regional organizations to extend urgent and generous assistance to bring about health development for the Palestinian people and meet its urgent humanitarian needs;

[1] Document A56/44.

7. EXTENDS ITS THANKS AND APPRECIATION to the Director-General for her report[1] and for her continued efforts of providing necessary assistance to the Palestinian people in the occupied Palestinian territories;

8. STRONGLY DENOUNCES the refusal by the Israeli occupation authorities to allow the Director-General to visit the occupied Palestinian territories to undertake her missions in accordance with World Health Assembly resolutions;

9. REQUESTS the immediate institution of a fact-finding committee on the deterioration of the health situation in the occupied Palestinian territory and enable this committee to undertake its role in the soonest possible time;

10. REQUESTS the Director-General:

(1) to take urgent steps in cooperation with Member States to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, in particular so as to guarantee the free movement of those responsible for health, patients, of health workers and of emergency services, and the normal provision of medical goods to Palestinian medical premises, including those in Jerusalem;

(2) to continue providing both the necessary technical assistance to support health programmes and projects for the Palestinian people and emergency humanitarian assistance to meet needs arising from the current crisis;

(3) to take the necessary steps and make the contracts needed to obtain funding from various sources including extrabudgetary sources, to meet the urgent health needs of the Palestinian people;

(4) to continue her efforts to implement the special health assistance programme, taking into consideration the health plan of the Palestinian people, and adapt it to the health needs of the Palestinian people;

(5) to report on the implementation of this resolution to the Fifty-seventh World Health Assembly.

Mrs GABR (Egypt), introducing the draft resolution, said that it was brief and objective, concentrating on health aspects rather than political issues. It emphasized that health was a basic human right and constituted a fundamental principle, which had been adopted in all international instruments, including the Constitution of WHO. Having the inherent competence and the mandate to deal with health issues in every part of the world, WHO held the responsibility to tackle any violation of the human right to a healthy and decent life.

The resolution reviewed the gross violations listed in reports by various neutral international organizations, whereby the Palestinian victims of oppression and coercion were being subjected to an economic embargo, depriving them of humanitarian aid, medicines and even their insurance benefits. Elementary health services had been disrupted, including programmes for mothers and children, family planning, immunization and epidemic control. Moreover, the occupying forces were preventing citizens from receiving hospital treatment, ambulances were unable to reach the injured after artillery and bombing attacks, and even ambulance crew members were being fired on and killed. As a result, the health status of the Palestinian people had deteriorated to an unprecedented level. Furthermore, the occupying force had refused to allow the Director-General to visit the occupied territories and had stated that it would never accept a fact-finding commission, in view of the terrible effects that the occupiers did not wish the world to know of or see. Israel was consequently called upon to cease such gross infringements of the Palestinians' human rights and to take the necessary steps to improve the health status of people in the occupied territories, in accordance with its responsibilities under the

[1] Document A56/44.

Geneva Convention. She urged the Health Assembly to adopt the draft resolution by consensus, thereby fulfilling its duties as the pre-eminent organization for health care and offering the possibility of a better future for the highly vulnerable Palestinian people.

Mrs GONZÁLEZ NAVARRO (Cuba), supporting the statement by the delegate of Egypt and speaking as a sponsor of the draft resolution presented in defence of the rights of the Palestinian people, said that, in the many reports and resolutions on the Palestinian question since the creation of the United Nations in 1945, the necessity of urgently addressing the human rights and health situations had been raised time and again. Year after year, the United Nations General Assembly, the Security Council and the Commission on Human Rights had raised objections on the issue, and the Health Assembly was doing likewise from the legal, health policy and human rights angles. All those bodies had unequivocally recognized the inalienable rights of the Palestinian people and rejected both the illegal Israeli occupation and its massive and flagrant human rights violations as the occupying power. That morning they had listened with great concern to the presentation in the plenary denouncing the health situation and problems of the Palestinian people as a result of the Israeli occupation. She urged the Health Assembly to adopt the draft resolution by consensus.

Mr SHABESTARI (Iran) said that, given the persistence and terrible extent of the unlawful acts committed by Israel in the occupied territories, including Palestine, and their consequences for the health conditions of the Arab population there, the question must remain at the top of the Health Assembly's agenda. The latest report of the Special Rapporteur of the Commission on Human Rights on the situation in the occupied Palestinian territories testified to a marked deterioration in the human rights situation, including health, during 2002.

Israeli military operations in the West Bank and Gaza had left physical, economic and social devastation which, coupled with curfews, intensified operations at checkpoints and the obstruction of movement between towns and villages, had led to a severe humanitarian crisis. Palestinians in the West Bank and Gaza had suffered many direct and indirect consequences of Israeli attacks and collective punishment measures and the Israeli response to the uprising had drastically increased the death toll and casualties. The wounded were mistreated, vehicles transporting them were obstructed, medical personnel were assaulted as they delivered life-saving services, the army raided health facilities and the injured were arrested in hospitals. Continuous closures and curfews deprived Palestinians of access to primary health services and hospital care for weeks and months, prevented physicians and community health workers from passing through Israeli military checkpoints, and denied the passage of ambulances and the deployment of new stocks of medicines and supplies. Health professionals had been killed or injured while providing emergency care to the wounded. The overall decline in preventive services and the disruption to the treatment of patients suffering from serious conditions had led to the development of complications and to premature death. Moreover, hundreds of peace activists, as well as international medical teams, had been abused and fired upon. Meanwhile, active measures had been taken to prevent the establishment of an effective independent Palestinian health-care system, in an attempt to make the Palestinians dependent on the Israeli system, which was mainly controlled by the military.

Israeli policies in the occupied territories flagrantly violated the principles of international law and the provisions of the Charter of the United Nations, the Universal Declaration of Human Rights and the Fourth Geneva Convention. Israel continued to flout all such provisions, particularly those banning disproportionate force and humiliating treatment, and had ignored both the many resolutions that had been passed and the calls to end its inhuman practices. Unfortunately, the many planned international missions established and mandated to look into the situation in the occupied territories had been neglected by Israel, in an obvious attempt to cover up its crimes.

In the light of events in the occupied territories it was imperative for the international community to take effective measures to end the Israeli atrocities. The Palestinians and their health situation were in desperate need of urgent international action and assistance to save and protect lives.

WHO, with its mandate to promote and protect the health situation throughout the world, was the most appropriate forum to reflect on the appalling health tragedy in the Palestinian occupied territories.

He expressed support for the draft resolution and the statement by the delegate of Egypt. Calling for the draft resolution to be adopted by consensus, he urged the Health Assembly and WHO to investigate thoroughly the severe health conditions in the occupied Arab territories and examine how assistance could be dispatched to the Palestinian population.

Dr OTTO (Palau) said that, even having studied the relevant documents and listened to previous observations, he was no more enlightened as to where the truth lay in the matter. Nevertheless, he expressed sadness at the tragic and obvious fact that people were still being injured and lives lost in Israel and Palestine, particularly since women and children were often affected. He encouraged WHO, other United Nations agencies, nongovernmental organizations and other relevant parties to work to improve the health situation, especially of children, in both Palestine and Israel.

He had hoped to be able to support the draft resolution as a strategy for improving the health situation in the occupied Arab territories, including Palestine, but was disappointed to state that, unless amendments were made so that the resolution addressed purely matters of health, and the political elements and provisions condemning a Member State were removed, he would not be able to do so. He was prepared to condemn all conflicts and acts of violence, and recalled his delegation's previous support of Taiwan's admission to WHO as an observer, which had been rejected on the grounds that it was a political issue. He was likewise unable to support the draft resolution since it strayed far from addressing health issues alone.

Mr SHA Zukang (China), speaking on a point of order, noted that the matter of Taiwan, which had been resolved decades before, had been raised again. He reminded delegations to respect previous resolutions and not to waste the Health Assembly's precious time.

The CHAIRMAN requested speakers to confine their comments to the agenda item.

Dr PYAKALYIA (Papua New Guinea) acknowledged that the issues raised deserved the attention of the world community. According to his understanding, the causes of the problems were long-standing and needed to be resolved promptly and effectively in order to improve the health of the communities concerned. However, he questioned whether they could be solved through a resolution such as the draft under consideration, which he would not support since it contained an element of political implication. The issue should be dealt with by the United Nations General Assembly, not the Health Assembly.

Dr TAHA ARIF (Malaysia) expressed apprehension at the deteriorating health situation in the occupied Palestinian territories, where the occupying forces had denied the population access to essential services, including health services. He was gravely concerned at the continuing acts of aggression, which had caused hundreds of deaths and injuries among Palestinians, and at the killing of health staff and military attacks on ambulances and hospitals. For those reasons, his country had once again joined the sponsors of the draft resolution.

The Director-General had invited three countries, including Malaysia, to serve as members of a fact-finding committee and his country had indicated its willingness to do so. The health system in the Palestinian territories must be allowed to start functioning again as soon as possible, to ensure the health and general well-being of the Palestinian people. He expressed the hope that the draft resolution would be adopted by consensus.

Dr TSHABALALA-MSIMANG (South Africa) noted with concern the deteriorating situation in the occupied Arab territories, including Palestine, which was largely due to the policy of collective punishment pursued by the Government of Israel. Excessive force had led to the death of many innocent non-combatants, primarily women and children. In addition to the toll in human lives,

infrastructure such as roads, schools, water and sanitation continued to be destroyed, with severe repercussions on public health.

It was against that backdrop that her delegation supported the need for WHO to be at the forefront of humanitarian assistance to the people of Palestine. That appeal came in the interests of public health and as an expression of her delegation's support for the struggle of the Palestinian people for nationhood and statehood. While condemning the use of excessive military force by the Israeli Government, she was equally critical of the suicide bombings by Palestinians, which did not advance their cause.

Voicing her delegation's support of the road map as the most recent effort to bring peace to the Middle East, she applauded the Palestinian Authority for its public acceptance of that initiative and appealed to Israel to follow suit.

She supported the resolution because it sent a simple but powerful message that the people of the world did care and were prepared to express their concern through action. The resolution should be adopted by consensus.

Dr AL HAJ HUSSEIN (Syrian Arab Republic) expressed support for the resolution and wished his country to be counted among its sponsors.

Mr LEVY (Israel) told of a leading surgeon who had operated on hundreds of Arab and Jewish patients and, in turn, had been wounded in a recent suicide bombing in Afula, in northern Israel. He recalled the recent spate of suicide bombings which had claimed many casualties in Israel. Those acts had been perpetrated by Palestinian suicide bombers who had been brainwashed, incited, financed and directed by various Palestinian factions openly claiming responsibility.

He asked whether the draft resolution gave adequate consideration to those crimes against humanity or whether it was merely a one-sided, politicized resolution. The text completely overlooked the pain and casualties that Israel had suffered.

That very week, Israelis and Palestinians were trying to mend the fragile fabric of confidence and rebuild the necessary trust. The new Palestinian Prime Minister was meeting Prime Minister Sharon for the first time. Therefore, it was not the time to engage in one-sided resolutions. Rather, the parties should be allowed to pursue their work despite the many obstacles to the peace process.

The current discussion, which focused on a single people, was the worst manifestation of singling out one country, Israel. He recalled that dozens of other conflicts were taking place around the world; yet only Palestinians were granted a special, so-called "country situation" debate. He argued that they were not debating health. Such politicization negatively affected the credibility of the Organization. It was a growing trend throughout the United Nations system. If the debate were truly about the health situation of the Palestinians, rapid research would clearly indicate that the situation of Palestinians was far better than that of dozens of other groups of people worldwide, including in the Middle East. The debate seemed to be making out that Palestinian violence did not exist, that Israel's defensive came unprovoked. Did the security, life and health of Israelis not count?

Despite the annual presentation of eloquent speeches and one-sided resolutions, he wondered why WHO had not as yet been able to establish a long-term presence in those territories. Was it because political rather than health issues were involved?

Israel's unwillingness to receive a fact-finding mission or a visit of a high-ranking WHO official pursuant to the previous year's resolution had been mentioned. That resolution, adopted with minor support, was a stain on the credibility of the Organization and, indeed, that of the United Nations. Israel had already cautioned against one-sided resolutions and it was no surprise that such resolutions could not be fulfilled.

Suffering was common to both Palestinians and Israelis, the latter being victims of terrorism through car bombs, sniper attacks and ambushes. Besides physical injury, many Israelis suffered from long-term mental and psychological trauma. Israelis were afraid to take the bus or go to clubs, cafes and restaurants, even weddings, for fear of attacks. Delegates should consider what their reaction

would be to such violence in their own cities. Eliminating restriction of movement from the West Bank and Gaza into Israel would enable suicide bombers to enter Israel with greater ease.

Before the recent crisis, public health had been an area in which Palestinians, Israelis and other Arab nations had worked together closely. Joint committees had been established on public health, environmental health, food control, drugs and pharmaceuticals. Unfortunately, that work had been frozen on orders from the Palestinian Authority. Still, cooperation continued in some matters. Israel's Magen David Adom and the Palestinian Red Crescent Society continued to cooperate in emergencies although Israeli ambulances arriving to treat the injured had been attacked. Public health laboratories of the Israeli Ministry of Health continued to assist the Palestinian Health Authority with tests for poliomyelitis and other viruses and with examination of imported food for bacterial contamination. Palestinian physicians were involved in a variety of professional activities in Israeli hospitals. As a result of the ongoing confrontation, Palestinian patients with kidney insufficiency who required haemodialysis and cancer patients needing chemotherapy were regularly brought to Israeli hospitals for treatment.

There was still little trust between both sides. On the political level, mistrust was probably understandable but on the humanitarian level re-establishment of trust was very important. His delegation valued and supported assistance programmes for Palestinians and was willing to cooperate with Member States, agencies and organizations to that end.

Past experience had shown that such a debate and draft resolutions contributed neither to peace in the area nor to the well-being of Arabs and Jews. If the Committee wished to play a productive role, it should keep to a professional path. He therefore appealed to all members of the Committee to reject the resolution in its entirety.

Mr SMITH (Australia) said that his country remained deeply concerned about the humanitarian situation in the occupied Arab territories, including the health consequences of the conflict as highlighted by the Director-General. He strongly supported WHO's Special Technical Assistance Programme and the work of UNRWA and other United Nations agencies and nongovernmental organizations in providing assistance to families and individuals affected by the current conflict.

Australia supported consideration by the Health Assembly of technical matters and other issues within WHO's mandate, but debating political issues in that forum was unhelpful. Although some of the more contentious and extraneous political references in the previous year's resolution had been removed from that currently under discussion, he remained concerned at the continued presence of unbalanced references to Israel in the text. Accordingly, Australia would vote against the resolution.

He wished to record his delegation's strong concern at the health situation in the occupied Arab territories and reiterated the need for the continued delivery of health programmes to address the pressing health needs of the Palestinians.

Mr WESTDAL (Canada) said that Canada was an active participant in the Health Assembly because it was deeply concerned about health in global society. The effect of conflict on the health of both Palestinians and Israelis was most disturbing. To help Palestinians, Canada had contributed more than Can$ 215 million in development assistance to international and other agencies in the past 10 years. The political situation in the Middle East was a matter of great concern; it could only be solved through negotiations based on the relevant United Nations Security Council resolutions and implementation of the road map.

The Health Assembly's agenda was replete with vital health issues affecting millions of people worldwide. It was unacceptable that a specific region, conflict or political issue should be singled out for attention. The Health Assembly should remain focused on the core health issues it had been established to address. However, much of the time allocated to Committee B was being devoted to a debate on a specific geographical region and a specific conflict that did not fall within the Health Assembly's remit and disrupted its substantive work. Canada judged all resolutions on the Middle East in any setting according to whether they would create an environment for productive negotiations. The draft resolution before the Committee was unbalanced. It did not pay satisfactory attention to the

regional context and its language was not conducive to building peace and understanding. The numerous organizations, such as UNRWA and UNDP, which worked actively with Palestinian refugees in the occupied territories, had provided reports that gave the international community a good understanding of the health situation in the area. Canada questioned the value of yet another report which, without a broader settlement of the underlying issues, would not help to improve health conditions in the occupied territories. In addition, the tasking of a fact-finding committee would further distract the Health Assembly from its core mandate without contributing to resolving the broader conflict. Canada would therefore vote against the resolution.

Mr M.N. KHAN (Pakistan) declared that every human being had a right to live with dignity and respect, regardless of creed or colour, and a right to health. In addition to managing outbreaks of disease, such as severe acute respiratory syndrome (SARS), WHO also had a responsibility to champion the cause of those maimed in conflict situations. The time had come to end the suffering of all those caught up in war and terror. It was incumbent on WHO and on national administrations to begin to build bridges as a first step towards resolving the world's problems. Those who carried out suicide bombings were committing a desperate act, and the underlying reasons could not be ignored. In that connection he completely disagreed with the delegate of Palau on the question of Taiwan, which had not been occupied by China. He urged delegates to adopt the draft resolution for the sake of the women and children in Palestine and for all who were the helpless victims of conflict everywhere.

Mr MOLEY (United States of America) said that his country remained deeply concerned about violence and terrorist activities in Israel, the West Bank and Gaza, and about the attendant human rights violations. It regretted all civilian casualties on both sides. The United States had worked intensively with both sides in an effort to find a way forward. However, Israel was not responsible for all the ills plaguing the people living in the region. Its actions took place in the context of terrorist attacks against Israeli civilians. The United States considered all acts of terrorism to be morally unjustifiable. Furthermore, Israel's right to self-defence was enshrined in the United Nations Charter. The United States therefore urged all members of the international community to exhort the Palestinians to end the violence, just as they had called on the Israeli Government to take all appropriate precautions to prevent the death of or injury to innocent civilians and damage to civilian and humanitarian infrastructure.

The resolution introduced political considerations into a debate within a technical agency, following a pattern witnessed in other United Nations organizations: blaming Israel but ignoring the Israelis who had suffered as a result of Palestinian actions. The resolution should confine itself to the health of the Palestinian people. In its current form it would neither help the search for peace in the Middle East, nor bring about any improvement in the health of those living in the occupied territories. A balanced and constructive resolution would not further inflame emotions.

The United States had consistently stressed the urgency of allowing access of medical and humanitarian organizations to the Palestinian civilian population and was committed to providing assistance to the Palestinian people for child survival, maternal health, nutrition and other humanitarian programmes, currently providing US$ 75 million a year in assistance; the allocation of a further US$ 50 million had recently been announced.

He urged delegates to join his delegation in rejecting the draft resolution and requested that it be put to a roll-call vote.

Dr AL-SHIRAFI (Palestine) said that the debate so far did not accurately reflect the situation in the occupied Arab territories. It was a matter of concern that permission had been refused for the proposed visits by both the Director-General and the fact-finding committee to examine the facts related to the health situation in the occupied territories. The situation was indeed serious with hospitals being bombed and armed incursions into treatment centres. In response to reports of the killing of Israeli adults and children in Gaza and Jericho, it should never be forgotten that they were there as part of an occupying force. At the same time there were eyewitness accounts of women

having miscarriages or giving birth at Israeli checkpoints and in the presence of Israeli officers and soldiers to babies who died soon afterwards for lack of medical assistance.

The delegate of the United States had referred to Israel's right to self-defence, but unfortunately Palestinians were denied any such right. Israel's commitment to peace was also questionable since it had rejected the road map approved by the United States and accepted by the Palestinian people and their leaders. His country was grateful to the United States for its assistance; however, until the Israeli tanks were withdrawn and proper medical services reinstated, it could not be accepted. The Palestinian people had never abandoned the peace process; it had been abandoned by the Israeli Government when its current Prime Minister entered the Al-Aqsa mosque. Nevertheless, Palestinians were being asked to remain silent while women and children were being killed.

Faced with a situation where children were malnourished and could not be vaccinated, despite WHO's policy on health for all, and with the tragic consequences of occupation, such as child fatalities caused by tanks, it had been impossible to focus exclusively on health matters, as he would have preferred, at the Health Assembly.

In the eyes of the Palestinian people, adoption of the draft resolution would represent much needed hope for the future including the prospect that the Fifty-seventh World Health Assembly would indeed be able to discuss ways of improving the health situation in the Arab region.

Dr HASSAN (Bahrain) said that his delegation wished to be added to the list of sponsors of the draft resolution.

Dr JOUKHADAR (Lebanon) pointed out that, although he shared the indignation voiced by the Israeli delegate about the deaths suffered on both sides of the conflict, what drove suicide bombers to commit their deeds was the sheer hopelessness of the young Palestinians' plight and their endless suffering, humiliation and utter deprivation, all their efforts at protest being met by the use of overwhelming force. The delegate of Israel had mentioned some 700 Israeli deaths, but the Palestinian dead numbered more than 3000. The right to self-defence mentioned by the United States was no ground for invasion and illegal occupation of another people's territory, of the sort seen in Iraq.

Mr AL-AGAIL (Saudi Arabia) said that WHO's specialized role in health and humanitarian issues meant that it could be called on to help heal Palestinian wounds caused by the aggression of the Israeli occupying authorities. His delegation therefore urged Member States to approve the draft resolution by consensus.

Dr CHRISTIANSEN (Norway) said that Norway was deeply concerned about the sharp deterioration of health conditions among Palestinians in the West Bank and Gaza, including Israel's restrictions and excessive use of military force, resulting in death and injuries among innocent civilians and making access to health services and drugs difficult and, at times, impossible. It was important for WHO, in close cooperation with the Palestinian Ministry of Health, to continue to address the situation. The road map for peace and the recent bilateral high-level contacts were encouraging, since it was important not only to achieve the immediate improvement of health conditions and other aspects of the Palestinians' daily life but also to establish a stable and peaceful two-State solution to the conflict by 2005. But attempts to derail the efforts could be clearly seen, and violence had escalated. The draft resolution did not mention Palestinian terrorist acts against Israelis, one of the root causes of the crisis, nor did it support the international peace efforts that WHO should support. Norway would therefore abstain during the vote.

Mr SARRIS (Greece), speaking on behalf of the European Union, the acceding countries and the associated countries Bulgaria and Romania, expressed deep concern over the deterioration of health conditions in the Palestinian occupied territories, and condemned the continued violence on both sides, which caused unbearable suffering on the part of the civilian population, mostly among Palestinians. The European Union had more than once called for an immediate end to the violence and

for a sustainable solution through negotiations based on international law and United Nations Security Council resolutions. It regretted, moreover, that the Director-General had not yet visited the occupied Arab territories, including Palestine, to assess health conditions there. Nevertheless, despite efforts to reach an agreed text, the European Union would abstain on the draft resolution as it was not limited to health issues and consequently was not adapted to the context and competence of the Health Assembly. Furthermore, it touched upon issues that would be better addressed in other, more appropriate, forums.

Mr BENFREHA (Algeria) said that the health situation of the Arab population in the occupied territories, including Palestine, was of concern to the entire international community. He urged delegations to vote in favour of the draft resolution to render justice to a people deprived of basic health care, and expressed the hope that it would be adopted by consensus. Although innocent victims of violence were to be regretted, it should be recognized that some violent acts were an effort to end an even wider circle of violence, stemming from occupation by armed forces and failure to respect a people's right to self-determination. The humanitarian crisis arising from the spread of malnutrition and disease, and aggravated by poverty, had been brought about by the reoccupation of Palestinian territory and military incursions into camps and villages since March 2002, as attested in reports by WHO and various intergovernmental and nongovernmental organizations. It reflected a degree of gravity not seen for 35 years, and all reports pointed to the same bitter reality.

Mr XIA Jingge (China) said that the health situation of the peoples in the occupied Arab territories, including Palestine, had become a traditional item on the Health Assembly's agenda. It was important, therefore, to consider the roots of the problem with a view to restoring peace and stability as a precondition to improving health conditions in the occupied territories. Specific measures had been proposed over the years, but the need was for resolute action. WHO must therefore mobilize resources, with concerted contributions from all countries, humanitarian agencies, and intergovernmental and nongovernmental organizations. China had always supported the just cause of the Palestinians and the exercise of their legitimate rights, and was prepared to work with the international community toward that end. His delegation hoped that the draft resolution would be adopted by consensus.

Mr MUGHRABI (Libyan Arab Jamahiriya) said that his delegation supported the draft resolution. He was astonished at some of the comments made about the situation in the occupied Arab territories, especially since the true conditions could be seen daily on television. The sole purpose of the draft resolution was to obtain permission for the medical assistance provided by WHO to be made available to the civilian population and to put an end to the attacks and restrictions suffered by medical personnel. The text should be adopted by consensus.

Mr TOPPING (Legal Counsel) recalled that there had been a request for the vote to be taken by roll-call. The draft resolution would be approved if it received a majority of the votes of Members present and voting. The Member States whose right to vote had been suspended by a Health Assembly resolution, four of which had not submitted credentials, and would therefore be unable to participate in the vote were: Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Chad, Comoros, Djibouti, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kazakhstan, Kyrgyzstan, Liberia, Nauru, Niger, Nigeria, Republic of Moldova, Somalia, Suriname, Tajikistan, Togo, Turkmenistan and Ukraine. In addition, Niue had not submitted credentials.

**A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Jamaica, the letter J having been determined by lot.**

**The result of the vote was as follows:**

**In favour:** Algeria, Bahrain, Bhutan, Botswana, China, Cuba, Democratic People's Republic of Korea, Egypt, Ghana, India, Indonesia, Islamic Republic of Iran, Jordan, Kuwait, Lao People's Democratic Republic, Lebanon, Libyan Arab Jamahiriya, Malaysia, Maldives, Mali, Mauritania, Mauritius, Morocco, Myanmar, Namibia, Oman, Pakistan, Philippines, Qatar, Saudi Arabia, Senegal, South Africa, Sri Lanka, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, United Republic of Tanzania, Venezuela, Viet Nam, Yemen, Zimbabwe.

**Against:** Australia, Canada, Costa Rica, Guatemala, Israel, Marshall Islands, Palau, Papua New Guinea, Tuvalu, United States of America.

**Abstaining:** Angola, Austria, Belarus, Belgium, Bolivia, Bosnia and Herzegovina, Brazil, Bulgaria, Chile, Colombia, Côte d'Ivoire, Croatia, Cyprus, Czech Republic, Denmark, Ecuador, El Salvador, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Mexico, Monaco, Netherlands, New Zealand, Nicaragua, Norway, Paraguay, Peru, Poland, Portugal, Republic of Korea, Romania, Russian Federation, San Marino, Serbia and Montenegro, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland, Uruguay.

**Absent:** Albania, Andorra, Azerbaijan, Bahamas, Bangladesh, Barbados, Belize, Benin, Brunei Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Congo, Cook Islands, Democratic Republic of the Congo, Dominica, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Gambia, Grenada, Guinea, Guyana, Haiti, Honduras, Jamaica, Kenya, Kiribati, Lesotho, Madagascar, Malawi, Federated States of Micronesia, Mongolia, Mozambique, Nepal, Panama, Rwanda, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Solomon Islands, Swaziland, The former Yugoslav Republic of Macedonia, Timor-Leste, Tonga, Trinidad and Tobago, Turkey, Uganda, Uzbekistan, Vanuatu, Zambia.

**The draft resolution was therefore approved by 42 votes to 10, with 55 abstentions.**[1]

## 4. FIRST REPORT OF COMMITTEE B (Document A56/58)

Mrs VELÁSQUEZ DE VISBAL (Venezuela), Rapporteur, read out the draft first report of Committee B.

**The report was adopted.**[2]

**The meeting rose at 17:05.**

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA56.5.

[2] See page 342.

## SECOND MEETING

**Friday, 23 May 2003, at 09:30**

**Chairman:** Dr R. CONSTANTINIU (Romania)

**FINANCIAL MATTERS:** Item 16 of the Agenda

**Appointment of the External Auditor:** Item 16.2 of the Agenda (Documents A56/31, A56/31 Add.1, A56/31 Add.2 and A56/31 Annex 10 Rev.1, 2, 3 and 4)

The CHAIRMAN said that candidates nominated by Colombia, Ghana, India, Mauritius, Netherlands, South Africa and Sweden were to be considered by the Health Assembly for the position of External Auditor.

Mr JUGNAUTH (Mauritius) withdrew his country's candidature.

The CHAIRMAN invited the candidates to make their personal presentations to the Committee.

Mr REYES RODRÍGUEZ (Colombia), on behalf of the Auditor-General of the Republic of Colombia, Dr López Obregón, presented her proposal for the post of External Auditor in her absence. She would be able to contribute greatly to the sound management and good practice of WHO with total independence, impartiality and competence.

Because Dr López Obregón's present tenure had begun on 1 April 2003, certain adjustments to the proposal had been necessary, principally the reduction in the proposed fees from US$ 1 500 000 to US$ 1 200 090 for each biennium through strengthening of the support infrastructure in Colombia, and a reduction in the length of the auditor's actual working time to 60 months.

The Office of the Auditor-General of the Republic of Colombia was the highest financial control body in the country and the Auditor-General was elected through a rigorous selection process headed by the Supreme Court of Justice and the Council of State. Dr López Obregón was a graduate in law from the University of Los Andes (Bogotá) and in economics from the University of Harvard (United States of America). She had wide-ranging experience from her posts as a university professor, Comptroller of Bogotá, adviser to the President of the Republic on economic affairs and consultant to both various ministries and UNDP. The Office of the Auditor-General had been consolidating its position of pushing forward discussion on the auditing process, introducing new concepts to control mechanisms and constant strengthening of institutions, through international technical cooperation agreements with the Inter-American Development Bank, the Canadian Government (through the Canadian Cooperation Agency), UNDP and the Andean Investment Corporation.

In order to perform the duties of External Auditor, high-quality, full and cross-cutting audits would be carried out, applying the principles of economy, efficiency, effectiveness, transparency and timeliness, to help improve WHO management. Similarly, policies and guidelines, as set out in a procedures manual for the auditing team, would promote an ethical, responsible and professional working environment, respect for different ideas, beliefs, opinions and lifestyles, and an environment free from discrimination. Quality would be assured by the setting up of auditing teams at several levels and in different specialities, and by supervision and monitoring of each phase by the Auditor-General and auditing coordinators, who would be present both in Geneva and in Colombia. The opinions, recommendations and conclusions expressed in the various audit reports would be duly supported by evidence, analysis and strict application of the rules and regulations laid down by the United Nations system.

The work, which would be based in the Office of Internal Audit and Oversight, would establish whether the financial statements reasonably reflected the results of WHO's operations and any changes in its financial situation. The audit would be prepared according to universally accepted principles of accountability and those prescribed in the WHO Financial Regulations. Controls would be carried out to determine the efficiency and effectiveness of WHO's resource management, and how far WHO's objectives were achieved and its plans, programmes and projects fulfilled.

Although consolidated work would be done on the financial statements annually, the final financial audit report would be submitted every two years, following the presentation of the Director-General's financial report, and would include opinions on the efficiency of financial processes, the accounting system, internal financial controls and administration management. Other auditing activities might also further explore issues of interest such as the Trust Fund of the Iraq Programme, as appropriate. It would be important to maintain direct, permanent contact with the Director-General's Office, Regional Offices, African Programme for Onchocerciasis Control, IARC, UNAIDS and especially with the Auditing Committee of the Executive Board, based on respect, cordiality and the mutual exchange of ideas, contributions and experience.

Mr KAUL (India), Comptroller and Auditor General of India, said that his organization had wide experience of auditing international and domestic entities in the complex areas of performance, value-for-money and management audit, as well as in financial and compliance audit. It had conducted performance audits of social and health sector programmes for over three decades. He himself had served on the Board of Auditors of the United Nations from 1993 to 1999, and as external auditor of some of its specialized agencies, and was currently on the United Nations Panel of External Auditors, being thus familiar with the common auditing standards. In India his office was the designated authority for prescribing accounting and auditing standards for the public sector, and its independence of the executive and legislature was secured by the country's Constitution. Its approach and auditing methodologies were in accordance with the International Organization of Supreme Audit Institutions (INTOSAI), and it was spearheading the movement for modernization of audit techniques and methodologies. He had been Chairman of the INTOSAI Standing Committee on IT Audit and was one of the representatives of the Asian group on the Governing Board of INTOSAI, and Secretary-General of the Asian Association of Supreme Audit Institutions. His organization had put in the most competitive bid, amounting to US$ 790 000 for the accounting period 2004-2005 and US$ 829 500 for 2006-2007. In the event of selection, a substantial proportion of audit time would be devoted to programme review, in addition to establishment and compliance audits. Subcontracting would not be necessary. A director would be installed in Geneva to conduct the audits with the help of several teams and experts. Objectives would include developing partnerships with the internal audit organization of WHO, its Audit Committee and Executive Board, and providing assurance to Member States about the effectiveness of the Organization. The core values of his organization were reliability and integrity. If selected, the professional body of auditors at whose head he stood would provide WHO with high-quality and cost-effective professional service.

Ms STUIVELING (Netherlands), President of the Netherlands Court of Audit, said that, from a professional point of view, the optimum total term was a period of eight years. On that basis, WHO should be changing its External Auditor at the end of the current biennium, and she would consider it appropriate for her own organization to seek selection for the coming financial period and reselection for one more financial period only. An external auditor from a country that mainly benefited from WHO programmes and activities should alternate with an external auditor from a country such as the Netherlands that mainly donated funds, thus enabling both perspectives to be reflected in the audits. Her organization had extensive audit experience relating to WHO programmes in the field, for example in Africa, together with substantial experience in the health field, having delivered several audits focused on health issues in the Netherlands in the past five years. Her organization was selective concerning its clients, handling only three international accounts at a time, thus offering dedicated service. The core vision of the Director-General elect was to achieve results at country level,

emphasizing measurable health objectives, efficiency and accountability. High-quality health data would be required for evidence-based operations. Her organization could seamlessly underpin that approach. She viewed audit as a process of cooperation and mutual learning and, in addition to certifying the yearly financial report, her organization would strengthen WHO's internal capability to function in a results-oriented, efficient and accountable manner. Her organization should not be disqualified on account of the level of its bid since the differential between bids was insignificant, all being way below the normal benchmark for external audit of between one half and one per cent of the annual budget of the organization concerned.

Mr FAKIE (External Auditor), presenting his candidature for reappointment to the office of External Auditor, said that his nomination had the fullest support of his Government. While South Africa had had a short but successful involvement in the auditing of international organizations, it remained underrepresented in the international community as a whole.

As External Auditor, he had sought to foster effective communication and provide an excellent audit service over the previous eight years. While fully supporting the principle of rotation with respect to the position of External Auditor, the timing of any such rotation was important. In recent years, WHO had experienced significant change and responded well to global health challenges; he had been proud to have fulfilled the role of independent auditor in those demanding times, contributing in some measure to enhanced accountability, transparency and good governance. Appointment for an additional term would make it possible to see through many of the new improvements in areas such as sustainable development and performance improvement, if not to their conclusion, at least past the critical stage. WHO had appointed a new Director-General, and a continuation of the external audit appointment could assist the new incumbent during the transition period, providing benefit to the Organization and its Member States.

Considerable investment had been made in the audit to establish a core foundation of expertise tailored to WHO; that had permitted greater efficiency and value added reviews without any need to seek additional remuneration. The proposed audit fee, which remained constant in real terms, would allow such a level of service to be provided in the future.

Continuity of audit staff and other specialist staff had been assured. Furthermore, as part of an initiative to transfer skills and build capacity within the African continent, colleagues from the audit offices of Gambia, Ghana, Mauritius and Namibia could be included in international audit assignments. Both he and his most senior staff had demonstrated their personal interest in and commitment to WHO by participating in the audit at grass-roots level. He would be honoured to continue as the External Auditor of WHO for one final term, and assured members that he would use his experience and knowledge of WHO to consolidate the initiatives already in progress with regard to improved governance and systems.

Mr LARSSON (Sweden), Auditor General, Swedish National Audit Office, reminding delegates of Dr Lee's comments two days previously about the growing demands placed on WHO, the need to concentrate efforts at county level and the importance of accountability within the Organization, said that his country's supreme audit institution's proposal focused on the performance, efficiency and cost-effectiveness of WHO. His Office had 15 years of experience auditing Swedish administrative bodies using a results-based approach to accounting processes similar to that currently being implemented by the Organization. His Office would offer high-quality auditing of all aspects of the Organization and was fully conversant with standards and methods for international audits. With its wide experience of building up accountability systems in organizations, it would be able to assist in enhancing such processes within WHO. Although not currently undertaking any major international assignments, his Office had, over the past decade, assisted auditing institutions in Africa, central and eastern Europe and Latin America in building up their institutions and possessed special expertise in internal audit and oversight mechanisms for auditing at government level. As one of three Auditors-General for Sweden he had extensive experience in both performance and financial audits in many areas, including the health sector, and had worked with the International Organization of Supreme

Audit Institutions on the standardization of methods and techniques, and with the Indian Audit Office on the IT Audit Committee. He had also recently been involved in investigating corruption for the European Union's Anti-Fraud Office. Should he be elected External Auditor, his Office would build up a team of auditors from the Nordic and Baltic countries to comply with WHO requirements to the full.

Mr AGYEMAN (Ghana), Auditor-General of Ghana, said that his country's audit service had extensive experience of international audits since Auditors-General of Ghana had served on the United Nations Board of Auditors for 24 consecutive years, and had audited various United Nations agencies. The Ghana Audit Service was not currently auditing any major international organizations and could therefore make its staff, expertise and capacities fully available to WHO if elected. The Auditor-General of Ghana was required to audit all public institutions and Government administrative bodies, including the courts, and to submit reports to Parliament. His Office had gained international recognition for its work and in 2002 it had been awarded a prize by the African Organization of Supreme Audit Institutions for its commitment and expertise. Should he be elected, his team would be made up of expert auditors supported by 28 certified public accountants and chartered accountants. He himself was a chartered accountant with 30 years' experience who, before being confirmed as the Auditor-General of Ghana, had held a number of positions in both the public and private sectors, including that of Programme Officer for the European Union Human Resources Development Programme under the Ministry of Local Government and Rural Development of Ghana; Executive Director of the Liberian Institute of Certified Public Accountants; Director of Education and Training of the Institute of Chartered Accountants of Ghana, and Director of Training for the West African Region at Pannell Kerr Forster. Given its background and expertise and the competitive price offered, he said that he hoped that delegations would vote for his Office as the most suitable candidate for the position of External Auditor.

In the absence of any further comment, the CHAIRMAN took it that the Committee wished to proceed to a vote in order to elect the External Auditor.

**It was so agreed.**

The CHAIRMAN suggested that, in order to save time, the Committee should use ballot papers on which the names of the countries presenting candidates were already indicated; instead of depositing its vote in the ballot box at the front of the room, each delegation could place its ballot in a box presented by an usher; and, rather than lots being drawn to decide the name of the first Member State to vote, the ballot box should simply be passed back from row to row from the front.

**It was so agreed.**

**Ms Haraldsdóttir (Iceland) and Mr Al-Bader (Kuwait) were appointed as tellers.**

Mr TOPPING (Legal Counsel) said that those Member States whose voting rights had been suspended were Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Chad, Comoros, Djibouti, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kazakhstan, Kyrgyzstan, Liberia, Nauru, Niger, Nigeria, Republic of Moldova, Somalia, Suriname, Tajikistan, Togo, Turkmenistan and Ukraine. In addition, Niue had not submitted credentials and would therefore not be called upon to vote.

**A vote was taken by secret ballot. The result was as follows:**

| | |
|---|---|
| Members entitled to vote | 166 |
| Members absent | 39 |
| Papers null and void | 1 |
| Members present and voting | 126 |
| Colombia | 6 |
| Ghana | 8 |
| India | 56 |
| Netherlands | 4 |
| South Africa | 25 |
| Sweden | 27 |
| Number required for a simple majority | 64 |

Mr TOPPING (Legal Counsel) reminded the Committee that, as no candidate had obtained the required majority, in accordance with Rule 81 of the Rules of Procedure, the second ballot for the choice of External Auditor would be restricted to the two candidates who had obtained the largest number of votes in the first ballot: those nominated by India and Sweden. He therefore invited delegates to indicate their choice of one of those two countries; ballots bearing the names of both, or of any other country, would be considered null and void.

**A vote was taken by secret ballot. The result was as follows:**

| | |
|---|---|
| Members entitled to vote | 166 |
| Members absent | 39 |
| Members present and voting | 127 |
| India | 92 |
| Sweden | 35 |
| Number required for a simple majority | 64 |

**Having obtained the required majority, the Indian candidate for the position of External Auditor was elected.**

**The draft resolution contained in paragraph 8 of document A56/31, completed in accordance with the result of the secret ballot, was approved.**[1]

**The meeting rose at 12:25.**

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.8.

## THIRD MEETING

**Friday, 24 May 2003, at 14:50**

**Chairman:** Mr L. ROKOVADA (Fiji)

1. **FINANCIAL MATTERS:** Item 16 of the Agenda (continued)

**Reports:** Item 16.1 of the Agenda

**Unaudited interim financial report on the accounts of WHO for 2002 and comments thereon of the Administration, Budget and Finance Committee** (Documents A56/28, A56/28 Add.1 and A56/47)

Dr YOOSUF (Maldives), speaking as Chairman of the Administration, Budget and Finance Committee (ABFC), said that at its meeting on 15 May, ABFC had considered the unaudited interim financial report on the accounts of WHO for 2002 contained in document A56/28 and the annex to the financial report covering extrabudgetary resources for programme activities contained in document A56/28 Add.1. ABFC had noted the salient points of the financial report and had welcomed improvements in its presentation.

The report followed the structure of the Programme budget for 2002-2003 and showed financial implementation against the budget by area of work. The overall level of implementation for all sources of funds was 56%, which was on target to meet the Organization's plans for the biennium. Extrabudgetary funding for the Organization during the year had remained strong, thereby maintaining the trend initiated in 1998-1999.

The rate of collection of assessed contributions for 2002 had fallen to 82% from the 87% achieved in the first year of the previous biennium. Total outstanding assessments at 31 December 2002 had increased to US$ 169 million, from US$ 146 million at 31 December 2001. Long-term outstanding assessed contributions had also risen. Consequently, internal borrowing had increased to US$ 107 million at 31 December 2002 compared with US$ 56 million at the end of 2001. It had been noted that the internal resources against which the Organization could borrow were in a healthy position.

Some Member States had encountered difficulties in paying their arrears of assessed contributions, but mechanisms were available to assist them. In accordance with the new Financial Regulations, Member States were able to pay their assessments in local currency subject to specific approval by the Director-General. Member States could also enter into special arrangements to settle their arrears.

ABFC recommended that the Fifty-sixth World Health Assembly accept the Director-General's unaudited interim financial report for 2002.

The CHAIRMAN drew attention to the draft resolution in paragraph 6 of document A56/47, recommended by ABFC for adoption by the Health Assembly.

Mr JHA (India) expressed great concern that total outstanding assessments had risen to US$ 398 million at 30 April 2003, representing about 48% of the regular budget for the current biennium. Cumulative arrears were also increasing steadily as evidenced by the previous year's figure of US$ 392 million, for the corresponding date. Although US$ 18 million had been collected in past

dues, the situation remained unhealthy. Furthermore, 24 countries had lost their voting rights owing to arrears although their cumulative dues amounted to only 17% of the Organization's total arrears.

The interim report also showed that WHO's Working Fund of US$ 31 million had been fully used to finance the implementation of the regular budget, and that an additional US$ 76 million had had to be borrowed internally. Even if only one third of the total arrears were paid, there would be no pressure on the Working Fund nor any need for internal borrowing.

The annex to the report showed a breakdown of extrabudgetary resources into specified and unspecified activities, and he asked whether donors would specify use for the latter category at a later time or whether the matter would be left to the discretion of WHO. Furthermore, by adopting the programme budget, was the Committee also authorizing appropriation of extrabudgetary resources? If not, what was the objective of showing activities by distribution of extrabudgetary resources in the programme budget document?

Ms WILD (Comptroller) said that the US$ 398 million shown as unpaid assessments at 30 April 2003 included almost US$ 300 million in contributions due for 2003. The figure represented a slightly lower rate of collection than was desirable, but could not technically be considered as arrears at the present stage.

With regard to extrabudgetary resources, unspecified funds were funds made available by donors at the organizational level, and their allocation therefore remained at the discretion of the Director-General. They were also occasionally made available at the area of work level or cluster level. In those cases, donors did not specify use of funds and left that task to the Secretariat. On adopting the programme budget for the biennium, the Health Assembly was asked to note other sources of funding, a process which, under the system of results-based budgeting, provided guidance to the Secretariat as to the areas to which extrabudgetary resources should be allocated. That noting of other sources also assisted in discussions with donors to attract funds for the areas of work that required funds to meet the expected results approved by the Health Assembly as part of the adoption of the programme of work. Extrabudgetary resources were shown because they related to the achievement of expected results irrespective of the source of financing.

**The draft resolution was approved.**[1]

**Interim report of the External Auditor** (Documents A56/29 and A56/49)

Dr YOOSUF (Maldives), speaking as Chairman of ABFC and introducing the item, drew attention to the second report of ABFC contained in document A56/49 and, in particular, to the information given in paragraphs 3, 5, 6 and 8.

Mr FAKIE (External Auditor), introducing the interim report, said that the practice of reporting in the interim year, which had been introduced in 1997, had become well established and enabled timely and relevant interaction between the External Auditor and the Health Assembly. His priority had been to develop governance relationships to ensure constructive and open communication. His interim report was not directed at the unaudited interim financial report and no audit opinion was expressed thereon. The Audit Committee had met twice since he had last addressed the Health Assembly. The first meeting had been devoted to audit strategy and planning and the second had focused mainly on the status of the audit for the current biennium. In addition to core audit activities comprising financial and compliance matters, efficiencies realized in the regular audit had allowed in-depth reviews to be conducted in selected areas where further value could be added. The work flow had been resourced from efficiency savings attributable to the sound platform on which the audit

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.9.

rested. Several initiatives had reached a stage where action was needed at the functional level, and should be seen through to their conclusion.

The importance of good governance structures had been receiving increasing attention and WHO's commitment was to be commended. Issues previously raised, such as fraud prevention policies, a code of ethics and environmental policies were currently receiving attention.

The interim report stressed the need for WHO to consolidate its current risk management measures to facilitate the implementation of a formal policy and a strategy to manage risk throughout the Organization. A follow-up review of the internal audit function had revealed that the Office of Internal Audit and Oversight had introduced some significant improvements to enhance its effectiveness, and had largely responded to all the recommendations in his previous review. Areas identified for further improvement included contributing to the risk assessment process throughout WHO and documenting annual operational planning decisions. The aim was to provide WHO with an independent external audit that promoted accountability, good governance and the effective, efficient and economic attainment of its goals.

Much audit activity in the first year of each biennium was devoted to planning. Initially, aspects of corporate governance had been identified for review, resulting in improved interaction with and reporting to the governing bodies. Thereafter, key management areas had been identified for high-level review. Risk management, environmental management policies, performance management and reporting, treasury management and internal audit had already been reported upon, and a review of other areas might be useful in the future. Several areas had been the subject of follow-up reviews during the year; value-added work with a country focus, and a further review of extrabudgetary funds, would be done during the current biennium.

The need for clearly defined delegation of authority and a consolidated source of information on WHO's policies and administrative instructions that supported effective and efficient operations emphasized the importance for the Secretariat of effecting improvements in those areas. Such initiatives would require several years to implement fully and the External Auditor would need to play a constructive role throughout the process.

His interim report highlighted the importance of an integrated planning process for funds from all sources and noted that the process would be facilitated by a more timely communication of budgetary planning figures. It also recommended that a more structured and transparent framework for the allocation of extrabudgetary resources be developed to ensure that operational planning supported the Organization's strategic goals. Further recommendations were: a more clearly defined resource mobilization framework; and clear criteria for the allocation of funds from the Special Account for Servicing Costs. The information used for monitoring the progress towards expected results needed to be improved. Further, a timely and complete sharing of information on proposed evaluations would result in a more coordinated effort across the Organization.

A comprehensive review of sound treasury management in 2000 had noted significant progress. While some aspects were still receiving attention, the interim report contained several recommendations for further operational improvements. In respect of financial and compliance matters, the financial records of the Organization were reliable and an adequate system of internal controls had been implemented. However, effective systems were needed for the administration of voluntary contributions, to monitor accounts payable and receivable to ensure that transactions were followed up and cleared in a timely fashion, and to ensure that long outstanding items in the personal accounts were cleared.

His final report for the 2000-2001 financial period had emphasized that certain information technology (IT) issues affecting the whole Organization required urgent attention, namely, the need for a comprehensive IT strategy and a well-defined IT governance structure supported by adequate staff with the requisite skills. The progress reviews at a regional office and at headquarters had revealed that several key actions had been taken and that the general IT control environments had been improved. Although certain matters still needed to be fully addressed, strategic plans had been developed to make improvements in the designated areas; they should be carried through within the planned time frames. A detailed audit on the network and security controls at WHO headquarters had

also been performed by IT audit specialists, revealing that, although WHO had implemented certain measures to minimize network security risks, significant security-related weaknesses existed in the network environment as a whole. A detailed report setting out the risks and related recommendations had submitted.

He continued to monitor the status of implementation of his audit recommendations and to provide the Audit Committee of the Executive Board with regular reports. At its eighth meeting, that Committee had confirmed the progress made, noting that all recommendations had been adequately addressed.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland), referring to paragraph 4 of document A56/49, asked whether the deadline of March 2004 for completion of the work was still tenable in view of the change of External Auditor.

Dr TSHABALALA-MSIMANG (South Africa) expressed appreciation for the interim report of the External Auditor and the second report of ABFC. She had noted the action taken on recommendations arising from the initial review of the External Auditor and asked the Director-General to pay particular attention to the areas requiring further action.

Ms WILD (Comptroller), replying to the delegate of the United Kingdom, said that the framework on delegation of authority in the WHO Manual would be completed by March 2004. It was the responsibility of the Secretariat to develop the delegation of authority and introduce the necessary improvements in regard to the Manual and the framework as a whole. That would be done in close cooperation with the new Director-General and there might be an impact on the time frame.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland), clarifying an earlier comment, said that one recommendation in the report of the External Auditor had called for more effective monitoring of the use of extrabudgetary resources. How would that recommendation be handled and over what time frame?

Mr FAKIE (External Auditor), referring to the question of the delegation of authority, said that in order to ensure a smooth transition, at the end of his term of office, all recommendations would be examined and the status of their implementation checked to enable the incoming auditors from India to monitor progress. With regard to extrabudgetary resources, he drew attention to paragraph 33 of document A56/29: the recommendation referred to the need to monitor all sources of funds used for the delivery of products and services. He planned to refer that recommendation to the new External Auditor.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that his question remained unanswered. How was the Secretariat intending to respond to that recommendation? How would the course of action proposed be put into effect?

Ms WILD (Comptroller) said that programme monitoring was an integrated process involving regular reviews of progress towards achievement of the expected results from all sources of funds. An internal mid-term review was carried out at all levels of the Organization and at the end of the biennium a report would be submitted to the governing bodies. That report would be reviewed by the Programme Development Committee and would contain financial data that would be aligned with the financial report submitted in accordance with the structure of the programme budget. The report at the end of the biennium thus enabled Member States to see what was happening.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that, although that clarification had been helpful, it had triggered a number of further questions that he would discuss directly with the Secretariat later on.

**The Committee noted the report.**

**Report of the Internal Auditor** (Document A56/30)

Mr BOTZET (Germany), drawing attention to paragraph 33 of the report referring to a bank transfer to the Regional Office for Africa in 1997 that had never been credited to its account, asked what measures had been taken to clarify the situation and to prevent the recurrence of similar cases.

Ms JAMAL (United States of America) asked how the auditing programme of the Internal Auditor was organized and, in particular, how frequent were audits in a particular region or section.

Mr LANGFORD (Internal Auditor), responding to the delegate of the United States, said that paragraphs 7 to 10 of the report gave a brief explanation on how priorities and programmes were established. Action was based more on risk assessment than on a periodic examination.

Ms WILD (Comptroller), in reply to the delegate of Germany, said that the bank transfer had been lost at the time of civil disturbances in the Congo, when the Regional Office had had to be evacuated. The financial institution to which the funds had been transferred had subsequently become bankrupt. WHO had taken steps through correspondence and meetings in the Region and at headquarters to seek ways to recover the money in order to avoid a significant write-off. Among the measures to prevent a recurrence, the most important was the timely reconciliation of bank accounts, which took place in normal circumstances. However, at the time of the evacuation of the Regional Office in the Congo, many records had been lost and the general confusion had made it difficult to reconstruct what had happened. It also explained why the matter had taken some time to come to light.

**The Committee noted the report.**

**Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution:** Item 16.3 of the Agenda (Document A56/32)

Dr AL-MAZROU (representative of the Executive Board) said that the Executive Board, at its 111th session, had noted the contents of the report contained in document EB111/14, which had been updated to include developments since 31 December 2002, the most notable being the increase in the full-year collection rate for 2002 to 85% by January 2003 and the drop in the arrears for prior years' contributions to US$ 140 million.

Dr YOOSUF (Maldives), speaking as Chairman of ABFC, introducing the report (document A56/32), said that ABFC had noted that the rate of collection had risen to 38.5% by 15 May 2003. Arrears of prior years' contributions had been reduced to US$ 106 million. ABFC had welcomed those developments, but expressed concern at the continuing high level of long-standing arrears. With regard to Member States in arrears to an extent that would justify invoking Article 7 of the Constitution, two of them, Argentina and Paraguay, had been due to lose their voting privileges as from the opening of the Fifty-sixth World Health Assembly. ABFC had been informed that Paraguay had hoped to make sufficient payment by then to retain those privileges. Belarus, Burundi, Peru, Saint Lucia and Venezuela were in arrears to an extent that would justify invoking Article 7; pursuant to resolution WHA41.7, ABFC accordingly recommended the adoption by the Health Assembly of a

resolution suspending the voting privileges of those Member States as from the opening of the Fifty-seventh World Health Assembly, unless sufficient payments had been received by then.

Ms WILD (Comptroller) reported that a further four Member States, Andorra, Greece, Rwanda and San Marino had paid their assessments for 2003 in full. Greece had also made payments towards contributions for future years. The rate of collection for the current year was consequently just under 40%, compared with 33% at the same time in 2002. Ninety-two Members had made payment in full, 59 had made part payment and 42 had made no payment so far. The overall situation had improved since the last meeting of ABFC. Further payments had been received in respect of prior years from Member States in arrears; Burundi and Paraguay had made payments that were sufficient to remove them from the provisions of Article 7; Nigeria had made a payment that was unfortunately not sufficient to remove it from the provisions of Article 7. As a result of those three payments, the total amount of arrears stood at just over US$ 106 million. As a consequence of the payments made by Burundi and Paraguay, those two countries should be deleted from the appropriate paragraphs of the recommended draft resolution. Three other Members had indicated that they would be making payments which, if received, would reduce the amount of their arrears.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by ABFC in paragraph 11 of document A56/32, as amended.

**The draft resolution, as amended, was approved.**[1]

**Special arrangements for settlement of arrears:** Item 16.4 of the Agenda (Documents A56/32, A56/33 and A56/33 Add.1)

Dr YOOSUF (Maldives), speaking as Chairman of ABFC, said that, following its review of the status of collection, that Committee had considered the request by Kazakhstan to reschedule its arrears in return for restoration of its voting privileges, as reported in paragraphs 8 to 10 of document A56/32. Kazakhstan was proposing to pay its arrears, totalling US$ 4.6 million, over 10 years, with a minimum payment each year of US$ 200 000. Concerned about the level of minimum payment and the length of the proposed arrangement, ABFC had concluded that its recommendation to the Health Assembly should be amended to include a requirement that at least half the total amount, US$ 2.3 million, should be repaid after five years, in addition to payment by Kazakhstan of the current year's contribution. ABFC had further expressed concern about the general tendency for such requests to include a longer period than it considered desirable for the settlement of arrears. It did not wish to see 10 years become the norm: a five-year period was more appropriate and arrears should be settled in full within that time.

Mr KULZHANOV (Kazakhstan) said that his delegation agreed to the ABFC's proposal to settle Kazakhstan's arrears by the end of a 10-year period and to repay at least half of the total amount outstanding by the end of 2007.

The CHAIRMAN invited the Committee to consider the draft resolution contained in paragraph 2 of document A56/33 Add.1.

**The draft resolution was approved.**[2]

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.10.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.11.

**Assessment of new Members and Associate Members:** Item 16.5 of the Agenda (Decision EB111(3))

Dr AFRIYIE (representative of the Executive Board) said that the Democratic Republic of Timor-Leste had become a Member of WHO on 27 September 2002. The Executive Board recommended in decision EB111(3) that its assessment should be US$ 1053 for 2002 and US$ 4213 for 2003. It also recommended ad hoc adjustments to the 2003 assessments for Afghanistan and Argentina of US$ 4213 and US$ 4 026 622 respectively, with the difference of US$ 611 135 resulting from the revised contributions being financed from the Miscellaneous Income account.

The CHAIRMAN invited the Committee to consider the draft resolution contained in decision EB111(3).

**The draft resolution was approved.**[1]

## 2. PROGRAMME BUDGET: Item 12 of the Agenda

**Proposed programme budget for 2004-2005:** Item 12.1 of the Agenda (Resolution EB111.R3; Documents A56/5,[2] A56/50 and A56/INF.DOC./9) (continued from the second meeting of Committee A)

The CHAIRMAN invited the Committee to consider the documents relating to the Real Estate Fund.

Dr AL-MAZROU (representative of the Executive Board) said that document A56/INF.DOC./9 outlined the plans for the construction of a new building at WHO headquarters and provided information on the financial arrangements and the interest-free loan to be approved by the Swiss authorities. The Executive Board at its 111th session had recommended approval of the draft resolution in EB111.R3; it had also drawn attention to the fact that more work needed to be carried out on the building at Brazzaville, and had requested ABFC at its meeting in May 2003 to submit a recommendation to the Health Assembly in that regard.

Ms WILD (Comptroller) confirmed that in April 2003 WHO had been informed that the Swiss authorities had approved and submitted for parliamentary authorization an interest-free loan of CHF 59 800 000 repayable over 50 years. WHO's share amounted to CHF 29 900 000, leaving a shortfall of CHF 3 100 000 in WHO's share of the estimated cost of the new building. Negotiation with the Swiss authorities in respect of the value of compensation for the demolition of the V building were continuing, and it was expected that the shortfall would be covered by the value of compensation provided, which meant that the estimated cost of the building remained unchanged at CHF 66 000 000. Consequently, the figure of CHF 61 000 000 stated in the draft resolution EB111.R3 should be amended to CHF 59 800 000 and the amount of WHO's share should be amended from CHF 30 500 000 to CHF 29 900 000; likewise, the difference of CHF 2 500 000 should be amended to CHF 3 100 000.

Referring to a question by Dr SHANGULA (Namibia), she confirmed that the loan remained interest-free and was repayable in equal instalments over 50 years, commencing from completion of the building.

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.12.

[2] See document WHA56/2003/REC/1, Annex 2.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB111.R3, as amended.

**The draft resolution, as amended, was approved.**[1]

The CHAIRMAN drew the Committee's attention to document A56/50, which contained a draft resolution on the Brazzaville building, recommended by ABFC for approval and submission to the Fifty-sixth World Health Assembly.

Dr YOOSUF (Maldives), speaking as Chairman of ABFC, said that ABFC had recognized the substantial increase in the number of Member States in the African Region since the current facilities had been built some 25 years earlier. Moreover, there were no commercial conference facilities locally and the number of staff working at the Regional Office had increased significantly since its move to Harare in 1997. Those considerations, together with the need to return the remaining staff from Harare, had led to the proposal to increase the office and residential accommodation. ABFC had noted that the request for funding had already been included in the proposed programme budget for 2004-2005. ABFC accordingly recommended approval of the draft resolution contained in document A56/50.

**The draft resolution was approved.**[2]

**The meeting rose at 16:10.**

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.13.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA56.14.

## FOURTH MEETING

**Saturday, 24 May 2003, at 09:25**

**Chairman:** Mr L. ROKOVADA (Fiji)
**later:** Dr R. CONSTANTINIU (Romania)

### 1. ASSIGNMENT AND TRANSFER OF MEMBER STATES TO REGIONS: Item 17 of the Agenda

**Assignment of the Democratic Republic of Timor-Leste to the South-East Asia Region:** Item 17.1 of the Agenda (Document A56/36)

Dr MARIA DE ARAUJO (Timor-Leste) said that his country would be proud to be assigned to WHO's South-East Asia Region. It had been working with the Regional Office since 1999 on the establishment and streamlining of its health system. He looked forward to further cooperation with WHO in the future, since development of the health sector was the highest priority of his Government.

Timor-Leste would do all it could to work with other Member States in the region to transform challenges into opportunities for better health for all.

Dr UTON RAFEI (Regional Director for South-East Asia) said that he would welcome Timor-Leste to the South-East Asia Region. Collaboration between his office and Timor-Leste had been well established for more than three years before the country's accession to membership of the Organization, and he had been delighted to see the constructive way in which its authorities had taken up the strategic focus and key programmes of the Organization and cooperated with its Representative in Dili. As a result, several well-founded collaborative programmes had been established, supported by generous voluntary contributions from other Member States as well as from WHO's own limited resources.

The CHAIRMAN invited the committee to approve the draft resolution contained in document A56/36.

**The draft resolution was approved.**[1]

**Reassignment of Cyprus from the Eastern Mediterranean Region to the European Region:** Item 17.2 of the Agenda (Document A56/37)

Mr KURTTEKIN (Turkey) said that WHO's successful record in achieving its goals since its establishment was the result of harmonious working relationships. His delegation opposed the request by the Greek Cypriot administration to be reassigned to the European Region as it challenged a harmonious relationship.

The Greek Cypriot administration in the south of the island did not represent the Turkish Cypriot people and was not recognized by his Government, and technical problems for work in the region would result if a transfer was effected to the European Region. Within the United Nations system there was increasing caution, if not reluctance, over considering demands for reassignment

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA56.15.

from one region or group to another, and he was concerned that in the case of Cyprus the European Regional Office had taken up the issue before it had even been discussed in the Eastern Mediterranean Regional Office. Furthermore, such a reassignment was untimely, and would not facilitate the ongoing efforts to reach a consensus on the Cyprus problem based on a new partnership between the two parties. Despite the fact that WHO worked on the principle of health for all, the Greek Cypriot population had capitalized on assistance to Cyprus at the expense of the Turkish Cypriots, an issue which deserved serious attention. According to information available to his delegation, over the past two decades WHO's financial assistance to Cyprus had exceeded US$ 5 million, yet the Turkish Cypriot population had received less than US$ 100 000 of that sum. The per capita income of the Turkish Cypriots was far below the US$ 13 000 per capita income of the Greek Cypriot community, which showed that it was they who were in real need.

He therefore requested that WHO introduce a special programme to assist the Turkish Cypriot people, perhaps using the remainder of the country budget for the 2003-2004 biennium for that purpose. Although his delegation's position on the request by Cyprus for reassignment remained unchanged, owing to the importance it attached to WHO and in a spirit of cooperation it would refrain from creating difficulties that would prevent consensus being reached on the issue.

Ms LANITOU WILLIAMS (Cyprus) said that the interregional reassignment of Cyprus was not a political but a technical issue. The political problem was being dealt with in the context of the Good Offices Mission of the United Nations Secretary-General, and it should not therefore be discussed in other forums. Recalling that a number of Security Council resolutions had clearly recognized the Government of the Republic of Cyprus as the only legitimate government of the island, and responding to the comments by the representative of Turkey, she said that since April 2003 a new set of practical health-sector measures had been put in place with a view to developing closer relations between Greek Cypriot and Turkish Cypriot doctors and medical institutions, and ensuring the continued provision of free medical services and emergency treatment to Turkish Cypriots in the Government-controlled area. She expressed her delegation's appreciation for the support Cyprus had received from both the Eastern Mediterranean and European Regional Offices.

Mr PURI (India) commended the constructive spirit displayed during the discussion, which should serve as a model for discussion of other politically sensitive issues. He noted that the Committee was dealing with two friendly countries, Cyprus and Turkey, and that paragraph 4 of document A56/37 stated that the Health Assembly had until that time acceded to requests from Member States to be reassigned from one region to another. That being the case, he believed that if the Member States of the Eastern Mediterranean Region had unanimously agreed to the reassignment, and if the European Region was prepared to accept Cyprus, any other issues could be dealt with separately. He thanked the delegate of Turkey for not raising objections to the draft resolution.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) said that good relations had been enjoyed with Cyprus over the years, and that his Region had done its best to serve Cypriots of north and south alike. The Cypriot Government had requested the transfer, and it had been discussed and accepted by both Regional Committees. Owing to the income ceiling, Cyprus, along with Kuwait, Qatar and the United Arab Emirates, had not been allocated a country budget for the 2004-2005 biennium. However, in order to avoid undue disparities, it had been decided that Cyprus would be allocated a relatively small amount of intercountry funding for the 2002-2003 biennium. Of the programmes for 2002-2003, about 70% had already been implemented. He had therefore discussed with the Regional Director for Europe the suggestion that implementation of those programmes continue until the end of 2003, and that European Region programmes would begin in 2004. Cyprus would be welcome to attend meetings of both Committees, as an observer and full member, respectively.

Dr DANZON (Regional Director for Europe) assured the delegate of Turkey that, if it was decided to transfer Cyprus to the European Region, he would take into account his concern that a spirit of harmony and respect for the principle of health for all should prevail.

The CHAIRMAN noted the statement by the delegate of Turkey and invited the Committee to consider the draft resolution contained in document A56/37.

**The draft resolution was approved.**[1]

Dr THIERS (Belgium) welcomed Cyprus to membership of the European Region.

Mr KURTTEKIN (Turkey) said that he wished it to be recorded that the continued presence of Turkey in the European Region, in which the Greek Cypriot administration would also be present, should in no way be construed as recognition of the so-called Republic of Cyprus by Turkey, nor should it imply any change in Turkey's well-known position that that administration did not represent the Turkish Cypriots in the island and did not possess the right or authority to become party to international instruments on behalf of Cyprus as a whole. Turkey's presence in the European Region would therefore not signify any obligation on the part of Turkey to enter into any dealings with the so-called Republic of Cyprus.

Ms LANITOU WILLIAMS (Cyprus) thanked both Regions for their support. She expressed the hope that her country's long and fruitful participation in WHO's work in the Eastern Mediterranean Region would contribute to harmonious relations between that and the European Region and act as a bridge between them.

## 2. SECOND REPORT OF COMMITTEE B (Document A56/60)

Mrs VELÁSQUEZ DE VISBAL (Venezuela), Rapporteur, read out the draft second report of Committee B.

**The report was adopted.**[2]

**Dr Constantiniu took the Chair.**

## 3. STAFFING MATTERS: Item 18 of the Agenda

**Human resources: annual report:** Item 18.1 of the Agenda (Documents A56/38, A56/38 Corr.1 and A56/39)

The CHAIRMAN drew attention to documents A56/38 and A56/38 Corr.1 on the human resources profile in WHO at the end of 2002.

Mr YOSHIDA (Japan) said that it was vital to draw Member States' attention to the situation with regard to human resources in WHO. His Government had consistently emphasized the

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA56.16.

[2] See page 343.

importance of balanced geographical representation, yet it emerged from the report that many countries were still underrepresented or unrepresented. A practical strategy based on the findings of the report should therefore be adopted, and further efforts made to achieve a more equitable distribution of posts.

**The Committee noted the report.**

The CHAIRMAN drew attention to document A56/39 on gender balance and, in particular, the draft resolution contained in paragraph 14.

Ms MIDDELHOFF (Netherlands), supported by Ms MACMILLAN (New Zealand), Dr CHRISTIANSEN (Norway), Dr THORNE (United Kingdom of Great Britain and Northern Ireland), Dr AHMED (Ghana), Mr BÁRCIA (Portugal), Mr BOTZET (Germany), Ms HEIKKINEN (Finland), Mrs CÁMARA ANGULO (Spain), Ms JAMAL (United States of America), Dr AHSAN (Bangladesh), Mrs QUINTAVALLE (Italy), Professor CHURNRURTAI KARNCHANACHITRA (Thailand), Mr KINGDON (Australia), Mrs SCHAER BOURBEAU (Switzerland), Mr PURI (India), Mr KALPOKAS (Vanuatu), Mrs HESSEL (Denmark) and Dr POPESCU (Romania), said that, although the report painted a clear picture of developments since the mid-1990s and of the current state of affairs, no explanation was given for the differences between regions or the lower number of applications from female candidates. A recruitment policy taking both gender and geographical balance into account was therefore required. While there was no point in setting unrealistic targets, the figures did indicate shortcomings in policy implementation, and steps should be taken to carry out the measures needed.

Her Government favoured an integrated plan of action for recruitment that clearly defined WHO's responsibilities. That idea should be reflected in the draft resolution. She proposed that, in the third preambular paragraph, the word "Recognizing" should be replaced by "Concerned". Paragraph 2 should be amended to read "REQUESTS the Director-General to redouble efforts in order to achieve the target of parity in gender distribution among professional staff, to raise the proportion of women at senior level and to report back on an action plan for recruitment that integrates gender and geographical balance to the Executive Board in January 2004".

Mr MACPHEE (Canada) said that his Government strongly advocated the goal of an equal gender balance in the Organization, and fully supported the policy of women's advancement adopted by the executive heads of all organizations in the United Nations system. It therefore welcomed the Director-General's efforts to propose more women candidates for appointment or election to intergovernmental and expert bodies and for positions at WHO. He supported the amendments proposed by the Netherlands.

Mrs LAMBERT (South Africa) said that her Government had long realized that gender equity was impossible so long as the relevant provisions remained vague and general. She therefore associated herself with the views expressed by previous speakers, and called for the development of clear plans, well-defined targets and realistic timescales. Affirmative action, particularly with regard to recruitment, would be the only way to secure gender equity.

**The draft resolution, as amended, was approved.**[1]

[1] Transmitted to the Health Assembly in the Committee's third report, and adopted as resolution WHA56.17.

**Representation of developing countries in the Secretariat:** Item 18.2 of the Agenda (Document A56/40)

The CHAIRMAN drew attention to the draft resolution contained in document A56/40 and to text proposed by the delegation of Pakistan, which read:

The Fifty-sixth World Health Assembly,

Having considered the report by the Director-General on representation of developing countries in the Secretariat,[1]

Guided by the Purposes and Principles of the Charter of the United Nations, in particular the principle of the sovereign equality of its member states;

Reaffirming the principle of equitable participation of all Members of the Organization in its work, including the Secretariat and various committees and bodies;

Bearing in mind Article 35 of the Constitution which upholds the principles of efficiency, integrity and internationally representative character of the Secretariat, and adherence to the principle of geographical representation in the recruitment of staff;

Recalling resolution WHA55.24 underlining that country ranges for appointment in the Secretariat should, in principle, be based on membership, equitable geographical representation, population criteria, and balance between developed and developing countries, with less emphasis on financial contributions to the Organization,

1. EXPRESSES CONCERN over existing imbalance in the distribution of posts in the WHO Secretariat between developing and the developed countries;

~~1~~2. APPROVES the updating of the various elements of the WHO formula ~~contained therein~~;

~~2. SELECTS the option designed to take better account of the population element;~~

3. APPROVES the following formula for appointment of staff at the WHO Secretariat:

(1) contribution 45%,

(2) membership 45%,

(3) population 10%, subject to the upper limit of maximum desirable range of each country as specified in paragraph 22 of the report of the Director-General;[2]

~~3~~4. SETS a target of 60% of all vacancies arising over the next two years in the professional and higher graded categories, irrespective of their source of funding, for the appointment of nationals ~~of unrepresented and underrepresented~~ from developing countries in all categories of posts particularly the posts in grades P-5 and above ~~and those below the midpoint of their desirable range within the geographical representation parameters~~;

4~~5~~. REQUESTS the Director-General:

(1) to give preference to candidates from developing countries ~~and countries in transition~~, while ensuring that the target is equally achieved at higher graded levels and at headquarters;

~~(2) to report to the Fifty-ninth World Health Assembly on geographical representation and recruitment of staff in the professional and higher graded categories.~~

(2) to submit a report to the Fifty-seventh World Health Assembly on implementation of this resolution.

[1] Document A56/40.

[2] Document A56/40.

Dr AL-MAZROU (representative of the Executive Board) said that, at its 111th session, the Executive Board had welcomed the information provided in document EB111/35, prepared in response to resolution WHA55.24. Ensuing discussions had indicated general support for maintaining the current criteria for determining the targeted ranges of geographical representation, although there had been some debate concerning the contribution factor of 55% and the population factor of 5%. The United Nations, UNIDO and WHO were the only three bodies within the United Nations system to use the population criterion as part of their formula for determining the geographical distribution of posts, and they applied the population factor to only 5% of posts. In response to a request from the Administration, Budget and Finance Committee, an information document (EB111/INF.DOC./9) had been prepared describing the formula used by FAO for determining geographical representation.

No consensus had been reached about the number of posts at WHO that should be subject to geographical distribution. Some members had argued that it should apply only to posts financed from the ordinary budget, others that it should also apply to posts financed from extrabudgetary resources. The general opinion had been that WHO should be more active in seeking greater representation for underrepresented and unrepresented States. The Board had been concerned to ensure that, within two years, 60% of staff in professional and higher grade posts would be from countries that were currently underrepresented, unrepresented or below the midpoint of their desirable range. Another proposal had been to raise the target to 80%. Two options were under consideration: to alter the contribution and population factors to 50% and 10% respectively; and to adjust the upper limit of the desirable range so as to take the population factor into account.

Mr M.A. KHAN (Pakistan), introducing the draft resolution proposed by his delegation, recalled that resolution WHA55.24 had been principally concerned with the underrepresentation of developing countries in the Secretariat and on expert advisory panels. Document A56/40 showed a marked imbalance within the Secretariat between the developed and developing countries. Since the publication of the report, its data had been discussed, with a view to implementing resolution WHA55.24. He noted that nationals of developed countries held 70% of fixed-term appointments in the Secretariat. Fewer than 30% were held by nationals of developing countries, although those countries accounted for over three-quarters of the membership of WHO. Of a total of 1282 posts, 414 or almost 33% of the total, were held by nationals from the six leading contributors to the budget of WHO. The imbalance was even more pronounced at higher levels, with nationals from 20 developed countries occupying over 52% of posts at grade P5, and 112 of the 206 posts at grade P6 and above.

The imbalance in country representation was due primarily to a lack of balance in the formula by which representation was calculated. It was not justifiable to weight the attribution of posts principally according to contributions to the budget, because WHO was not a commercial organization. Account should also be taken of the needs and requirements of developing countries, in which most WHO activities took place.

Even the present formula was not being properly implemented. Some countries did not have the number of posts to which they were entitled, and 46 countries were entirely unrepresented. The question whether countries fell into the category of underrepresented, overrepresented or adequately represented had been determined on the basis of resolution WHA46.23. However, the assessment was unrealistic, since many countries with a large number of posts were still being assigned to the underrepresented category.

The imbalance in the current formula must be corrected urgently. The formula should be revised, making appropriate use of the three factors involved. Special measures should be adopted to recruit more professionals from the developing countries in the next few years.

His delegation's text reflected concerns about the draft resolution contained in document A56/40. Because excessive emphasis on the population criterion might benefit only a few countries, a new formula for population was proposed in operative paragraph 3, subject to a ceiling on the maximum desirable range of each country, as specified in paragraph 22 of the Director-General's report. The imbalance between developed and developing country nationals, particularly in the higher grades, was addressed in operative paragraph 4. The words "from developing countries in all

categories of posts particularly the posts in grades P-5 and above" fell into line with the Director-General's recommendation, in paragraph 3 of the draft resolution contained in document A56/40, that more professionals should be drawn from developing countries. It was proposed to delete the words "unrepresented and underrepresented" because, as noted earlier, the criteria used to assign countries to those categories did not reflect reality. In the final paragraph, for the sake of consistency with the language of resolution WHA55.24, it was proposed to delete the words "and countries in transition". It was also proposed to delete paragraph 4(2) of the draft resolution, instead requesting the Director-General to report to the Fifty-seventh World Health Assembly on implementation of the resolution.

Mr BÁRCIA (Portugal), supported by Mr HEMMI (Japan) and Professor CHURNRURTAI KARNCHANACHITRA (Thailand), said that the draft resolution proposed by the delegation of Pakistan warranted detailed study. It would be desirable to have a table showing the implications of the proposal.

Mrs LAMBERT (South Africa) recalled that the purpose of resolution WHA55.24 was to increase the representation of developing countries in the Secretariat, whereas the emphasis in document A56/40 was on increasing the representation of unrepresented and underrepresented countries. That had the unintended consequence of broadening the scope to include the representation of some developed countries. The three options proposed in the report of the Director-General would not, therefore, deal with the concerns set out in the resolution. Alternative formulas should be considered. Regarding the steps taken to increase diversity, as described in the report, she welcomed the idea of putting in place a strategy to widen the recruitment net. However, in order to be consistent with resolution WHA55.24, the strategy should aim to encourage applicants from developing countries, not from unrepresented and underrepresented countries. Innovative ways of targeting the former group must be found, to supplement the traditional methods. She welcomed the launch of an electronic recruitment system, reported in paragraph 26 of document A56/40. However, in most of the countries targeted by resolution WHA55.24 access to the Internet was still a dream. Furthermore, attention had so far focused on recruitment to professional rather than general service posts. According to Staff Regulation 4.4, vacancies must be filled by promotion of persons already in the service of the Organization, in preference to persons from outside. To ensure that the upward movement of general service staff members did not adversely affect the representation of developing countries in senior positions, it was vital to address the representation of general service staff.

The CHAIRMAN announced the formation of an open-ended working group to study ways of reconciling the various proposals submitted concerning agenda item 18.2.

Mr HENNING (Human Resources Services) announced that tables showing the implications of the draft resolution proposed by Pakistan would be distributed shortly.

Mr BOTZET (Germany) said that his country continued to favour bringing an early end to the underrepresentation of some countries in the Secretariat, but the proposal presented by the delegation of Pakistan was somewhat contradictory. It departed from the principle of the sovereign equality of Member States by drawing a distinction between countries depending on whether they were developing countries. If such a criterion were adopted, representation within the Secretariat was in danger of becoming more unequal. Moreover, it was not clear whether least developed countries would be given more preferential treatment, or whether countries in transition and middle income countries would be taken into account.

The CHAIRMAN suggested that discussion of the subitem should continue in the working group.

**It was so agreed.**

(For continuation of discussion and approval of a resolution, see summary record of the ninth meeting, section 2.)

**Increased representation of developing countries on Expert Advisory Panels and in Expert Committees:** Item 18.3 of the Agenda (Document A56/41)

Professor CHURNRURTAI KARNCHANACHITRA (Thailand) expressed appreciation of the Director-General's efforts to increase the representation of developing countries on Expert Advisory Panels and in Expert Committees. Once action had been taken, her delegation would welcome some quantitative information to monitor changes in the representation of developing countries.

**The Committee noted the report.**

**Amendments to the Staff Regulations and Staff Rules:** Item 18.4 of the Agenda (Resolutions EB111.R9 and EB111.R10)

Dr AL-MAZROU (representative of the Executive Board) referred to the amendments to the Staff Regulations and Staff Rules with regard to the salaries of staff in ungraded posts and of the Director-General. The International Civil Service Commission had recommended that the salaries of WHO professional and technical staff should be increased by an average 5.7% in line with the proposed increase in the United Nations. The United Nations General Assembly had decided not to adopt that recommendation in its entirety, but had approved real net salary increases for professional and higher categories effective from 1 January 2003, which the Board had confirmed in resolution EB111.R9; no salary increases had been decided on for staff in grades P1 to P3 because their salaries already exceeded the average level by an amount that was considered to represent the correct relationship between the salaries of United Nations staff and those in the United States of America. Resolution EB111.R10 recommended to the Health Assembly a draft resolution proposing that the salaries of staff in ungraded posts should be adjusted in line with the proposed salary increases for staff in category D2, with similar adjustments to the salary of the Director-General.

Mr YOSHIDA (Japan) requested clarification on when and how the Executive Board would determine the conditions of reappointment of Regional Directors, and asked for his comment to be noted.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB111.R10.

**The draft resolution was approved.**[1]

**Report of the United Nations Joint Staff Pension Board:** Item 18.5 of the Agenda (Document A56/42)

**The Committee noted the report.**

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA56.18.

**Appointment of representatives to the WHO Staff Pension Committee:** Item 18.6 of the Agenda (Document A56/43)

The CHAIRMAN invited the Committee to appoint one member and one alternate member of the WHO Staff Pension Committee, in accordance with the rotational schedule explained in document A56/43. In the absence of objections he would take it that the Committee wished to convey the following draft decision to the plenary:

> **Decision:** The Fifty-sixth World Health Assembly approved Dr A.J. Mohammad of the delegation of Oman as a member and Dr J.K. Gøtrik of the delegation of Denmark as an alternate member of the WHO Staff Pension Committee, the appointment being for a three-year period.
>
> The Fifty-sixth World Health Assembly also appointed Dr A.A. Yoosuf of the delegation of Maldives as an alternate member for the remainder of the term of office of Dr S.P. Bhattarai.[1]

**The Committee recorded its appreciation of the services of the outgoing members.**

**The meeting rose at 11:10.**

[1] Decision WHA56(9).

## FIFTH MEETING

**Monday, 26 May 2003, at 09:55**

**Chairman:** Mr L. ROKOVADA (Fiji)

### 1. THIRD REPORT OF COMMITTEE B (Document A56/62)

Mrs VELÁSQUEZ DE VISBAL (Venezuela), Rapporteur, read out the draft third report of Committee B.

**The report was adopted.**[1]

### 2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 20 of the Agenda (Document A56/45)

Professor CHURNRURTAI KARNCHANACHITRA (Thailand) said that her delegation, in welcoming the report, wished to emphasize WHO's role in collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Organization had done much to provide aid at regional and country levels, but should be more proactive in the Global Fund, especially in providing expertise in the Technical Review Panel, on which WHO experts should be able to serve in a personal capacity, in addition to the provision of technical support in general.

Mr LANARAS (European Commission) said that earlier that month the latest high-level meeting had taken place between the European Commission and WHO, the third since the exchange of letters in December 2000. European Union Commissioners and the Director-General had discussed a wide range of health issues, including communicable disease surveillance and control, the outbreak of severe acute respiratory syndrome (SARS), the WHO framework convention on tobacco control, and how they might increase cooperation. Dr Brundtland had also attended the Extraordinary Council of the European Union Health Ministers (Brussels, 6 May 2003) on SARS. At the technical level, the third meeting of senior officials was scheduled for October 2003. At the second meeting (Copenhagen, October 2002), participants had reviewed collaboration and taken note of recent work in both organizations. Special emphasis had been laid on tobacco control, including the Community's tobacco legislation, negotiations on the framework convention and preparation for the High Level Round Table on Tobacco Control, held in February 2003. The fourth Ministerial Conference on Environment and Health, to be held in Budapest in June 2004, had also been discussed. Consultation had covered several key areas identified in an exchange of letters, including meetings between officials from the WHO office in Brussels, the Regional Office for Europe and the Commission's Public Health Directorate, which took place every few months. Under an agreed staff-exchange programme on communicable diseases, an official from that Regional Office had already been seconded to the Public Health Directorate for one year; the initiative was proving helpful in facilitating cooperation, particularly in the revision of the International Health Regulations.

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[1] See page 343.

The Commission had appreciated Dr Brundtland's commitment in building up the relationship, and looked forward to further collaboration under the leadership of the Director-General elect, Dr Lee.

Mr BURKART (IAEA) said that the Agency was the only organization in the United Nations system authorized by its Statute to establish standards of health protection from radiation. Some standards adopted, most recently those on the protection of patients, had been prepared in collaboration with WHO. The Agency's human health programme, which had been associated with WHO since 1959, included priority areas identified in the Johannesburg Plan adopted at the World Summit on Sustainable Development (Johannesburg, South Africa, 2002), through its nuclear medicine, radiotherapy and nutrition subprogrammes. The number of collaborative projects had risen considerably in recent years, and included programmes to monitor HIV/AIDS, malaria, tuberculosis and cancer, in which the Agency was also in active partnership with other organizations. IAEA intended to increase its collaboration with WHO and UNAIDS for the use of molecular techniques to monitor HIV/AIDS and for the testing of a new vaccine. Radiotherapy, one of the earliest applications of radiation, remained a major factor in the treatment of cancer, and nuclear medicine techniques had proved valuable in diagnosing and treating heart disease, liver and thyroid cancers, and infectious and childhood diseases.

The Agency was also working closely with the African Union's Pan African Tsetse and Trypanosomiasis Eradication Campaign, using the sterile-insect technique, and welcomed the Health Assembly's adoption of resolution WHA56.7. Research would also be undertaken into the possible application of the sterile-insect technique's key components in a field programme against mosquito vectors of malaria. Working with WHO, the Agency had assisted in the transfer of molecular isotope-based test procedures to Member States for timely detection of drug-resistant malaria.

The Agency assisted Member States mainly through its technical cooperation programme; over 800 projects, valued at nearly US$ 400 000 000, had supported priority actions since 1992 in areas such as food, agriculture, health, water and the environment. The Agency's activities were based mainly on partnership, through many regional projects, research programmes and the promotion of networks of excellence. IAEA looked forward to working with WHO towards meeting the health targets of the Millennium Development Goals.

**The Committee noted the report.**

## 3. POLICY FOR RELATIONS WITH NONGOVERNMENTAL ORGANIZATIONS: Item 21 of the Agenda (Resolution EB111.R14; Document A56/46)

Dr AFRIYIE (representative of the Executive Board) said that the report reflected comments made in the discussions at the 111th session of the Board,[1] when members had welcomed a new policy and the Standing Committee on Nongovernmental Organizations had suggested a new introductory paragraph to clarify the Committee's rule relating to accreditation. Other comments by Board members included the need for more details on the definition of nongovernmental organizations, clarification that accreditation and collaboration should conform to policies adopted by the Health Assembly, and the suggestion that applicants for accreditation should be asked for details of their status with any other United Nations entities. Further, accreditation by regional committees should be consistent with the criteria set forth in the policy. Collaboration should include regional and national nongovernmental organizations, and the Director-General or a designated official should assess the suitability of collaboration. Methods to distinguish different kinds of nongovernmental organizations should be established. Further suggestions by Member States had been taken into consideration, and the policy had been updated accordingly for submission to the Health Assembly.

[1] Document EB111/2003/REC/1, summary record of the tenth meeting.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB111.R14 and that proposed by the delegation of China, which read:

The Fifty-sixth World Health Assembly,

Having considered the policy for relations between the World Health Organization and nongovernmental organizations,[1]

**Emphasizing the important role the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations have played since its adoption;**[2]

Recognizing the importance of civil society and its contributions to public health, and the growth in the numbers and influence of nongovernmental organizations active in health at global, regional and national levels;

Further, recognizing that, in accordance with Article 2 of the Constitution, one of the main functions of WHO is to act as the directing and coordinating authority on international health work and that, in accordance with Article 71 of the Constitution, the Organization may make suitable arrangements for consultation and cooperation with **international** nongovernmental organizations in carrying out its international health work;

**Recognizing also that, in accordance with Article 18(*h*) and Article 71, only with the consent of the government concerned may the Organization make suitable arrangements for consultation and cooperation with national governmental or nongovernmental organizations;**

Noting that the existing Principles Governing Relations between the World Health Organization and Nongovernmental Organizations (resolution WHA40.25) adopted by the Fortieth World Health Assembly in 1987 have been reviewed;

**Realizing** ~~Noting~~ the need to improve existing collaboration and dialogue with nongovernmental organizations, and to encourage new cooperative activities with such bodies;

**Bearing in mind the need for consistency in the Organization's policy for the relations with nongovernmental organizations,**

1. ENDORSES the policy for relations between WHO and nongovernmental organizations, which replaces the current Principles Governing Relations between the World Health Organization and Nongovernmental Organizations;

2. DECIDES that, as a transitional measure, all nongovernmental organizations in official relations with WHO as of the date of this resolution shall be advised of the new policy and invited to submit an application for accreditation, and that, pending receipt of the duly completed application for accreditation and decision by the Executive Board on the application, they will be deemed to be accredited to WHO governing bodies;

3. REQUESTS the Director-General to establish suitable measures to implement the policy, including guidelines on the accreditation of, and collaboration with, nongovernmental organizations.

Dr AHMED (Ghana) proposed that in paragraph 3 of the policy annexed to document A56/46, the words "and not-for-profit organizations that represent or are closely linked with commercial interests" should be deleted. Interaction with such organizations was clearly covered in the guidelines

[1] Document WHA56/46.

[2] **Text adopted by the Fortieth World Health Assembly (resolution WHA40.25, 1987) in replacement of the Principles adopted by the First and Third World Health Assemblies.**

on interaction with commercial enterprises to achieve health outcomes;[1] a separate accreditation form could easily be devised for them. In addition, to ensure that all relations between WHO and other entities were covered, the draft resolution in resolution EB111.R14 should include a reference, in its preamble, to the guidelines – a topic that had been under discussion for several years. Because WHO had no definition of civil society or nongovernmental organization, the amendment would be crucial to distinguishing between business-interest and public-interest nongovernmental organizations.

Mr HOHMAN (United States of America) said that he was surprised at the previous speaker's proposals, since the topic had been debated extensively in the Executive Board whose comments were fully reflected in its submission to the Health Assembly. His delegation could not accept the proposals: nor could it accept the extensive amendments proposed by the delegation of China. It should be noted that the guidelines had not been adopted, that they were currently under review and would be submitted to at least one of the governing bodies.

Mrs GONZÁLEZ NAVARRO (Cuba) said that her delegation welcomed the excellent contribution of nongovernmental organizations but had difficulty with the proposals before the Committee, since the guidelines had not all been reviewed. Before any definitive change in the role of nongovernmental organizations was decided on, the matter should continue to be examined. A working group might make some progress; or it might be necessary to forego any conclusion at the present Health Assembly.

Mrs LAMBERT (South Africa) expressed uncertainty about the origin of the proposed sweeping changes, which had only been brought to the attention of delegates that morning. She associated herself with previous speakers regarding the untimeliness and nature of the changes, which South Africa was unable to accept.

Dr COSTA FILHO (Brazil) expressed his country's satisfaction with the documents on the policy towards nongovernmental organizations. In its health system, Brazil had always recognized the importance of working with such organizations, especially at the local community level. Business and professional associations played a key role in health, particularly in regard to the prevention of epidemics, and were therefore indispensable partners. However, grass-root humanitarian and community-based nongovernmental organizations facilitated closer contact with the daily needs of the Brazilian population and the provision of care to the ill. There were various possibilities for individuals and social organizations to take action, especially in the control of epidemics. Brazil therefore welcomed the efforts to stimulate and facilitate relations between WHO and nongovernmental organizations. Such efforts should result in a significant contribution through the greater participation of nongovernmental organizations from the southern hemisphere in WHO's work.

Mr ANDERSSON (Sweden) shared the concerns of previous speakers regarding the extensive proposed amendments by China, and suggested a small drafting group should be set up to discuss the matter further.

Dr OTTO (Palau), welcoming document A56/46, said that his country benefited greatly from the contributions made by nongovernmental organizations. Palau associated itself with the amendments proposed by Ghana, but, like other countries, had been unable to give adequate consideration to those tabled by China. Discussion should therefore be either postponed to the next Health Assembly or transferred to a working group.

[1] Document EB107/20, Annex.

Ms MACMILLAN (New Zealand) said that the nongovernmental community made a vital contribution to WHO and ways should be sought to facilitate their greater participation. The Board had discussed the subject at length at its 111th session but, unfortunately, substantive changes to the draft resolution had been proposed that very morning. As there had been no time to discuss the matter with her Government, she suggested that a small working group be set up.

In exchanges with Mr HOHMAN (United States of America) and Mr SHA Zukang (China), the CHAIRMAN explored the possible scheduling of a meeting to discuss the proposals made by China and Ghana.

Mr FETZ (Canada) pointed out that certain times would make it difficult for him to obtain instructions from his Government.

Mrs LAMBERT (South Africa) commented on the impossibility for her delegation of attending an excessive number of parallel meetings.

Ms MACMILLAN (New Zealand) remarked on the difficulties of attendance facing a small delegation such as hers.

In response to Mr HOHMAN (United States of America), the CHAIRMAN said that various nongovernmental organizations had asked to speak on the item.

Mrs BENAVIDES COTES (Colombia) supported New Zealand's position as smaller delegations experienced difficulties in attending working groups that met simultaneously, thus demonstrating the need for the Committees to deal with those matters assigned to them as set out in the agenda for a particular day. The Cuban proposal to keep the matter under review would enable the substantive amendments proposed by China to be dealt with and allow delegations to keep abreast of the discussions. She proposed that the Committee should take note of the report and the requests of China, and recommended further study of the subject. That course of action would also provide an opportunity to hear the opinions of nongovernmental organizations.

Mrs HERNÁNDEZ (Venezuela) agreed with the previous speaker as her delegation was small. The matter under consideration was very important to Venezuela, however, having received the draft resolution proposed by China only that morning, she had not had time to seek instructions. She therefore supported the proposal to postpone the matter to the next Health Assembly or the 113th session of the Executive Board in January 2004.

Dr OTTO (Palau) expressed his support for the position of Colombia and Venezuela.

The CHAIRMAN asked the representative of China if it was acceptable to him to defer consideration of the item to the Fifty-seventh World Health Assembly.

Mr SHA Zukang (China) said that some countries were ready to continue to explore the matter at working-group level. China would like to pursue consultations in the hope of reaching agreement at the current Health Assembly and, for the time being, was not willing to accept postponement to the Fifty-seventh World Health Assembly.

Mr SILBERSCHMIDT (Switzerland) considered that the item should be referred back to the Executive Board and not directly to the Health Assembly.

Ms WIGZELL (Sweden) said that, as a draft resolution had been adopted by the Executive Board at its 111th session, it was regrettable that China had tabled a counter-proposal. Owing to the

difficulties of convening a working group, it would be more appropriate to refer the matter back to the Executive Board. However, the subsequent delay in updating WHO's policy in that area was to be regretted.

Ms MACMILLAN (New Zealand), supported by Mr FETZ (Canada), said that the important subject needed substantive and extensive discussions. Although she would support the convening of a working group, it would be preferable to defer further discussion to the next session of the Executive Board in order to give the whole question the consideration it deserved.

The CHAIRMAN, noting that most delegations appeared to wish to refer the matter to the Executive Board at its 113th session in January 2004, asked whether such a step was acceptable to China.

Mr SHA Zukang (China) said that China had no difficulty in giving the necessary time to discussion of the issue. China had always taken an active and positive attitude towards collaboration with nongovernmental organizations and considered its amendments to the resolution to be constructive. The policy for relations with nongovernmental organizations was a most important matter and positive, comprehensive discussion of it should continue in further meetings.

The CHAIRMAN thanked the representative of China for accepting the proposal to refer the matter back to the Executive Board, which would then place it before the Fifty-seventh World Health Assembly in 2004. He took it that the Committee agreed to that procedure.

**It was so agreed.**

## 4. TECHNICAL AND HEALTH MATTERS

**WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration:** Item 14.3 of the Agenda (Document A56/11)

Dr AFRIYIE (representative of the Executive Board) said that the Executive Board at its 111th session had highlighted the need to view the Millennium Development Goals in the broader context of development and other international processes including the Fourth WTO Ministerial Conference (Doha, November 2001), the International Conference on Financing for Development (Monterrey, Mexico, 2002) and the World Summit on Sustainable Development (Johannesburg, South Africa, 2002), the last of which in particular had set targets relevant to the achievement of Millennium Development Goals. Board members had stated that WHO should continue to provide technical guidance and advice on the monitoring of progress towards such goals, including the definition of indicators and country-level information, but had drawn attention to the burden that reporting placed on already overstrained national information systems. Monitoring should be complementary to other reporting processes. It had been noted that, while there was no specific Millennium Development Goal for reproductive health, the goals reflected maternal health, child health and HIV/AIDS. Certain goals, including those for poverty reduction, gender equality and health, would require action in the broad area of reproductive health, where WHO had an important leadership role, focusing on the critical human rights and gender dimensions that went beyond specific public health interventions. The Board had called for more information on WHO's practical support for the achievement of Millennium Development Goals and for due attention to the global partnership needed to back up the efforts being made by developing countries, as reflected in Goal 8.

Dr SOEPARAN (Indonesia), welcoming the concise and comprehensive report, said that his Government was taking into account the Millennium Development Goals in its "Healthy Indonesia 2010" programme which set guidelines for the quality, equity and accessibility of health services to the most needy people and vulnerable groups. In his country, the maternal mortality ratio and infant mortality rate remained high in comparison with other developing countries despite the focus on maternal and child health care since 1952. As the programme aimed to improve maternal health and reduce child mortality, Indonesia was focusing on skilled child-delivery attendance, accessible hospital care and the prevention of unwanted pregnancies and unsafe abortions. Another goal was reflected in the new National Strategy to Combat HIV/AIDS 2003-2007, which covered many aspects of the problem including information and treatment. Achievement of the goals would, however, depend on support from international donors and WHO to increase investment in health, focus resources on public goods and services, create new strategies for nongovernment sectors and increase effectiveness by placing more emphasis on sustainable policies. It was also important to promote effective decentralization at all levels of the system. He acknowledged WHO's support to Indonesia at country and regional levels. However, support on specific goals and country-based strategies should take account of national beliefs and practices.

Dr ANNUS (Hungary) said that the Millennium Development Goals affected health both directly and indirectly and that health had a significant impact on development. Poor health and ineffective health systems always jeopardized economic and social development. He emphasized the importance of reproductive health, which affected individuals throughout their lives. Hungary urged WHO to continue its excellent work in reproductive health research and programme development and to extend its activities to other related areas. Hungary had one of the oldest collaborating centres on reproductive health and wished to continue its cooperation with WHO and other countries in that area. He thanked WHO for its invaluable assistance to the efforts of countries to achieve the Millennium Development Goals.

Mrs ROSSUKON KANGVALLERT (Thailand), welcoming the report, expressed serious concern that countries in sub-Saharan Africa had made least progress and that much of South Asia was unlikely to achieve the targets set. More effort was needed by governments and international donors, especially in those areas. At country level, Millennium Development Goals could be used to promote intersectoral dialogue in a broader context in order to generate political commitment and additional resources, and could facilitate dialogue with United Nations agencies.

In regard to the monitoring of health indicators, the reporting system should not create additional burdens. Nevertheless, countries would need to develop their health information systems in order to reflect gender equality and to include vital registration, reporting on morbidity, and epidemiological surveillance, which were not covered in most developing countries. The monitoring of progress towards Millennium Development Goals should be used as far as possible by national policy-makers to adjust health policies. She recommended that WHO should provide technical support to help to set up a national health account that could both track resource flows and more accurately identify gender and population groups. Ad hoc studies on the access to and use of health care services by poor people would provide a strong foundation for effective health financing policies to help the poor. WHO should work in partnership with other stakeholders to establish a more independent mechanism for monitoring and evaluating progress towards Millennium Development Goals. It should use the experience gained in implementing the health-for-all programme to identify its major advantages and drawbacks.

Mr CHAKALISA (Botswana), welcoming the report, congratulated the Director-General on WHO's leadership in pursuing health-related development goals. Important conclusions of the report were that many of those goals would not be met by 2015 unless international efforts were significantly increased, and that sub-Saharan Africa had made less progress than any region, particularly in the reduction of maternal and child mortality. His delegation commended the formation of the millennium

project task forces, which were to determine the best strategies and means for achieving development goals and identifying operational priorities. Botswana had recently had an opportunity to be involved in such a process, through a visit by a task force on HIV/AIDS, which had been investigating Botswana's AIDS control programme and in particular its antiretroviral treatment, still in the early stages. His country looked forward to the results of that process and to identifying best practices to be shared with other parts of the world.

Additional resources should be attracted to those regions needing them most, for the sake of more even progress in achieving the goals. Assistance to countries in improving their reporting mechanisms should be designed with a view to complementarity, so as to improve coordination between Member States and development partners.

Mr ANDERSSON (Sweden), speaking on behalf of the Nordic countries, said that in 2002 the key to achieving the health-related Millennium Development Goals lay in improving WHO's work at country level, which made the country focus initiative particularly important. The chief constraints included inadequate financial resources, particularly in regard to domestic resource mobilization, insufficient human resources, including motivated and skilled staff in health facilities, and the harmonization of donor practices, in order to turn agreed principles into actual practice.

Issues of specific concern included the need to tackle the Millennium Development Goals in a multisectoral and coordinated manner. Ten years had elapsed since the International Conference on Population and Development in Cairo and follow-up had so far been inadequately organized. For example, sexual and reproductive health ought to be handled as an agenda item in its own right and not merely included under issues such as HIV/AIDS or maternal health. Furthermore, in monitoring results, poverty needed to be a prime concern since progress measured in terms of national averages might disguise a widening gap between rich and poor populations within countries. Consequently, there was a need to focus on non-discrimination, as well as on mechanisms to ensure a fair distribution of resources. WHO's lead in advancing the work on health-related Millennium Development Goals was welcome, but it was also essential to strengthen the role of governments and to harmonize donor efforts and multisectoral approaches in implementing and monitoring those goals.

Mr SOLANO ORTÍZ (Costa Rica) said that in his country the Millennium Development Goals were a public policy yardstick. In order to achieve them, a series of governmental and nongovernmental projects had been launched, including a programme to eradicate poverty, which had been implemented in 37 cantons with the greatest needs. A further objective was to reduce already low maternal and infant mortality levels; to do that would be extremely costly, particularly with regard to hospital care. Negotiations were currently being concluded with the Inter-American Development Bank to promote primary health care programmes. Costa Rica was drawing up its first national implementation report on the Millennium Declaration, to be presented to the United Nations early in 2004.

Ms BUIJS (Netherlands) said that, as WHO's work extended beyond the areas covered in the Millennium Development Goals, her Government welcomed the initiative to explore the relationship between those goals and health systems. She stressed the importance of the concrete recommendations contained in the report, which could be used at country level to strengthen health systems and improve health outcomes. Her country welcomed WHO's support at country level to ensure reliable health statistics.

She underscored the significance of sexual and reproductive health, both in relation to programmes for maternal and child health, HIV/AIDS, poverty reduction and gender equality and as an issue in its own right, as agreed at the International Conference on Population and Development (Cairo, 1994). Although not mentioned in the report, nutrition was an area of crucial importance. Nutrition of under-five-year-olds was an indicator for the eradication of poverty and hunger, and improvement in nutrition was a prerequisite for improving the health of mothers and children, and of those suffering from such diseases as AIDS and tuberculosis. In that context, WHO had an important

role to play, in setting standards and strategic directions as well as in reporting on the nutritional status of young children.

Mrs VU THI BICH DZUNG (Viet Nam) said that the adoption of the United Nations Millennium Declaration and the Millennium Development Goals reflected the strong commitment of governments and the international community to the cause of development and the eradication of poverty. As those goals were closely interlinked, their implementation required close global, regional and national coordination. The fact that three of the eight development goals, eight of the 18 targets, and 18 of the 48 indicators were health-related, underlined the importance of health to development.

Since 1990 Viet Nam had made considerable progress, although its national income was still low. It was regarded as a leading country in the developing world owing to its success in reaching the goal of halving its poverty rate (to 32% in recent years) much earlier than the target year of 2015. During the past decade, it had also made remarkable improvements in increasing access to primary education, health care services, clean water and environment, and other basic services: some 90% of Vietnamese children were enrolled in primary education; and both infant and maternal mortality were markedly lower. Those achievements owed largely to government-launched institutional and policy reforms, coupled with increased investment in human development, especially in health and education. The Millennium Development Goals were reflected in national strategies and development plans for economic and social development, as well as health care. However, those successes were considered to be only initial, and the Government would continue its reform programme in order to reduce the development differential between town and country. She thanked WHO and the international community for their support and cooperation, which had substantially contributed to Viet Nam's achievements.

Dr SHANGULA (Namibia) noted with concern that, unless current trends changed significantly, sub-Saharan Africa was unlikely to reach the desired goals, especially for maternal and infant mortality and the control of HIV/AIDS. He therefore proposed that, in addition to noting the report, the Health Assembly should request the Director-General to identify the health-specific impediments that prevented sub-Saharan Africa from reaching the targets and to devise an appropriate strategy to assist those countries in attaining the Millennium Development Goals.

Dr NDOUR (Senegal) said that the report pinpointed two important issues: the central role of the health sector in international development objectives, and the risk of non-attainment without redoubled efforts. Country support should therefore be twofold: at the strategic level, through coherent development policies, based on initiatives such as the New Partnership for Africa's Development and the poverty-reduction strategy papers; and through capacity strengthening, particularly in relation to monitoring and evaluation, since reliability of data was vital.

Mrs LOZANO (Mexico) recalled that the World Health Survey had been presented to the Executive Board, as a means to follow up the Millennium Development Goal indicators. Not all countries, however, participated in the survey on a regular basis because of the high cost; instruments needed to be developed for wider use.

With regard to the target for reducing infant mortality, Goal 4, Mexico had succeeded in reducing mortality in under-five-year-olds as a result of coordination between the health and education sectors. Its integrated programme of action for infant health was aimed at making better use of resources and improving intersectoral coordination; health centres provided basic services for mothers and children and those services were being improved to try and ensure that all children realized their full potential. Mexico was also developing strategies for community participation, human development, the prevention of disability, health personnel training and improvement of health units, with a view to achieving the goal of reducing infant mortality by 66% by 2015.

In order to achieve Goal 6, a multisectoral programme including preventive health care measures had been developed for the most at-risk and vulnerable populations, while respecting their

human rights and fundamental freedoms. In line with those measures, Mexico had joined the global strategy to increase access to HIV/AIDS medicines, allocating resources to cover the most disadvantaged sectors of the population. It expected to achieve all its goals by the end of 2003. Civil society and people living with HIV/AIDS were being included in preventive care and other health care strategies. Basic indicators were currently being established, in order to measure progress on an annual basis.

Dr FRASER (United Kingdom of Great Britain and Northern Ireland) said that, while he welcomed WHO's commitment to the Millennium Development Goals, progress in attaining them in many countries would be difficult, if not impossible, owing to the devastating impact of HIV/AIDS. More information about WHO's support for country efforts to lower maternal mortality would have been useful. The attention to reproductive health overall was much appreciated, as it was central to attainment of key Millennium Development Goals and the international development goals agreed at the International Conference on Population and Development (Cairo, 1994). He had also been pleased to note the work under way to develop a strategy for accelerating progress on reproductive health in response to resolution WHA55.19. He consequently proposed an additional element for that strategy explicitly concerned with improving and strengthening the evidence base for enhancing the delivery of reproductive health within the context of sector-wide reform and poverty reduction strategy processes.

Mr SADDIER (France), welcoming the report's emphasis on poverty and reproductive health, wanted WHO to work closely with UNDP to achieve the Millennium Development Goals. However, it was a matter of some concern that certain regions, particularly sub-Saharan Africa and South Asia, might be unable to reach those goals unless their national health systems were further strengthened. He consequently supported the measures outlined in paragraphs 11 and 13 of the report and the key elements of the strategy defined in paragraph 18, stressing the importance of information on and access to contraception.

Mr YANG Qing (China) supported the actions proposed for realization of the Millennium Development Goals. Referring in particular to infant and maternal mortality, the targets and goals to be achieved by 2015 had been based on 1990 figures rather than on figures for 2000. Goals 4 and 5 would not be easy to achieve: for developed countries where the maternal mortality rate was already as low as 5 or 6 per 100 000, a further 75% reduction would be difficult, just as it would for developing countries where the rate currently stood at 200 per 100 000.

Mr JHA (India) emphasized that the developing countries could not achieve the ambitious Millennium Development Goals unless they received significant resources from the developed countries. India had incorporated the goals into its national plans and health policy, but found it difficult to accept the idea of progress towards national achievement of those goals being monitored by the United Nations. National monitoring and record-keeping had not been mandated by the Member States but had been an idea put forward by the United Nations. United Nations bodies such as UNDP and the Economic and Social Council had no legislative mandate for country-level monitoring of the Millennium Development Goals. Such initiatives could be considered intrusive and in violation of a country's sovereign rights. Use should instead be made of the vast body of data scientifically collected and assessed by governments that was available in the public domain.

Mr KAMAL (Canada) said that, in order to reinforce its commitment to the Millennium Development Goals, Canada had announced an increase in its overseas development assistance for the 2002-2004 fiscal year, and expected to double it by 2010. It had also renewed its commitment to the development of Africa by spearheading the establishment of the New Partnership for Africa's Development. It was therefore concerned that many countries were unlikely to achieve the Millennium Development Goals and he urged United Nations agencies, donor organizations and developing countries to make concerted efforts to accelerate progress. The Accelerating Health Millennium

Development Goals Initiative promoted by the World Bank and other agencies and follow-up activities by the World Bank and WHO were welcome; Canada participated in that process through the Canadian International Development Agency.

Although the Millennium Development Goals did not place much emphasis on reproductive health as a whole, that subject was important in promoting women's and children's health, gender equality and overall health of the population. In keeping with the spirit of the International Conference on Population and Development and the World Summit on Sustainable Development, sexual and reproductive health should continue to receive special attention from the United Nations and development partners.

The importance of strengthening health systems in developing countries to achieve the Millennium Development Goals could not be overemphasized.

Dr FETISOV (Russian Federation) said that the inclusion of such a broad spectrum of health problems in the goals for sustainable development had resulted from the collection of reliable data by WHO, particularly macroeconomic health data. WHO's strategy for achieving those development goals was reinforced in its day-to-day activities, its programme budget and its coordination of the work of Member States in combating poverty and inaccessibility of medical services. Many of those problems needed to be addressed differently in each country. Recommendations at the global level to highlight the linkages between the various efforts in the field of health to reduce poverty and improve socioeconomic development had been timely.

He supported WHO's plans to develop indicators to assess the progress toward each goal and its intentions to publish in *The world health report 2003* the country results for the 17 health indicators monitored by WHO.

Mr MARTIN (Switzerland) highlighted WHO's crucial role in achieving the Millennium Development Goals and the need for WHO to collaborate closely with UNDP and UNFPA. He emphasized the need for WHO to assist countries in the area of capacity development to enable them to achieve those goals, with due regard for specific objectives already set in the area of sexual and reproductive health and gender balance.

It was particularly important that progress should be properly measured. WHO could assist countries in adopting methods for comparing country data, which would facilitate policy decisions at the national and international levels.

Mrs GONZÁLEZ DE SUSO (Spain) noted, like other delegates, that reproductive health was not among the Millennium Development Goals, although some of its key aspects were incorporated in Goals 4, 5 and 6. A strategy paper to accelerate progress in achieving the goals related to reproductive health was essential. To that end, improvements should be made in measuring reproductive health and a link should be established between reproductive health and poverty. Attention should also be given to risk factors such as access to contraceptives and sexual behaviour and to the development of national and international alliances.

WHO was the appropriate organization to spearhead joint action with other United Nations agencies. To that end, greater resources would need to be allocated to health.

Dr AHMED (Ghana) noted that the report said little about reproductive health and noncommunicable diseases. The conclusion in paragraph 4 that many of the goals would not be reached by 2015 unless international efforts are significantly increased, and the statement that health goals, unlike other development goals, were expressed in terms of national averages rather than gains, were of great concern and needed close analysis.

In Ghana, all issues relating to women were dealt with by the Ministry for Women's and Child Affairs that had links with other ministries to ensure that all relevant problems were addressed. The targets of the Millennium Development Goals had been incorporated into Ghana's planning process,

and a macroeconomic health forum, launched by the President, had been taken over by the Ministry of Planning and Development.

With regard to Goals 4, 5 and 6, the international community must make more effort to ensure the economic and social stability of sub-Saharan Africa. Initiatives such as the New Partnership for Africa's Development should provide solutions that could be built upon. With regard to maternal mortality, the number of deliveries attended to by skilled personnel was an important issue for sub-Saharan Africa which experienced migration of health care workers. In Ghana, the number of health officers had remained unchanged for 25 years. The retention of skilled personnel was a problem that required attention if disadvantaged countries were to achieve the targets set in the Millennium Development Goals.

Dr CASSELS (Strategy Unit), noting the focus on sexual and reproductive health and reporting and monitoring progress towards the goals, said that the discussion had highlighted the importance of health in relation to overall development, and a concern to keep that issue on the agenda at a political level both nationally and internationally. The concerns expressed by several delegates that progress was mixed illustrated the importance of having goals with clear targets to keep the world focused on the agenda and on ways of advancing more rapidly.

In accelerating progress, both national and international efforts were important: the issues identified in Goal 8 and the monitoring of progress in that area were important to health and other development goals. In addition, as several delegates had pointed out, the problem was one of not only resources but properly and fairly functioning health systems and human resources as well: they were essential to goal attainment. Systems should, therefore, be kept at the centre of all efforts geared towards achieving the Development Goals.

The Millennium Development Goals had been described as proxies for a broader agenda. As the goals were interrelated, intersectoral action between specific sectors and in the public sector as a whole was required to achieve them. Several delegates had mentioned the plethora of initiatives focusing on individual countries, specific activities or health conditions, and had pointed out that all such initiatives should be synergistic and should support nationally-led development efforts. There had been a call for strategic support at the country level to create cohesion among the various initiatives.

In relation to reporting, the importance of indicating status at the aggregate level and at the level of different groups within society, so as to check that progress was being made equitably, was critical. In that connection selected indicators needed to be supplemented by others that illustrated not only outcomes but how and why progress was being achieved. The point made by the Netherlands on the importance of reflecting nutrition in the future had been noted.

Dr TÜRMEN (Executive Director), also observing the importance attached to sexual and reproductive health, said that reproductive health was implicit in Goals 4, 5 and 6, which focused on infant and maternal mortality and HIV/AIDS. Reproductive health also contributed to other goals, notably those on poverty reduction, gender equality and women's empowerment. In recognition of the major contribution of reproductive health to the achievement of the Development Goals, Member States at the Fifty-fifth World Health Assembly had called on the Organization in resolution WHA55.19 to develop a strategy for accelerating progress towards attainment of goals and targets related to reproductive health. That strategy was being developed in close consultation with Member States, WHO regional and country offices and other key stakeholders.

In the coming months, a series of regional consultations would be held in Denmark, Sri Lanka, the United States of America and Zimbabwe to bring together countries and the various partners involved in delivering reproductive health interventions at the country level. The suggestion made by the United Kingdom of Great Britain and Northern Ireland was welcome and would be added to the key elements of the strategy. That strategy would assist countries and partners in translating global goals and targets into action through operational, country-owned frameworks. A report on the outcomes of those consultations would be submitted to the Executive Board at its 113th session and to the Fifty-seventh World Health Assembly.

Dr MECHBAL (Health Financing and Stewardship) observed that many delegates had highlighted the importance of monitoring achievement of the Millennium Development Goals and interaction with the various United Nations agencies to avoid duplication of efforts and placing increased burden on countries. Some delegates had pointed to the need to reduce the country burden of developing instruments and the use of different methods.

Monitoring systems should be evidence-based and criteria should be clear on validity and comparability. Consultation with countries was also important for the data, for example, reproduced in the annexes to WHO reports, which should show methods and sources used. National data, already in the public domain, should be put to use as the delegate of India had said, particularly in countries where surveys were not feasible.

At the international level, efforts with other United Nations agencies, particularly UNICEF, UNFPA, UNDP and UNAIDS, to standardize methods and to use and share similar sources of data were currently under way. Consultation at the country level gave countries an opportunity to give feedback, particularly on elements of importance to them that had not been taken into consideration.

The issue of burdening countries, the need for integrating all instruments and methods as part of national health information systems, and the question of the affordability of the World Health Survey were high on WHO's agenda.

The launch of the health matrix network initiative announced by Dr Lee would provide greater support to countries in strengthening health statistics and health information systems. In addition, the feedback from the 73 countries currently involved in the World Health Survey would be an important input at the next stage for continuing to reduce costs and for validating that instrument as part of the national health information system. The aim was to have a flexible, modular survey instrument that countries could use as the need arose to build an evidence base.

The annual publication of the Millennium Development Goals indicators as an annex to *The world health report* would provide an increased evidence base and an important means whereby countries could learn from one another and monitor achievement.

Ms RUOFF (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed the commitment to Millennium Development Goal health indicators reflected in the report. She echoed its concerns particularly in relation to the absence of specific indicators on noncommunicable diseases and health systems funding and to the danger of focusing on outcome indicators. Her Organization called on the Health Assembly to consider the addition of process indicators relating to health systems, such as the percentage of rural health posts filled. Publication of *The world health report 2003* was eagerly awaited as it would examine the relationships between the Millennium Development Goals and health systems. Such technical assistance was essential in helping countries to develop their national poverty strategies. Governments, however, should involve civil society more widely in the process. There was increasing evidence that the poorest third of the population of sub-Saharan Africa lacked any access to health care, while the middle third was selling finite capital assets to pay for it, thereby creating even greater poverty. She urged WHO and national governments to consider further disaggregating data and indicators in order to highlight and remedy equity gaps within countries and populations. An increase in technical assistance by WHO to both donors and governments would ensure that only proven and effective interventions were used in combating malnutrition.

It was a matter of concern that health spending was still predominantly prioritized on the basis of analysis of cost-effective approaches in terms of disability-adjusted life years. By prioritizing economically productive populations, it tended to promote increasing inequity for sections of the population that were already marginalized. The Save the Children Fund called on WHO to investigate the impact of using that analysis over the past 10 years and undertook to work with the Organization and national governments to devise an equity-oriented and pro-poor rights-based method of analysis for international and country health resource allocation and prioritization. That would also help to ensure that children's rights were addressed with dignity, allowing them to achieve their full potential.

**The Committee took note of the report.**

**World Summit on Sustainable Development:** Item 14.5 of the Agenda (Document A56/13)

Ms PORNPIT SILKAVUTE (Thailand) said that sustainable development had been on the agenda of governments, the private sector and nongovernmental organizations since the United Nations Conference on Environment and Development in Rio de Janeiro in 1992 and Agenda 21. There had also been a growing awareness that the human and social dimensions of development and the link between health and sustainable development were not adequately recognized. Nevertheless, Thailand remained concerned about international cooperation in the field of chemicals management. Since 1994, substantive work had been carried out on chemical safety by the Intergovernmental Forum on Chemical Safety. In 2000, Forum III had endorsed the Bahia Declaration on Chemical Safety and the Priorities for Action Beyond 2000, which emphasized sound management of chemicals as essential to sustainable development and protecting human health and the environment. Subsequently, paragraph 23(b) of the World Summit on Sustainable Development plan of implementation called for further elaboration of a strategic approach to international management of chemicals and urged relevant international organizations to cooperate closely in that regard. Both the Intergovernmental Forum and UNEP would be holding meetings in Bangkok in November 2003: Forum IV (1-7 November) and UNEP's first preparatory meeting on a strategic approach to international management of chemicals (9-13 November). The meetings would provide an opportunity for all stakeholders, including governments, relevant international bodies and nongovernmental organizations, to discuss and chart the course of further cooperation, and for the two bodies to begin to cooperate more fully to foster a strategic approach to international chemicals management.

Thailand, in conjunction with Brazil, Canada, China, Japan, Norway, South Africa and Switzerland, consequently proposed a draft resolution that read as follows:

> The Fifty-sixth World Health Assembly,
>
> Recalling the first principle of the Rio Declaration on Environment and Development, namely, that "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature";
>
> Noting that the Bahia Declaration on Chemical Safety and the Priorities for Action Beyond 2000 of the Intergovernmental Forum on Chemical Safety emphasized the essential role of sound management of chemicals in sustainable development and the protection of human health and the environment;
>
> Further noting that the World Summit on Sustainable Development plan of implementation, paragraph 23(b) calls for further development of a strategic approach to international chemicals management and urges international organizations dealing with chemical management to cooperate closely in this regard;
>
> Fully supporting the UNEP Governing Council Decision 22/4 to further develop a strategic approach to international chemicals management following an open, transparent and inclusive process and providing all stakeholders opportunities to participate; and the invitation to a range of international organizations, including WHO, to collaborate actively in the further development of the strategic approach;
>
> Noting the involvement of WHO in the Steering Committee of the strategic approach to international chemicals management established to act as a facilitative steering mechanism to deal with practical aspects of the strategic approach;
>
> Noting also the role of WHO as the administering organization for the Intergovernmental Forum on Chemical Safety;
>
> Mindful of WHO's contribution to the international management of chemicals through the International Programme on Chemical Safety, a cooperative venture between ILO, WHO and UNEP;

Recalling resolution WHA45.32 on the International Programme, which emphasized the need to establish or strengthen governmental mechanisms to provide liaison and coordination between authorities and institutions involved in chemical safety activities, and resolution WHA42.26 on WHO's contribution to the international efforts towards sustainable development, which considered that equitable health development is an essential prerequisite for socioeconomic development;

Recognizing the need for health interests at country level to be reflected in, and addressed by, the strategic approach to international chemicals management,

1. URGES Member States to take full account of the health aspects of chemical safety in further development of the strategic approach to international chemicals management;

2. REQUESTS the Director-General:

(1) to support the continuing roles of WHO and the Intergovernmental Forum on Chemical Safety in overseeing development of the strategic approach through membership of its Steering Committee;

(2) to contribute to the content of the strategic approach, in accordance with the invitation of the UNEP Governing Council, through initial submission of possible health-focused elements and participation of WHO in preparatory meetings and the final conference;

(3) to submit a progress report to the Health Assembly before the estimated date of completion of the strategic approach;

(4) when completed, to submit the strategic approach to international chemicals management to the Health Assembly for consideration.

Mr YOSHIDA (Japan) endorsed the statement by Thailand. The World Summit on Sustainable Development had recognized that poverty alleviation was a crucial element in achieving sustainable development. Japan had consistently maintained that creating a healthy environment with a sufficient number of properly trained personnel was an essential component in any poverty alleviation strategy. A vital step in that direction was the provision of technical assistance to countries by WHO, in close cooperation with other relevant international organizations. Human beings should always be at the centre of concern for sustainable development strategies. The Intergovernmental Forum on Chemical Safety had highlighted the role of sound management of chemicals in protecting human health, and the World Summit on Sustainable Development had called for further improvements in the strategic approach. As a member of the Steering Committee on the strategic approach to international chemicals management and through its involvement as the administering organization for the Intergovernmental Forum on Chemical Safety, WHO should continue to play a key role in developing the strategic approach.

Mr KAMAL (Canada) strongly endorsed the draft resolution. Canada intended to participate actively in the meetings of UNEP and the Intergovernmental Forum on Chemical Safety to further the strategic approach to international chemicals management, in accordance with the decision of the World Summit on Sustainable Development. WHO and other international and intergovernmental organizations should participate fully and endorse the strategic approach upon its completion. Canada urged countries to implement the new globally harmonized system for the classification and labelling of chemicals by 2008. Key sectors included consumer chemicals, pest control products, transport of dangerous goods and workplace chemicals.

Canada remained committed to ensuring that the Health and Environment Ministers of the Americas process led to concrete results, and was working with regional counterparts and representatives of PAHO and UNEP to support the work of the task force established by the ministers at their meeting in Ottawa in March 2002. Canada was also active in United Nations activities such as the General Assembly special session on children, and committed to minimizing environmental threats

to children's health. It was contributing actively to the development of priorities for action for children in the Region of the Americas under the auspices of PAHO. The Canadian Earth Summit secretariat had drawn up a list of World Summit for Sustainable Development commitments for national action, which would be implemented under the leadership of the Environmental and Sustainable Development Coordinating Committee.

Mrs HESSEL (Denmark), speaking on behalf of the Nordic countries, noted that the report contained in document A56/13 emphasized the importance of stimulating multisectoral partnerships in working for sustainable development, and the link between economic, social and environmental aspects of sustainable development and improvements in health. Although primary responsibility for implementing the commitments undertaken at the World Summit on Sustainable Development still lay at national level, a greater emphasis on the regional level and stronger linkages between global, regional and national efforts were critical elements in achieving progress towards sustainable development. The Nordic countries had prepared national strategies to that effect and were also cooperating at regional level. For example, the Nordic Council of Ministers had established a set of statistical indicators for the social and health sectors, while the Arctic Human Development Report, published by the Arctic Council, would assess living conditions in the Northern region.

The challenges facing developing countries, in particular, were enormous, and extensive efforts would be required to translate the commitments made at the World Summit into actions. The WHO report on macroeconomics and health indicated that investment in basic health care was a prerequisite for sustainable development.[1] Health care interventions through reproductive health and other measures should remain a priority in areas of high mortality and morbidity. A major challenge for WHO was to enhance its performance at country level in order to assist Member States in reaching their health and development targets, including the pledges made at the World Summit. Expansion of its Country Focus Initiative would greatly assist in that respect.

Dr AL-HOSANI (United Arab Emirates) said that the World Summit on Sustainable Development had reaffirmed investment in people as the key to sustainable development and had highlighted the importance of protecting and promoting human health. The provision of better health care and the fight to control all forms of disease were closely related to environmental protection and the adoption of healthier lifestyles. His country reaffirmed its commitment to cooperate more actively, through the United Nations system, as well as in national and local health-related sectors, to improve the health environment and meet the health-related development goals. In line with some of the recommendations of the World Summit plan of implementation, the United Arab Emirates had already made progress towards some of its own development goals which were closely linked to the Millennium Development Goals, namely: the provision of essential medicines; expanded immunization programmes; improvements in reproductive health, particularly maternal and child health; and the eradication of communicable diseases such as malaria, poliomyelitis and tuberculosis. His country was willing to share its positive experiences with other Member States.

Mr JHA (India) pointed out that paragraph 3 of document A56/13 indicated that the political declaration was one of the major outcomes of the World Summit. However, that had not been a negotiated outcome. The United Nations Commission on Sustainable Development, at its 11th session, had accorded a central role to the World Summit on Sustainable Development plan of implementation, which should be regarded as the outcome document. Building on work undertaken through the World Summit process to encourage partnerships, the Commission on Sustainable Development had laid down criteria and guidelines for partnerships formed with the intention of promoting sustainable

[1] *Macroeconomics and health: investing in health for economic development.* Report of the Commission on Macroeconomics and Health, Geneva, World Health Organization, 2001.

development. All future references to such partnerships, therefore, should reflect the outcome of the 11th session of the Commission on Sustainable Development.

Mr YANG Qing (China) agreed that health and human resources should be treated as priority areas in sustainable development. His country had developed a plan for eradicating poverty by 2023 in which primary health care occupied a central place. Health programmes were being established covering the period 2001 to 2010, including a primary health care plan for rural areas, a programme designed to control the spread of HIV and to reduce the prevalence of tuberculosis and malaria, and programmes for women and children. China supported the draft resolution.

Dr CHIRWA (Zambia) commended WHO's contribution to the current view of health as a precondition for and means of achieving sustainable development. In particular, he supported the Director-General's conceptualization of health, as first set out in the 1987 Brundtland Report "Our Common Future". Zambia strongly supported the focus on future generations, the need for change instead of stagnation, the integration of the economy, the environment and health, institutional collaboration, and the need for empowerment and democracy. Only when parents could see a bright future for their children would they consider it worthwhile to participate in society, help to protect the fragile environment and work for the common good. Sadly, too many children in developing countries, including Zambia, lacked that hope. Every effort by WHO to put health high on policy agendas would contribute to a truly sustainable development worldwide. An effective way of giving people hope was to promote activities targeting the Millennium Development Goals. Zambia supported the draft resolution.

Dr NABARRO (Executive Director) agreed that the linkages between health, the environment and sustainable development were gaining wider recognition. The delegate of Denmark had pointed out that, although the primary responsibility for progressing the work lay at national level, strong linkages at global, regional and national levels were needed. The delegate of Zambia wished to see health kept high on the policy agenda to attain that end. Several speakers had indicated the challenge of ensuring that commitments made in the World Summit on Sustainable Development plan of implementation were undertaken; several countries including Canada had indicated how they were responding to those commitments and the role they envisaged for WHO in supporting their efforts. Given the challenge of enhancing intersectoral performance at country level, he had noted the ongoing process of the regional meetings of the Health and Environment Ministers of the Americas and Canada's commitment to reducing environmental threats to children's health. One outcome of the implementation plan had been the proposal for a strategic approach to international chemicals management. Most of the speakers had expressed strong support for a central role for WHO in the strategic approach by working across the United Nations system to bring together all the different elements of support to ensure that adequate attention was paid to human health interests. That approach was clearly set out in the draft resolution.

The comment made by the delegate of India had been duly noted.

**The draft resolution was approved.**[1]

**The meeting rose at 12:35.**

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA56.22.

## SIXTH MEETING

**Monday, 26 May 2003, at 14:40**

**Chairman:** Dr R. CONSTANTINIU (Romania)
**later:** Mr L. ROKOVADA (Fiji)

**TECHNICAL AND HEALTH MATTERS:** Item 14 of the Agenda (continued)

**Eradication of poliomyelitis:** Item 14.12 of the Agenda (Document A56/20)

The CHAIRMAN opened the debate by inviting the delegates of Egypt, India, Nigeria and Pakistan to report on progress in eradicating poliomyelitis in their countries.

Dr EL TAYEB (Egypt) said that Egypt had successfully implemented national campaigns to increase monitoring for severe cases and raise routine rates of immunization against poliomyelitis. With political support and community-wide participation, and by providing house-to-house vaccinations in both rural and urban areas for the first time, the campaigns had achieved an officially-reported coverage of more than 95%. Another two- or three-dose national campaign was planned for late 2003, following assessments of the immunization programmes so far undertaken. The ultimate goal was the complete eradication of poliomyelitis. He submitted a detailed memorandum on the eradication campaign in Egypt.

Mr NAIK (India) said that his country had achieved a dramatic reduction in the number of poliomyelitis cases, from 1934 in 1998 to 265 in 2001. However, as a result of complacency and a halving of immunization rounds to three, in 2002 there had been a resurgence of the virus in endemic districts of Uttar Pradesh and Bihar, compounded by the low rate of immunization in those states. Efforts to obtain the support of all levels of the administration had been successful, resulting in a multisectoral programme, with six subnational and national immunization rounds foreseen between April 2003 and February 2004. The coverage of children and households had increased considerably in the two national rounds of January and February 2002. Of particular importance was the June round of immunizations, carried out at a time when the virus normally began to multiply, and it was expected that transmission at that time would be checked. Resistance to poliomyelitis eradication campaigns that had been experienced in recent years had been largely overcome with the support of religious leaders, state governments and other influential members of civil society. India was one of the few countries that had still to eradicate poliomyelitis, but was determined to do so within the next two years. It had spent US$ 138 million on its programme in 2002, and would spend US$ 165 million in 2003.

Dr ABEBE (Nigeria) said that, with the personal support and leadership of its President, Nigeria had eliminated poliomyelitis in three-quarters of its federal states. The disease was restricted to a few states in the north-east and north central zones. Recent successes were attributable to improvements in surveillance and monitoring, an efficient network of laboratory services and an increase in social mobilization and advocacy. To counter resistance in communities, traditional leaders and religious teachers had been persuaded to support immunization. In order to meet the eradication target as quickly as possible, the frequency of supplementary immunization activities had more than doubled over the past year. Halting poliovirus transmission in 2003 would mean reaching every child in each of the remaining affected states during the forthcoming campaigns. The financial implications were

huge, and she thanked WHO and Nigeria's partners for their continuing support. The strategies were evidently working and, if fully applied in 2003-2004, would eradicate the remaining pockets of poliomyelitis.

Dr MOHAMMAD (Oman) said that, despite the considerable efforts at both national and international levels that had led to spectacular results in eradicating poliomyelitis, there were no grounds for complacency, since the virus could move readily across borders. Efforts should not be relaxed at a time when the goal was so close. The postponement of activities in the past two years in several countries, as a result of limited resources, had resulted in the resurgence of the disease in some regions that had previously been free of it. It would be a dreadful loss, in both human and financial terms, if the efforts of the past 15 years were wasted. He urged WHO and its partners to mobilize additional resources to permit implementation of the revised strategic approach to eradication.

Dr AL-HOSANI (United Arab Emirates) said that the absence of any reported cases of poliomyelitis in her country since 1992 testified to its commitment to the Global Polio Eradication Initiative and the effectiveness of its national eradication programme. She commended the technical and technological support provided by the Regional Office for the Eastern Mediterranean and the Regional Commission for Certification of Poliomyelitis Eradication. Her country would continue to support the Initiative, and looked forward to benefiting from world expertise in strengthening health systems in order to eradicate and contain other diseases.

Ms GIBB (United States of America) commended the progress made to eradicate poliomyelitis, and emphasized the critical role played by the core partners. The United States Agency for International Development had supported eradication activities in more than 40 countries, and was dedicated to interrupting poliovirus transmission.

The Global Polio Eradication Initiative was experiencing severe cash flow problems, which had already resulted in the cancellation of activities in some countries, including Ethiopia and Sudan. She urged other donors to fulfil their pledges quickly. The funding gap, projected at US$ 275 million for 2003-2005, was a barrier to successful eradication. She also urged all countries to ensure the effective containment of poliovirus stocks, as an important element in the eradication campaign.

Mrs LEKKA (Greece) noted the improvements in the quality of surveillance of acute flaccid paralysis and wild-type poliovirus. It was important to minimize the risk of importing wild-type poliovirus from the remaining endemic countries. The eradication campaign was a good example of what WHO could achieve, when it focused its efforts on a few priority areas.

Dr SOMBIE (Burkina Faso), welcoming the report, said that he was submitting a document on the eradication of poliomyelitis in Burkina Faso.

Dr SHANGULA (Namibia) said that the Southern Africa Development Community was committed to becoming a poliomyelitis-free zone by 2005 and to improving the quality of surveillance of acute flaccid paralysis to certification standard. In 2004 member states of the Community would be conducting a synchronized mass immunization campaign to interrupt transmission of wild-type poliovirus in the region. Such collaboration was one of many examples of joint actions for health conducted by the Community. The last case of poliomyelitis in Namibia had been reported in 1995; national immunization days, involving all sectors of society, had been held since 1996. A poliomyelitis certification committee had been set up. With the commitment of government, the private sector, development partners and individuals, he was confident that poliomyelitis would be eradicated in Namibia by the target date.

Dr MISHKAS (Saudi Arabia) said that his country had been monitoring worldwide efforts to eradicate poliomyelitis and deal with the disease in the countries still affected, which posed a threat to

other countries. He congratulated WHO and its partners on their efforts to eradicate the disease. WHO should focus more on technical means of eradication in the areas still affected, and should step up its monitoring of national programmes. More technical and financial resources were needed from WHO and its partners, and more commitment from the countries affected. As a result of intense effort, Saudi Arabia had succeeded in eradicating poliomyelitis in the mid-1990s.

Dr RAFILA (Romania), praising the poliomyelitis-free certification of the European Region, said that Romania had benefited from the support of various partners, such as UNICEF, the United States Agency for International Development and Rotary International. Until poliomyelitis could be eradicated globally, efforts must be maintained to continue surveillance and immunization. The Romanian Government was ensuring that those activities were kept up and adequately funded. Within its community programme for public health, the Ministry of Health and Family had adopted an action plan to keep the country free of poliomyelitis. Medical staff and the public health authorities were vigilant in preventing new cases stemming from imported poliovirus. The routine immunization programme was being maintained, together with surveillance of acute flaccid paralysis cases and the identification and safe containment of all potentially infected materials. The last poliomyelitis case due to wild-type poliovirus had been registered in 1992, although more than 700 cases of acute flaccid paralysis had been detected since then in children under 15.

He strongly supported the measures taken by WHO to achieve the global eradication of poliomyelitis. The experience acquired in that area could be extended to other WHO projects.

Mrs BITNER (Poland) said that, although the European Region had been certified poliomyelitis free in 2002, it was important to maintain effective surveillance of acute flaccid paralysis and high vaccine coverage, given the risk of importing wild-type poliovirus. The absence of cases of poliomyelitis should also be documented each year as part of acute flaccid paralysis surveillance, thus all surveillance procedures should remain in place. In Poland, those procedures included detection of acute flaccid paralysis in children under 15 and collection in each case of two stool samples for examination at the WHO-accredited national poliovirus laboratory, located in the National Institute of Hygiene.

Mr YANG Qing (China) noted that, although WHO had declared three of its regions poliomyelitis free at the end of 2002, seven countries remained endemic, and there was still a risk of introduction of wild-type poliovirus. In some regions, cases of poliomyelitis due to vaccine-derived poliovirus had been reported. In recent years China had identified mutant forms of poliovirus, presenting a new challenge to the objective of global eradication. He endorsed the suggestions made in the report. WHO should provide continued assistance to developing countries to eradicate poliomyelitis, and especially to countries directly threatened by wild-type poliovirus. It should work with national governments to keep countries free of poliomyelitis and to eradicate the disease at country and global level. Studies on vaccine-derived polioviruses should be made in countries where oral poliomyelitis vaccine was used, including China.

Mr ASLAM (Pakistan) congratulated WHO on its successes in eradicating poliomyelitis. Pakistan was one of the seven countries where poliovirus transmission still occurred, but it was expected to halt transmission by the end of 2003. Transmission was confined to three areas of the country. In 1994 there had been 1803 cases, declining to 91 by 2002; in 2003 there had been only 22 cases so far. Four rounds of both national and subnational immunization days would be conducted in 2003 and 2004. Every effort was being made to ensure that no eligible child was missed. Pakistan met the global standards for surveillance, and was operating an efficient and sensitive acute flaccid paralysis surveillance system. Its poliomyelitis laboratory had been accredited by WHO, and was also serving as the WHO regional referral laboratory for Afghanistan.

His Government had faced many challenges, including inaccessibility of target populations, lack of education, malnourishment and poor health conditions among children. However, it remained

committed to poliomyelitis eradication. He was grateful for support from WHO, UNICEF, the Department for International Development of the United Kingdom of Great Britain and Northern Ireland, Rotary International, the International Federation of Red Cross and Red Crescent Societies, Centers for Disease Control and Prevention, Canadian International Development Agency, the Government of Japan and other bodies. Pakistan would leave no stone unturned to fulfil its global commitment to eradicating poliomyelitis by 2005.

Ms BUIJS (Netherlands) welcomed the significant progress made in eradication and noted the concern of WHO to secure the funding required to continue. She asked what the order of priorities would be if funds did not become available, and whether WHO had envisaged an emergency scenario. In light of the issues mentioned by the delegates of Poland and China, she suggested that WHO should develop and share with Member States a strategic vision of how to proceed once poliomyelitis had been eradicated.

Mr YOSHIDA (Japan) commended WHO's leadership in eradicating poliomyelitis. His country keenly supported the Global Polio Eradication Initiative, and between 1993 and 2001 had contributed US$ 230 million to the Initiative, mainly through the Japan International Cooperation Agency. Japanese experts had been sent to the South-East Asia Region and technical support had been provided for diagnostic capacity building in Ethiopia. Excellent results were being achieved: for example, although there had been 1601 new cases in the South-East Asia Region in 2002, all of them in India, the country with the highest prevalence, there had only been 70 new cases from January to April 2003. Several issues had still to be tackled, including the containment of wild-type poliovirus in laboratories and vaccination strategies after eradication. WHO should take the initiative in addressing those issues.

Global eradication should be achieved as soon as possible. WHO should prioritize all eradication programmes and mobilize resources on that basis, even beyond regions if necessary. It should not implement another infectious disease eradication programme until poliomyelitis had been eradicated worldwide. To complete the eradication initiative in India, Nigeria and Pakistan, WHO should support their governments through resolutions in their Regional Committees. It should also facilitate technical cooperation from other regions and countries where the disease had already been eradicated.

Dr BAL (Turkey) said that in 1989 his country had adopted the goal of poliomyelitis eradication and launched an eradication programme. It had made considerable progress since then, and had set up a nationwide acute flaccid paralysis surveillance system to detect cases of poliomyelitis due to wild-type poliovirus. Turkey, as part of the European Region, had been certified poliomyelitis free in June 2002. It had prepared plans for containment procedures and had completed staff training for that purpose. Turkey was committed to continued poliomyelitis-free status and to collaboration with WHO.

Dr AHMED (Ghana) said that his country had achieved certification standard, and was emphasizing surveillance of acute flaccid paralysis and education for health workers and communities about the need to report suspected cases. The Noguchi Memorial Institute for Medical Research offered laboratory support, and was one of the WHO subregional laboratories. Ghana was still intensifying its routine immunization procedures, and was adopting various outreach activities. There was close collaboration with local and international partners, including WHO, Rotary International, UNICEF and the Japan International Cooperation Agency. The Global Alliance for Vaccines and Immunization had helped provide a regular supply of vaccines. With the final stages of eradication being reached, activities were being kept up in difficult-to-reach areas. Cross-border immunization activities were carried out periodically with neighbouring countries. His country aimed to be certified free of poliomyelitis by 2005.

Dr WANCHAI SATTAYAWUTHIPONG (Thailand) expressed appreciation of WHO's strong technical and financial support, despite the budgetary shortfall, and of its successful collaboration with

other organizations, such as the Global Alliance for Vaccines and Immunization and the Rockefeller Foundation.

The last case of poliomyelitis due to wild-type poliovirus in Thailand had been identified six years previously, in the presence of standardized surveillance and high immunization coverage. Efforts were still being made to improve poliomyelitis eradication activities and maintain the country's poliomyelitis-free status. He endorsed WHO's revision of strategies to reduce the risks to global eradication arising from the funding shortfall. International public health alliances and donors should be called upon for urgent assistance in meeting the shortfall, so that the last stage of the global eradication campaign could proceed.

Dr MOETI (Botswana) noted with satisfaction that several countries in the African Region, including his own, had achieved the certification standard for surveillance of acute flaccid paralysis in 2002. Poliomyelitis eradication structures were fully operational in Botswana, and surveillance activities were accorded the highest priority. No cases of poliomyelitis due to wild-type poliovirus had been isolated since 1991. He thanked WHO and its partners for supporting the efforts of Botswana and other countries in the region in working towards eradication. However, it was important to note that the African Region was particularly challenged by efforts to control HIV/AIDS, which placed a great strain on resources. He called upon WHO to pay special attention to supporting the efforts of countries in that Region towards controlling poliomyelitis and other vaccine-preventable diseases, which in turn could help to strengthen immunization infrastructure and systems, and to maintain standards in vaccine-preventable disease control.

Dr FRASER (United Kingdom of Great Britain and Northern Ireland) commended the efforts of WHO, individual countries and organizations towards eradicating poliomyelitis. However, owing to a shortfall in funding during 2003, eradication activities had been scaled back. The United Kingdom had contributed substantial resources to the campaign, but unless an additional US$ 33 million was provided by September 2003, further cuts would be necessary. That would markedly aggravate the risks to eradication programmes at a time when eradication was virtually complete. He shared the concerns previously expressed that a follow-through strategy should be put in place, and urged all Member States to strengthen their commitment to eradication as a matter of urgency. Failure to achieve such a tangible target could jeopardize future international health campaigns.

Mr KINGDON (Australia) welcomed the informative report and the proposed strategies for achieving total eradication of poliomyelitis by 2005. Although the Western Pacific Region had been certified free of poliomyelitis, he accepted the continuing need for vigilance, surveillance and the maintenance of high immunization levels. Most importantly, the report identified the global funding gap of US$ 270 million to the end of 2005 as the greatest threat to the goal of eradication. His country continued to provide financial assistance through the International Health Programme of the Australian Agency for International Development; about Aus$ 2 million had been given to WHO for work on vaccines and biologicals in 2000-2001. His Government had pledged to match Australian corporate private sector contributions to the Rotary International's Polio Eradication Campaign, dollar for dollar, up to Aus$ 10 million over the period 2001-2005.

Dr BELAY (Ethiopia) said that, two years previously, poliomyelitis had been endemic in her country. Thanks to unreserved support from WHO, the United States Agency for International Development, Rotary International, Japan, UNICEF and others, currently no cases were being reported. In spite of active surveillance, it was uncertain whether immunization coverage was complete. Ethiopia had the third largest population in Africa and its large area and difficult terrain made it difficult to reach isolated communities by ordinary transport. The complete coverage of all children necessary to ensure full eradication would require the provision of additional means of transport.

Ethiopia, also suffering from drought and HIV/AIDS, faced difficulties in allocating resources to poliomyelitis eradication. Additional funds and volunteers were being sought, with the assistance of the National Interagency Coordination Committee and the Technical Assistance Group. Efforts were being made to raise the coverage of the Expanded Programme on Immunization, as one of the prerequisite strategies for eradicating poliomyelitis, but in that area too there were challenges to face. In 2003 "mop-up" activities at subnational level had been planned for April and May, but because of funding shortages they had had to be postponed to October and November. It was to be hoped that extra funds would be forthcoming from WHO and others to enable her country to achieve its goal.

Dr AHSAN (Bangladesh) said that, although her country had been free of poliomyelitis for two-and-a-half years, it was still at risk, because the disease was endemic in neighbouring countries. Two national immunization days had taken place in 2003. The national action plan to completely eradicate the virus was underpinned by a strong political commitment. She thanked WHO and its partners for their ongoing support.

Dr SADRIZADEH (Islamic Republic of Iran) said that progress in eradicating poliomyelitis worldwide depended on overcoming the social, economic and political impediments in some countries, and reaching people who had not been vaccinated. There had been no indigenous transmission of poliovirus in his country since 1997, and no imported case had been reported since 2000. Routine coverage with oral poliomyelitis vaccine was almost 100%, and mopping-up operations were being conducted among population groups at risk. Supplementary immunization was also being carried out in areas bordering endemic countries, simultaneously with national immunization days in those countries. An award system for the detection and reporting of acute flaccid paralysis had been initiated, and surveillance formed part of doctors' further training. For his country to remain free from the disease, eradication programmes in neighbouring endemic countries would have to be strengthened, and cross-border activities promoted.

Dr TARANTOLA (Vaccines and Biologicals) expressed appreciation to those Member States that had given an account of their work. In particular, he commended the determination of Egypt, India, Nigeria and Pakistan to eradicate poliomyelitis. He welcomed the readiness of all Member States to collaborate and engage in cross-border activities, such as the synchronization of national immunization days, the exchange of information and the sharing of resources. Despite such a magnificent display of international solidarity, however, it had proved difficult to provide developing countries where poliomyelitis was still endemic with the resources they needed.

The partners, UNICEF, the Centers for Disease Control and Prevention in the United States of America, and Rotary International, had likewise worked closely with WHO and Member States in a campaign that could be summed up in the word "voluntarism", whereby in 2002 10 million volunteers had immunized 500 million children against poliomyelitis, thus paving the way to the achievement of the Millennium Development Goals.

The immediate concern of countries where poliomyelitis was endemic was the funding gap, which had to be closed in 2003, since it was the single greatest obstacle to eradication. To that end, WHO and its partners had substantially revised strategic directions and funding priorities, so as to focus more on endemic areas while improving global surveillance and establishing emergency response capacity, in order to be able to react promptly to the emergence or re-emergence of the poliovirus in non-endemic countries. Cutbacks in preventive campaigns entailed a collective risk. A minimum level of financing therefore had to be maintained, and an amount of US$ 35 million in 2003 and a total of US$ 210 million for the period 2003 to 2005 still had to be found.

The two key issues arising in connection with surveillance to ensure that the disease was not being transmitted to areas that were already free of it were, first, the time that had elapsed since the last reported case, and secondly, the quality of laboratories. A country could not be deemed to be free of poliovirus transmission until one year had passed since the last documented case of poliomyelitis. An unprecedented level of surveillance quality had been attained in 2002, because the network of

145 WHO-accredited laboratories had become accessible to every country in the world. Nevertheless, care had to be taken to ensure that no undue risk was run, and response capacity had to be improved still further. It was vital to have the means to respond promptly to the emergence of poliomyelitis in non-endemic areas, and a fund of US$ 15 million per annum had therefore been set up by WHO and UNICEF. As for laboratory containment, it had been demonstrated in 2002 that wild poliovirus stocks could be identified and inventorized. Some 125 countries had conducted a survey of laboratories and 79 had submitted full inventories. The challenge was to implement fully the global containment plan and to have an effective set of activities in 2004 and 2005.

The use of oral poliomyelitis vaccine raised the risk of the re-emergence of mutant strains of virus, and hence it was necessary to consider vaccination policies in both the short and the long term. Paradoxically, more vaccinations lowered the risk of circulating vaccine-derived polioviruses. High immunization coverage was crucial, and therefore routine vaccination had to be stepped up.

In 2002 and 2003, WHO had established a steering committee to guide, monitor and evaluate research on halting poliomyelitis immunization, and had commissioned 20 new studies to evaluate the risks and the burden of vaccine-derived polioviruses. Over 5000 viruses had been screened to assess the risk and a framework for countries using oral poliomyelitis vaccine had been set up. The latter had shown that vaccine-derived polioviruses posed a very small risk. Ever since the eradication campaign had begun, only four circulating vaccine-derived polioviruses had been identified around the world. That finding had confirmed the advisability of halting poliomyelitis vaccination once the disease had disappeared.

WHO was starting to draw up a plan for the period 2004-2008 through an active consultative process focusing on complete eradication and post-eradication certification activities. Conclusions would have to be drawn from poliomyelitis eradication efforts in order to build stronger health systems, and to ensure that the benefits of poliomyelitis eradication could be passed on to other activities and programmes. Countries' capacities for surveillance and the prompt investigation of suspected outbreaks had to be maintained. Scenarios for funding were going to be worked out in order to ascertain what resources would be required for that purpose. The lessons learned from poliomyelitis eradication would be applied to collaboration between the public and private sector in other health initiatives aimed at meeting the Millennium Development Goals.

Mr AUSTVIK (Rotary International), speaking at the invitation of the CHAIRMAN, said that his organization was proud to have been a partner in the Global Polio Eradication Initiative since 1985. Thanks to volunteer efforts, advocacy and financial contributions, it had helped to plan and implement activities in poliomyelitis-endemic countries and to mobilize additional resources in areas free of the disease. Moreover, it had repeatedly impressed the importance of that initiative upon the heads of State and government of both poliomyelitis-endemic and poliomyelitis-free countries. It had contributed over US$ 500 million of its own resources to eradication. That money had bought vaccine for more than 2000 million children, had helped to transport the 20 million volunteers who had immunized those children and had helped to pay for the global surveillance and laboratory network underpinning the whole programme. As 209 countries were already free from the disease, there was no doubt that it could eventually be eradicated once and for all, but the single greatest threat to achieving that goal was lack of financing. The expected announcement at a meeting, to be held on 3 June, of 16 000 Rotarians in Australia that an extra US$ 80 million had been raised for that purpose would therefore be good news. He called on governments that had yet to play a role in the programme to help to close the funding gap for poliomyelitis eradication, and appealed to corporate foundations and nongovernmental organizations all over the world to redouble their efforts and provide support so as to ensure that by 2005 the world was free of the disease.

Dr MORINIÈRE (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, commended the progress towards the eradication of poliomyelitis. Participation in that campaign had enabled his organization, which sought to improve its response in that field, to serve as a partner of national health authorities. In that connection, it would

be helpful if WHO and Member States were to support voluntary contributions in order to respond to priority community needs. That would probably be a long-term process, which could ultimately include routine immunization and other health services, thereby leading to the greater involvement of nongovernmental organizations and civil society, as was already happening as a result of the participation of the International Federation and national societies in the Measles Partnership. Strong country-based interagency coordination committees might be a good way of bringing together ministries of health, WHO, UNICEF, national societies and other partners in the planning and implementation of supplementary immunization activities.

Concerns about the funding shortfall had led his organization to launch its global appeal for poliomyelitis eradication, which had already attracted resources from Red Cross societies in Canada, Norway, Sweden and the United States of America. The aim was to use the money collected through that appeal to stamp out the disease in six countries.

His organization did its best to ensure that its plans were coordinated with those of national governments and with the recommendations of the Technical Consultative Group. Eradication activities had provided a much appreciated opportunity for national societies to help to improve the health and quality of life of their communities, and he therefore looked forward to further collaboration with WHO.

**The Committee took note of the report.**

**Joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission:** Item 14.19 of the Agenda (Document A56/34[1])

The CHAIRMAN invited the Committee to consider a version of the draft resolution contained in paragraph 29 of document A56/34, revised and proposed by the delegations of Canada, Denmark, Japan, Norway and South Africa, which read:

> The Fifty-sixth World Health Assembly,
>
> Recalling resolution WHA40.20 on the Codex Alimentarius Commission and resolution WHA53.15 on food safety;
>
> Having considered the report on the joint FAO/WHO evaluation of the Codex Alimentarius Commission and other FAO and WHO work on food standards;[2]
>
> Acknowledging with appreciation the statement of the Codex Alimentarius Commission on the outcome of the joint FAO/WHO evaluation annexed to the present resolution;
>
> Welcoming the recommendation to give higher priority to setting science-based standards for food safety, nutrition-related issues and health;
>
> Noting with satisfaction the excellent collaboration between WHO and FAO in the area of food safety and nutrition;
>
> Aware that the rise in the global distribution of food is linked to an increased need for internationally agreed assessments and guidelines related to food safety and nutrition;
>
> Recognizing that one of the prerequisites for economic development is a safe food production system for both domestic and export markets based on regulatory frameworks protecting consumers' health;
>
> Emphasizing the lead responsibility of WHO, in collaboration with FAO, in providing sound scientific assessments of hazards in food and nutrition as a basis for managing risk at national and international levels;
>
> Stressing the urgent need to reinforce the participation of the health sector in standard-setting activities related to food in order to promote and protect consumers' health,

[1] See document WHA56/2003/REC/1, Annex 4.

[2] Document A56/34.

1. ENDORSES WHO's increased direct involvement in the Codex Alimentarius Commission and an enhanced capacity within WHO for risk assessment;

2. URGES Member States:
(1) to participate actively in international standard-setting in the framework of the Codex Alimentarius Commission, especially in the area of food safety and nutrition;
(2) to make full use of Codex standards for the protection of human health throughout the food chain, including for the promotion of optimal nutrition and healthy diets;
(3) to stimulate collaboration between all sectors involved at national level in setting standards related to food safety and nutrition, with particular focus on the health sector and fully involving all stakeholders;
(4) to facilitate the participation of national experts in international standard-setting activities;

3. INVITES the regional committees to review regional policies and strategies for strengthening capacity in the areas of standard-setting for food safety and of nutrition information, in collaboration with FAO;

4. CALLS ON Member States and other donors to increase funding for WHO's activities related to the setting of standards for food, with special attention to least developed countries;

5. REQUESTS the Director-General:
(1) to support the development and implementation of an action plan to address the recommendations in the Codex Evaluation Report, and, in collaboration with FAO, to consider means to improve the efficiency of the Codex standard-setting process by meeting the unique governance needs of Codex within the overall structure of WHO and FAO;
(2) to strengthen WHO's role:
(a) in the management of the Codex Alimentarius Commission and to give a higher profile to the Commission and related work throughout the Organization;
(b) in linking the work of the Codex Alimentarius Commission to other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in World Health Assembly resolutions and to the International Health Regulations;
(c) in risk assessment, including through the system of joint FAO/WHO expert bodies and consultations and through a coordinating function in WHO;
(d) in supporting the capacity of food-safety systems to protect human health throughout the food chain;
(e) in supporting analysis of links between data on foodborne disease and foodborne contamination;
(3) to provide support to Member States in strengthening capacity in the above areas;
(4) to stimulate the establishment of networks between national and regional food-safety regulatory authorities;
(5) to continue to foster collaboration with FAO, especially within the framework of the Joint FAO/WHO Food Standards Programme.

Mr KAMAL (Canada), introducing the revised draft resolution, said that his Government was pleased with the Director-General's support for the work of the Codex Alimentarius Commission, and welcomed the opportunity for the Health Assembly to consider a draft resolution outlining the context for WHO's activities in response to the evaluation and requesting that it become more involved in the Commission's work. Iceland, Norway and Sweden had joined in sponsoring the draft resolution.

Mr YOSHIDA (Japan) said that food safety had become an important international issue, and the role of the Codex Alimentarius Commission had become more significant as international trade in food had expanded and diversified. An evaluation of the Commission's activities 40 years after its founding was timely, and the recommendations made in the report were most useful.

Mrs HERNANDEZ (Venezuela) announced that her country's Ministry of Health and Social Development had revived the National Codex Alimentarius Committee as part of the FAO/WHO regional project to strengthen national Codex Alimentarius committees in Latin America. She commended the report, and endorsed both the findings of the evaluation team and the comments made by the Director-General. Venezuela supported the draft resolution, whose recommendations should facilitate attainment of the National Committee's aims.

Mr KINGDON (Australia) strongly supported the thrust of the evaluation and the recommendations made by the evaluation team. While Australia accepted the four main areas for improvement identified in paragraph 5 of the report, its priorities were more autonomy for the Codex Alimentarius Commission, the prioritization of food hazards, and the provision of timely and robust scientific advice.

He proposed that in paragraph 2(2) of the draft resolution "including for the promotion of optimal nutrition and healthy diets" should be replaced by "including assistance with making healthy choices regarding nutrition and diet", thus emphasizing individual responsibility and avoiding any inference that Codex labelling advised on optimal nutrition and diet. Paragraph 4 should be replaced by a new paragraph requesting the Director-General to reallocate resources for WHO's activities related to the setting of standards for food, with special attention to least developed countries, thus encouraging WHO to prioritize the resources available to it. The first phrase of paragraph 5(2)(b) should be replaced by "in complementing the work of the Codex Alimentarius Commission with other relevant WHO activities...", thus emphasizing the importance of collaboration between the Commission and WHO without inferring any dependence of the former on the latter.

Ms BLAKER (Norway), speaking on behalf of the Nordic countries, welcomed the evaluation of the work of the Codex Alimentarius Commission, FAO and WHO on food standards. More needed to be done to combat food-borne and diet-related diseases, including obesity, and to meet the challenges facing countries with changing dietary patterns. The development of standards impacting on consumer health and safety was the Commission's chief priority, and WHO should give precedence to that work.

She welcomed WHO's increased commitment to securing food safety, as reflected in the budget for the coming biennium. Greater participation by developing countries in the future work of the Commission was important, and she welcomed the FAO/WHO trust fund, which should assist the least-developed and other low-income countries. Capacity building in such countries should be supported, to build or enhance national structures and expertise required for compliance with international standards. Better cooperation between FAO and WHO should be based on a clear division of responsibilities and on proactive collaboration.

The Nordic countries supported the revised draft resolution, as it reflected a commitment to work for food safety and provided timely support to the development of the global strategy on diet, physical activity and health which was to be considered at the Fifty-seventh World Health Assembly.

Mrs MONTALVO (Bolivia) said that her country, supported by Peru, proposed that in paragraph 2(3) the words "based on the Codex" should be added after "standards". In paragraph 5(1), the words "including a more coordinated capacity-building effort, notably in the context of the joint FAO/WHO programme" should be inserted after "in collaboration with FAO".

Dr LEVENTHAL (Israel) commended the active role of WHO in the development of the Codex Alimentarius, and supported evaluation of the work. He endorsed the draft resolution, which rightly

emphasized the potential of the Codex in the promotion of food safety, good nutrition and healthy diet. Diet and nutrition were important components in the global strategy for health promotion and the prevention of noncommunicable diseases, which the Fifty-fifth World Health Assembly had requested the Director-General to launch, and he enquired whether there had been any progress towards the formulation of a resolution on health promotion.

Dr SOMBIE (Burkina Faso) commended the report for identifying weaknesses in the system for monitoring food safety; developing countries faced problems in implementing food standards. His country had recently established an efficient national public health laboratory, which accepted orders to perform food monitoring operations, for example from airlines, but it had been unable to publish the results of systematic monitoring performed on bread, oils and other commodities. Political will, pressure from consumer associations, and national capacity building, as recommended in the report, would be decisive factors in the achieving implementation of food standards in poor countries. He supported the draft resolution.

Mr TOURÉ (Mali) said that in recent years his Government had come to consider food safety and security a vital priority. A national institutional framework had been established, and a national food safety and security agency was to be set up that would be responsible for coordinating related risk assessment and risk management operations. Mali's Minister of Health had applied to WHO for membership of the Codex Alimentarius Commission but no reply had been received to date. He requested that his country's desire to be a member of the Commission and to contribute to its work be reflected in the summary record of the meeting.

He thanked WHO, FAO and all partners concerned for setting up a trust fund to assist developing countries to participate effectively in the work of the Commission, and expressed support for the draft resolution.

Mr AL-FAKHIRI (Saudi Arabia) said that the criteria established by the Commission were important for improved monitoring of food safety and consumer protection, and vital for international trade. Focus on consumer health and enhanced monitoring capacities in developing countries was necessary in order to facilitate access by those countries to world markets.

He supported the practical measures called for in paragraph 15 of the report and the recommendations concerning new strategies to combat food-borne diseases, particularly those relating to food supplements and pesticides, based on scientific expertise. The Codex Alimentarius criteria should be discussed with developing countries, so that appropriate local criteria could be established.

Ms PORNPIT SILKAVUTE (Thailand), referring to the four main areas for improvement identified in paragraph 5 of document A56/34, said that the focus should be on making Codex standards more practical and a point of reference for WTO. She commended the emphasis in the evaluation report on strategy implementation, and thanked the Director-General for launching the FAO/WHO trust fund. Participation by developing and least developed countries in the Commission's work would ensure the dissemination of worldwide Codex standards. The criteria by which fund recipients were selected should be urgently revised, as few countries would be eligible under the current criteria.

She supported the amendments proposed by Australia, but proposed the addition of the words "and to ensure fair practice in the food trade" at the end of operative paragraph 5(1)(d); "particularly developing and least developed countries" after "Member States" in paragraph 5(3); and "by expeditiously reviewing the specific criteria for selection of recipients of the FAO/WHO trust fund" at the end of paragraph 5(3). Paragraph 4 was redundant and could be deleted.

**Dr Rokovada took the Chair.**

Mr HOHMAN (United States of America) said that he supported most of the recommendations for the strengthening of the Codex, and his country would work with the Commission and FAO to evaluate, adopt and implement them. He would encourage an increase in WHO involvement in and support of the Commission, in order to enable it to serve effectively as the premier international food safety standards organization, and would support an enhanced capacity within WHO for carrying out food- safety-related risk assessment.

Referring to the Australian proposal for the replacement of paragraph 4 of the draft resolution, he preferred the existing text to remain, with the addition of a formulation such as "through the trust fund". The paragraph could then go on to request the Director-General to reallocate resources for that purpose. In his view, support from the fund should be given to those developing countries best able to benefit from it. He could support the amendments proposed by Bolivia.

Ms VAN BOLHUIS (Netherlands) welcomed the revised draft resolution. She valued the Commission highly, for both the many standards it had delivered and its important role in stimulating the development of views on food safety issues at international level. Codex could also play a role complementary to that of WHO in the field of nutrition policy.

She commended WHO's commitment to the Codex process, which would help to meet the needs of that process for staffing and financial support as well as the needs of Member States for quick access to high-quality independent advice. However, she urged that the necessary management involvement of WHO should not lead to micromanagement. Close and strong collaboration between WHO and FAO would be important to achieve optimum added value by both organizations, while avoiding duplication.

She welcomed the creation of a trust fund as an important instrument for facilitating the participation of developing countries in Codex work.

Dr CICOGNA (Italy) added his support for the draft resolution, and endorsed the report's recommendations to strengthen the use of science-based standards in the Codex and to increase the speed and efficiency of its committees. He agreed with the Director-General's comment that risk assessment and capacity-building should remain joint activities of WHO and FAO, and that collaboration between them should continue to draw on mutual strengths and synergies.

Mr JHA (India) said that, although his delegation recognized that the work of the Commission helped to raise food safety standards and to facilitate international trade, the stringent standards being formulated in the Codex, which created difficulties for developing countries in exporting their products, had largely been determined by the requirements of the developed countries. There was no reference in the draft resolution to the needs of developing countries, and he therefore proposed that after the seventh preambular paragraph a further paragraph should be added, reading: "Conscious of the need of full participation by developing countries in setting globally relevant standards". He also proposed the addition of a new subparagraph 5(2)(f) which would read: "in collaboration with FAO in providing special assistance to developing countries for generating data for development of global Codex standards". The words "and particularly at country level" should be added at the end of paragraph 5(4).

Dr FRASER (United Kingdom of Great Britain and Northern Ireland) said that the findings of the joint evaluation had the full support of his delegation, but the draft resolution needed to reflect those findings more appropriately. He endorsed the amendments proposed by Australia to paragraphs 2(2) and 5(2)(b), and the general content of the amendments proposed by Bolivia and India. While he acknowledged the Codex Alimentarius Commission's general relevance to other areas of policy, such as the alleviation of poverty and the well-being of children and adolescents, the link between food safety and nutrition needed to be stronger in its activities. He supported the call made in paragraph 5(1) of the draft resolution for the development of an action plan to implement the report's recommendations.

Dr TAHA ARIF (Malaysia) pointed out that the report could have major implications not only for the diet and health of populations worldwide, but also for the economic, political and social development of countries that produced and traded in food commodities. He therefore called upon WHO, FAO and the Health Assembly to be sensitive to the political constraints on many developing countries and not to insist on implementation of all the recommendations in the report when formulating and shaping global strategies.

He offered to contribute Malaysia's expertise to the WHO/FAO expert consultations, particularly on the topic of fats and oils, and pledged its full support for all efforts to make the world a healthier and fairer place. He supported the draft resolution as amended by Thailand and India.

Mr YANG Qing (China) said that an overall review of food standards was of particular significance on the fortieth anniversary of the establishment of the Codex Alimentarius. He welcomed the report and endorsed the draft resolution in principle. He proposed that cooperation between FAO and WHO should be strengthened, and developing countries supported in building up their capacity to implement food standards. He also proposed that more nationals of developing countries should be recruited to the secretariat of the Codex Alimentarius Commission, so that they could obtain practical management experience which could be applied in their own countries.

Mr SOARES DAMICO (Brazil) strongly supported WHO's efforts to enhance the Codex Alimentarius, which was a key tool in setting science-based standards for food safety, nutrition and nutrition-related issues. He endorsed the comments by Bolivia, India, Thailand and Malaysia that the developmental dimension of the Codex should be given greater emphasis in the draft resolution.

Mr BILLY (Codex Alimentarius Commission), speaking at the invitation of the CHAIRMAN, said that the fortieth anniversary of the Commission was an appropriate time to carry out an evaluation of its progress. Countries valued the Codex, and used its standards to ensure that their food products were safe and wholesome. He looked to FAO and WHO for help in implementing some of the recommendations in the report, such as the need to increase the scientific support provided to the Commission for improved public health data, exposure assessments and other expert advice. There was also a need for an increase in the support provided by WHO to the Codex Alimentarius secretariat to make it more responsive to the demands of the countries that participated in it. He commended the establishment of the new trust fund to support participation of national experts in the Codex so that it would better serve national needs.

Dr NABARRO (Executive Director) thanked delegates for their comments. Member States evidently valued the work of the Codex Alimentarius Commission and the findings of the evaluation, and he had noted the emphasis given to science, particularly public health science, as the underlying principle for that work. Many delegates had stressed the need for a developmental dimension to the Commission's work, and had recognized the potentially positive role of the trust fund. The discussion had made WHO aware of the importance of responding promptly to developmental and health issues thereby assisting capacity building in countries and enabling them to participate more fully in the Commission's work.

In response to Australia's concern about whether adequate attention was being paid to the Commission in financial allocations. he pointed out that the greatest increase in the proposed programme budget for the 2004-2005 biennium had been in the area of food safety. However, he was aware that more resources would be needed, and it was to be hoped that Member States would follow up the suggestion made by the United States delegate for internal reallocation and increased extrabudgetary resources. In response to the question by Israel, he said that a report would be made to the Health Assembly on the progress of health promotion work, and specifically on the global strategy on diet, physical activity and health, in 2004. He confirmed that Mali had been made a member of the Commission, and that a formal letter to that effect had been sent via FAO to that country's Ministry of Health. In response to the concerns of the United States of America regarding criteria for the use of the

trust fund, he confirmed that a set of proposals for criteria had been elaborated, and would be submitted to the Codex Alimentarius Commission's meeting at the end of June 2003. Lastly, he had noted the Chinese delegate's comments on the staffing of the secretariat of the Commission, and would take up the issue bilaterally.

The next challenge would be to mobilize resources to ensure a proper contribution from WHO and its scientific bodies to the Codex process, at the same time recognizing the importance of an autonomous Commission.

Mr VILLAVERDE (International Organization of Consumers Unions), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, said that the work of the Commission had become increasingly important since the establishment of WTO, as many governments were coming under pressure to limit their legislation on consumer health protection in the interests of harmonization and the facilitation of trade. Food safety and nutrition were being given low priority compared to trade facilitation in the formulation and implementation of Codex standards. He regretted that the report's brief section on communication saw that as a one-way process for explaining decisions to the public, thus undermining the consumer's right to accurate information and full participation. In order to protect health, there had to be improved participation of experts from developing countries in the risk assessment process, input from consumers and public interest nongovernmental organizations with no commercial links, and public meetings with participation by observers from such bodies to ensure transparency and prevent undue influence from commercial interests.

He welcomed the establishment of the new trust fund to promote participation by economically disadvantaged countries and WHO's assurances that contributions would not be sought from food and food-related industries. He called for stronger emphasis on the promotion and protection of health in the goals of the Codex Alimentarius, whose decisions had to be unbiased and protected from commercial influences. WHO had a crucial role in defending the protection of health and in ensuring that relevant Health Assembly resolutions were included in Codex standards and guidelines.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that his organization adhered to the highest food safety and nutrition standards, promoted sound nutrition for human health worldwide, and actively supported the Commission. Priority needed to be given to speeding up of the work of Codex's committees in providing scientific advice; the setting of science-based standards related to food safety, nutrition-related issues and health; increasing efficiency by ensuring that the work of all the committees was time-limited; focusing on emerging technologies; and improving coordination and distribution of work between WHO and FAO. His organization also strongly supported the recommendations that the independence and transparency of the Commission within FAO and WHO be reinforced; that chairmen be selected more rigorously; that checks on credentials be tightened to ensure that governments sent appropriate representatives to committee meetings; and to ensure that nongovernmental delegates had the relevant qualifications and did not use Codex forums to block committee work or promote particular interests. He applauded WHO's efforts to improve the effectiveness of the Codex Alimentarius Commission.

The CHAIRMAN suggested that a new text of the draft resolution incorporating the amendments proposed should be prepared for consideration at the next meeting.

**It was so agreed.**

(For continuation of discussion and adoption of resolution, see summary record of the seventh meeting, section 2.)

**The meeting rose at 17:20.**

## SEVENTH MEETING

**Tuesday, 27 May 2003, at 09:25**

**Chairman:** Mr L. ROKOVADA (Fiji)

### 1. FOURTH REPORT OF COMMITTEE B (Document A56/64)

Mrs VELÁSQUEZ DE VISBAL (Venezuela), Rapporteur, read out the draft fourth report of Committee B.

**The report was adopted.**[1]

### 2. TECHNICAL AND HEALTH MATTERS: Item 14 of the Agenda (continued)

**Joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission:** Item 14.19 of the Agenda (Document A56/34[2]) (continued from the sixth meeting)

The CHAIRMAN drew attention to the text of the draft resolution, which incorporated amendments proposed by Australia, Bolivia, India and Thailand at the previous meeting of the Committee:

> The Fifty-sixth World Health Assembly,
>
> Recalling resolution WHA40.20 on the Codex Alimentarius Commission and resolution WHA53.15 on food safety;
>
> Having considered the report on the joint FAO/WHO evaluation of the Codex Alimentarius Commission and other FAO and WHO work on food standards;[3]
>
> Acknowledging with appreciation the statement of the Codex Alimentarius Commission on the outcome of the joint FAO/WHO evaluation annexed to the present resolution;
>
> Welcoming the recommendation to give higher priority to setting science-based standards for food safety, nutrition-related issues and health;
>
> Noting with satisfaction the excellent collaboration between WHO and FAO in the area of food safety and nutrition;
>
> Aware that the rise in the global distribution of food is linked to an increased need for internationally agreed assessments and guidelines related to food safety and nutrition;
>
> Recognizing that one of the prerequisites for economic development is a safe food production system for both domestic and export markets based on regulatory frameworks protecting consumers' health;
>
> Conscious of the need for full participation of developing countries in setting globally relevant standards;

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[1] See page 344.

[2] See document WHA56/2003/REC/1, Annex 4.

[3] Document A56/34.

Emphasizing the lead responsibility of WHO, in collaboration with FAO, in providing sound scientific assessments of hazards in food and nutrition as a basis for managing risk at national and international levels;

Stressing the urgent need to reinforce the participation of the health sector in standard-setting activities related to food in order to promote and protect consumers' health,

1. ENDORSES WHO's increased direct involvement in the Codex Alimentarius Commission and an enhanced capacity within WHO for risk assessment;

2. URGES Member States:

(1) to participate actively in international standard-setting in the framework of the Codex Alimentarius Commission, especially in the area of food safety and nutrition;

(2) to make full use of Codex standards for the protection of human health throughout the food chain, including assistance with making health choices regarding nutrition and diet;

(3) to stimulate collaboration between all sectors involved at national level in setting standards based on the Codex Alimentarius related to food safety and nutrition, with particular focus on the health sector and fully involving all stakeholders;

(4) to facilitate the participation of national experts in international standard-setting activities;

3. INVITES the regional committees to review regional policies and strategies for strengthening capacity in the areas of standard-setting for food safety and of nutrition information, in collaboration with FAO;

4. CALLS ON Member States and other donors to increase funding for WHO's activities related to the setting of standards for food, with special attention to least developed countries;

5. REQUESTS the Director-General:

(1) to support the development and implementation of an action plan to address the recommendations in the Codex Evaluation Report, and, in collaboration with FAO, to consider means to improve the efficiency of the Codex standard-setting process by meeting the unique governance needs of Codex within the overall structure of WHO and FAO;

(2) to strengthen WHO's role:

(a) in the management of the Codex Alimentarius Commission and to give a higher profile to the Commission and related work throughout the Organization;

(b) in complementing the work of the Codex Alimentarius Commission with other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in World Health Assembly resolutions and to the International Health Regulations;

(c) in risk assessment, including through the system of joint FAO/WHO expert bodies and consultations and through a coordinating function in WHO;

(d) in supporting the capacity of food-safety systems to protect human health throughout the food chain and to ensure fair practices in the food trade;

(e) in supporting analysis of links between data on foodborne disease and foodborne contamination;

(f) in collaboration with FAO, in providing special support to developing countries for generating data for development of global Codex Alimentarius standards;

(3) to provide support to Member States, particularly developing and least developed countries, in strengthening capacity in the above areas by expeditiously reviewing the specific criteria for selection of recipients for use of the FAO/WHO Trust Fund;
(4) to stimulate the establishment of networks between national and regional food-safety regulatory authorities and particularly at country level;
(5) to continue to foster collaboration with FAO, including a more coordinated approach between WHO and FAO to capacity-building, especially within the framework of the Joint FAO/WHO Food Standards Programme;
(6) to reallocate resources for WHO's activities related to the setting of food standards with special attention to least developed countries.

Mr KINGDON (Australia) said that the amendment to paragraph 2(2) proposed by his country should read "healthy choices" rather than "health choices" in order to retain the form of words used in the Ottawa Charter for Health Promotion.

Mr SOARES DAMICO (Brazil), referring to paragraph 5(3), said that his delegation agreed with the emphasis on developing and least developed countries but had misgivings about the final provision of the subparagraph, which it would be preferable to end after the words "in the above areas".

Dr FRASER (United Kingdom of Great Britain and Northern Island) reiterated his view that paragraph 5(2)(b) needed to be amplified by a reference to past work, proposing the insertion of the words "such as global strategies" between "WHO activities" and "in the areas of food safety and nutrition".

Mr HOHMAN (United States of America) said that the amendment proposed by the United Kingdom lacked the specificity sought in resolutions of that kind. If intended as a reference to ongoing discussions concerning strategy on diet and nutrition that had yet to come before any WHO governing body, it was premature and therefore unacceptable. Nor could his country agree to the words "and to ensure fair practices in the food trade" in paragraph 5(2)(d).

Mr KINGDON (Australia) considered that the text would be acceptable with the change he had suggested. He could accept the United States position on two proposed amendments and the proposed amendment to paragraph 5(3).

Dr FRASER (United Kingdom of Great Britain and Northern Ireland), in reply to the CHAIRMAN, signified his acceptance of the United States and Australian positions.

Dr WANCHAI SATTAYAWUTHIPONG (Thailand) recalled and reiterated the proposals made at the previous meeting to delete paragraph 4; in the new draft, paragraph 5(6) requested the Director-General to reallocate resources with special attention to least developed countries.

Mr KINGDON (Australia) said that Australia had indeed asked for the deletion of paragraph 4 but had subsequently been persuaded that it had a specific meaning in regard to the trust fund, and so had agreed to its retention. He was glad that paragraph 5(6) had incorporated Australia's concern regarding the re-prioritizing of WHO resources.

Dr WANCHAI SATTAYAWUTHIPONG (Thailand) observed that Member States already contributed to the fund and that a subparagraph (6) had been added to paragraph 5 requesting the Director-General to reallocate resources. He therefore still felt it preferable to delete paragraph 4.

Mrs GONZÁLEZ NAVARRO (Cuba) proposed that the words "based on the Codex Alimentarius" be added after "standards" in paragraph 5(6), just as Bolivia and other countries had suggested inclusion of that phrase in paragraph 2(3).

The CHAIRMAN asked whether the Australian delegation could accept the deletion of paragraph 4.

Mr KINGDON (Australia) said that it would cause Australia no difficulty but his impression was that the other Member States wanted to retain the paragraph, so that his own judgement had to be left aside.

Mr HOHMAN (United States of America) said that the text as it stood was based on the establishment of a trust fund and on the idea that that fund, distinct from the WHO regular budget and other extrabudgetary resources, would be made up of contributions from Member States and other donors. He could see no compelling reason to delete paragraph 4 and he favoured its retention.

Dr WANCHAI SATTAYAWUTHIPONG (Thailand) proposed, as a compromise, deleting the words "Member States and other" in paragraph 4, which would then read: "Calls on donors to increase funding for WHO's activities related to the setting of standards for food, with special attention to least developed countries". In Thailand's view, many countries, especially developing countries and least developed countries, could ill afford to make such contributions.

The CHAIRMAN, seeing no objection to the proposals by Cuba and Thailand, took it that the Committee wished to approve the draft resolution as amended.

**The draft resolution, as amended, was approved.**[1]

**Implementing the recommendations of the *World report on violence and health*:** Item 14.15 of the Agenda (Resolution EB111.R7; Document A56/24)

Dr AL-MAZROU (representative of the Executive Board) said that the Board had considered the *World report on violence and health*, which contained recommendations that health should play a leading role in the prevention of violence and the mitigation of its consequences. Violence was a major health problem that affected many age groups and both genders, undermining the social and economic health of local communities and whole societies. Board members had noted, however, that its causes could be dealt with and that prevention was possible. The Board had agreed that the report raised global awareness about the risks of violence and the possibilities of preventing it and that its recommendations provided a framework to promote preventive action by Member States. WHO could play a leading role by providing technical guidance and practical knowledge that would assist in the elaboration of policies and programmes. Some members had commented on the report's strong emphasis on primary prevention which should be strengthened through science-based policies and intersectoral action. Finally, the Board had adopted a resolution containing a draft resolution for consideration by the Health Assembly.

Mr BERWAERTS (Belgium) congratulated WHO on the report and the considerable progress made in just a few years. Belgium strongly supported the resolution. The first *World report on violence and health* had been presented in Belgium in October 2002 in the presence of His Majesty Albert II. In January 2003, the King had focused his annual address to the Belgian authorities on that theme. Among other things, he had stated that the WHO report provided an excellent basis for action

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA56.23.

to eradicate violence both internationally and nationally. There was no simple answer to the problem but different approaches, especially prevention work among groups at risk, were needed. Belgium considered that WHO's approach made an enormous contribution to the fight against violence; treating violence as a public health problem should be regarded as one of WHO's major successes in recent years. Belgium was contributing actively to the programme through a group of experts and the publication of their national report. It had also increased its financial support. However, the budget devoted to the programme had not been increased and Belgium hoped that voluntary contributions would be forthcoming from various countries in support of WHO's role in that field.

Mr KAMAL (Canada) welcomed the report, its suggested approaches to preventing violence and mitigating its effects, and the recommendations made. In regard to document A56/24, he drew attention to the reference to "witnessing violence" in paragraph 2. Experts in Canada and elsewhere generally preferred to refer to "exposure" to violence – especially in the case of children's exposure to interparental violence – since witnessing implied "eyewitnessing" whereas many children heard or otherwise perceived evidence of interparental or peer violence without actually seeing it.

More generally, Canada envisaged a growing role for WHO in facilitating the sharing of experience and the collecting of data on the causes of interpersonal violence and abuse, especially against women and the elderly. At the recent international Child and Youth Health Congress (Vancouver, Canada, May 2003), the *World report* had been presented to the Canadian health authorities and its recommendations had been endorsed. Canada was therefore pleased to support the resolution and encouraged all Member States to share their experiences in regard to the prevention of violence.

Mr SOLANO ORTÍZ (Costa Rica), thanking WHO for the report, observed that violence was a constant factor in contemporary societies, with, each year, more than 1.6 million people dying a violent death. Consequently, violence had to be regarded as a public health priority. Costa Rica had adopted a series of measures to combat the scourge and had incorporated them in its national health policy. The problem had been analysed, and an inter-institutional process was under way, involving an integrated set of activities with full political backing. A national workshop was shortly to be held to devise a strategic plan to combat social violence and to reconcile positions with a view to the implementation of national policies and actions. His delegation fully supported the objectives and conclusions of the report.

Mr THOMSEN (Denmark) said that violence was undoubtedly a serious threat to health and had clear consequences both for public health in general and for individuals. While the health sector played an important role in that context, in many countries, including his own, the chief responsibility for preventing and combating crime lay with ministers of social affairs or justice. His delegation would therefore prefer the Health Assembly to be less specific in its resolution with regard to follow-up by Member States.

He suggested that the first line of paragraph 2 should read: "URGES Member States to promote the *World report on violence and health* ...". Paragraphs 3 and 4 should be deleted.

Mr RYAZANTSEV (Russian Federation), welcoming the report as representing the culmination of research into one of the most serious public health problems, observed that violence was not a new issue to WHO. The report under consideration was, however, the first comprehensive work and a direct practical contribution by the Organization to overcoming the problem of violence.

Various forms of violence and aggression particularly affected economies in transition, including his own. Apart from the direct health implications of injury and psychological trauma, in addition to the casualties of crime and terrorism, violence caused huge indirect harm to the health of society. Uncertainty about life and the welfare of one's family and children also heightened alarm and depression among the population, which led in a vicious circle to more aggression and self-aggression besides causing somatic disorders and reducing life expectancy.

The report examined in detail just how violence arose and provided reasoned recommendations for dealing with it. His delegation therefore hoped that detailed guidelines for implementing each of those recommendations would be issued. Welcoming WHO's readiness to take the lead in international cooperation to prevent and control violence, the Russian Federation gave the draft resolution its full support.

Mrs BALOSANG (Botswana) congratulated the Director-General on the first comprehensive report to assess violence as a global public health problem that required immediate multisectoral action at all levels. Like many countries, Botswana had not been spared violence and its horrific effects, which were aggravated by HIV/AIDS. The report would be instrumental in stimulating debate in her country, provoking a heightened response and guiding the implementation of recommendations at all levels. Botswana had set up a multisectoral committee to carry out a situation analysis and to formulate a national plan of action.

She had noted with concern the sobering statistics on women who had been physically or sexually abused. Gender-based violence continued to be the worst form of reported violence; hence Botswana's response had been to focus on the most vulnerable members of society, namely women and children, in its prevention and control strategies. Her country would welcome further support from WHO, encouraging Member States to learn from one another's successful experiences. The absence of gender-related statistics and of adequate documentation on domestic violence and sexual harassment impeded efforts to design specific intervention strategies. She therefore appealed to WHO to strengthen and support Member States' capacity for research in those areas and to maintain a relevant database management system. She expressed her delegation's support for the draft resolution.

Dr NANTA AUAMKUL (Thailand) said that violence had long gone unrecognized as a health problem even though it was a major cause of death, injury and psychological disorders the world over. Many cases of violence were still unreported, and violence based on culture or gender often went unnoticed. A deeper understanding of such phenomena was essential to mitigate the impact of such forms of violence, to which women and children were most vulnerable. In 2001 the Thai Government had devised a master plan to eradicate violence against women and children and had declared November as the month for an annual campaign against violence. The Ministry of Social Development and Human Security had overall responsibility for implementing the plan of action, comprising violence prevention and control, promotion of close family links, law enforcement, care for victims and welfare provision, research, the establishment of mechanisms for coordination and collaboration, monitoring and evaluation, and an information system. In the preceding 18 months, the Ministry of Public Health, in collaboration with other ministries and nongovernmental organizations, had launched a "one-stop crisis centre", additionally providing a 24-hour hotline in 20 hospitals. Such centres were soon to be set up throughout the country. Furthermore, a national round-table discussion on violence and health had recently been held with WHO's support, involving participants from related agencies, nongovernmental organizations and the media. The discussion had identified four areas for special attention: management information systems; networking; increasing public awareness; and community involvement. Gender equity was also crucial to eradicating violence and required global, national and local promotion. In that connection, Thailand continued to rely on technical and financial support from WHO and other related agencies.

Thailand fully supported the recommendations in the report and the draft resolution.

Mr DEBRUS (Germany) said that all forms of violence had to be controlled, including the more subtle forms, such as psychological violence in the form of insults, verbal abuse and vulgarity. A further major incidence of violence affected elderly people in need of long-term care, who were frequently unable to report on the maltreatment to which they had been subject. Hence there were many unreported cases of such violence. The obligation to adopt preventive measures was founded on not only health policy but also the human rights and civil liberties of each individual senior citizen. In Germany, several projects had been initiated in the field of prevention. The *World report* was soon to

be officially presented in his country by government departments in collaboration with the Regional Office for Europe. His delegation supported the draft resolution.

Mrs DARKAOUI (Morocco) welcomed the report and its recommendations. Subsequent to a royal message to parliament in 2000, Morocco had focused on combating violence against children and had set up a specialized committee to mobilize action against exploitation and maltreatment. Furthermore, 1999 had been adopted as the year for combating all forms of violence against children, involving a comprehensive strategy with legal, social and health aspects. From the legal perspective, her country had updated a law by which doctors were empowered to report acts of violence against children to the competent authorities. On the social front, a hotline service had been upgraded to protect violence-prone children, under the supervision of a national monitor for the rights of the child. A network for legal and psychological assistance had also been established under the Ministry for Human Rights. The Ministry of Health, for its part, played a role within that strategy by creating an integrated network for the counselling of victims, together with an information centre for data analysis and follow-up. Her country supported the draft resolution.

Mrs LOZANO (Mexico) said that Mexico was planning to hold a special event to introduce the report, with the participation of government agencies, including the health, education and justice departments, nongovernmental organizations, academics and members of the international community. The terms of reference had been drafted for a national report on violence and health, expected to be available by 2004. Programmes already existed in the domains of education and justice to prevent violence in the family, which tended to generate other types of violence. Since the creation of an appropriate national programme in 1999, results had included the establishment of an official Mexican standard on criteria for medical care in cases of family violence, providing data to gauge the extent of the phenomenon and assistance to other sectors in resolving such problems. Mexico had also set up health promotion activities to encourage healthy lifestyles in the school population of 4- to 15-year-olds. An administrative unit within the health secretariat was responsible for coordinating health actions on behalf of women, including those concerned with violence. However, despite progress in the public health domain, it was essential to encourage a greater response on the part of society itself, involving leadership at the highest levels. The aims were several: to reinforce the health infrastructure for prevention and rehabilitation services; to strengthen intersectoral coordination, to raise awareness through the media, and to strengthen national activities supporting information, guidance and training in regard to human rights, gender equity and social factors leading to violence; to promote strategies to resolve conflicts through dialogue and negotiation; to speed up the adoption of legislation to prevent family violence; and to provide the financial and human resources such actions demanded. Her delegation supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) welcomed the report as an important contribution to understanding the various forms of violence and their consequences for public health policy. The prevention of violence required a multisectoral approach, particularly as the combating of violence diverted health service resources to other areas. There was consequently a need for stronger links between public health and social services, educational and economic policy, together with programmes for alleviating poverty in order to deal with the many facets of violence. Emphasis should also be placed on domestic violence, as women were sociologically, culturally and economically vulnerable to violence. The different types of violence had been extensively analysed in the report. Nonetheless she stressed the importance of preventing the psychological, economic and pharmaceutical abuse of the elderly, particularly in institutions. She supported WHO's efforts to develop research and establish model prevention programmes adapted to the needs of individual Member States, based on a public health approach. Her delegation supported the draft resolution, subject to some minor amendments. In the first line of the penultimate preambular paragraph, she proposed adding a comma and the words "dignity and human rights" after "human security".

Furthermore, she considered that in paragraph 4 one year was too short a period, so that the first line should read: "ENCOURAGES Member States to prepare in due time a report on violence ...".

Dr FRASER (United Kingdom of Great Britain and Northern Ireland), supporting the draft resolution on violence and health, said that policy implementation should place sufficient emphasis on domestic violence. A key feature of many cultures was alcohol abuse and domestic violence was a complex social problem, leading to poverty, ill-health, social exclusion, loss of potential and loss of life. It was estimated that 5% of health years of life were lost worldwide by women owing to domestic violence.

Prevention was crucial to combating violence. The role of alcohol abuse in violence was significant in many countries, including his own, and several national strategies were focusing on patterns of alcohol abuse, particularly among young people. The influence of binge drinking on violence in general and domestic violence in particular needed to be reflected more since it contributed to violent behaviour in over half of all cases in his country.

Domestic violence could not and must never be tolerated, excused or ignored. Priority should be given to stopping domestic violence and bringing perpetrators to justice. In that regard, his country had identified five critical areas of action: increasing safe accommodation choices for women and children; improving the interface between criminal and civil law; ensuring a consistent and appropriate response from the police and prosecution services; promoting education and raising awareness; and the health service's contribution to developing early and effective health care interventions. Through that approach, health care of pregnant women was favoured as the most effective situation for initiating schemes of early intervention in the health service. Some 30% of domestic violence was known to start in pregnancy, and existing abuse often intensified during pregnancy.

In addition to tackling alcohol problems, detecting domestic violence and taking appropriate action, other public health measures such as offering information about local help lines or refuge services had the potential to break the cycle and prevent a violent situation from becoming one of repeated and intensifying victimization.

Ms INGÓLFSDÓTTIR (Iceland) said that her country, like any other, was afflicted by violence. She welcomed the report, which had already challenged the secrecy, taboos and feeling of inevitability that surrounded violent behaviour in her country and increased understanding of a complex phenomenon. Iceland was committed to preventing violence, although it had not yet fully measured the task and support needed for victims and their families and friends. The country was determined to play its role in preventing violence worldwide. Although all types of violence existed in Iceland, the country was currently focusing on suicides, sexual abuse and violence against children and the elderly. An action plan for suicide prevention had already been drawn up and the same would be done for violence prevention using a multisectoral approach. Practical prevention programmes had been started and would be followed up and evaluated. They would focus on providing information to the public and to professionals and on better coordination among primary care services, mental health services, general hospitals and voluntary groups. Raising awareness of the fact that violence could be prevented was the first step in shaping a response.

Dr MADELA-MNTLA (South Africa) congratulated WHO on producing the first ever comprehensive *World report on violence and health*. Violence was undoubtedly a leading cause of death and non-fatal injuries worldwide, with far-reaching adverse effects on public health. She thanked WHO for including her country as one of the launch sites for important work. South Africa had experienced a cycle of violence over the decades and hoped to reap benefits from the recommendations of the report.

The report demonstrated that violence could indeed be prevented and its impact reduced, making a strong case for public health services to intervene in preventing violence. South Africa supported the recommendations of the report and the draft resolution contained in resolution

EB111.R7. However, she disagreed with the proposal to delete the third and fourth paragraphs of the latter.

Much had been done since 1996, when the then Minister of Health of South Africa had tabled a motion at the United Nations calling for violence to be accepted internationally as a public health priority. She was more convinced than ever that the root causes of violence could be prevented or altered through a public health approach. Nevertheless, much work lay ahead. Most victims of violent acts were either too young or too weak to protect themselves. The latest national statistics revealed that non-natural deaths accounted for 8.2% of all deaths – close to 60% of those deaths were intentional and preventable; 15% of rape victims/survivors were under 12 years and 41% under 18 years of age. As to the economic costs of violence, it had been estimated that a significant portion of the health budget was spent on emergency and trauma services for both intentional and unintentional injuries. It was unfortunate that violence was glorified in the electronic and print media.

The local launch of the *World report on violence and health* had helped the country to highlight its achievements and realize how much remained to be done. The results had been possible thanks to strong political commitment and an understanding among the various sectors that violence required strong partnerships. Locally, policies had been developed in various departments, laws had been passed and Parliament was regularly informed of the progress made by her Department. Joint ventures had been undertaken to reduce violence and implement life skills in schools. Health care practitioners were being trained in management of victims to ensure high-quality care. The task was enormous and required assistance.

South Africa had made a commitment to forming a central team to coordinate efforts by the major sectors, with a focal point for violence prevention in the Department of Health.

She supported the draft resolution with two amendments: in the final line of the third preambular paragraph, she proposed inserting, after a comma, "the disabled" between "women" and "and the elderly"; in the second line of paragraph 5(2), she suggested inserting, after a comma, "family" between "individual" and "and societal".

Dr BELLO DE KEMPER (Dominican Republic), expressing her support for WHO's efforts to highlight violence in all its forms and causes as a basic public health concern, agreed that alcohol was a trigger of violence. In her country, violence also had a gender dimension sometimes referred to as *feminicidio* (femicide). Homicides often included suicides, which orphaned children and adolescents. The health authorities, including the mental health division, had developed domestic violence prevention and treatment programmes with a view to establishing relevant laws and providing services through, *inter alia*, awareness programmes at the community level, pilot projects and care for survivors. A main objective was to set up a national network of domestic violence prevention and treatment. Studies in the Dominican Republic had shown that the legislative reforms of 1997 were inadequate and that a strategy encompassing the social, health and education dimensions was needed. In that regard, she considered that WHO should play a leading role in the implementation of national domestic violence prevention and treatment plans which met the specific needs of each country.

She expressed her support for the draft contained in resolution EB111.R7.

Ms VALDEZ (United States of America) said that her country strongly supported a science-based public health approach to the prevention of violence, focusing on elements such as the role of parents and families, better data and surveillance and a solid research agenda. Violence was a complex and multifaceted issue that required the collaboration of sectors outside the traditional health purview; education, labour and justice systems were critical to its prevention.

WHO's proposed recommendations on violence prevention provided a broad framework for countries to build capacity and tackle the public health threat. The United States was ready to work with WHO on implementation of the recommendations in ways that would increase understanding of the risks and impacts of violence and identify sustainable solutions.

The United States supported the draft resolution contained in resolution EB111.R7 as it stood.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that violence was caused by a complex interaction of individual, relationship, community and social factors and required action precisely at those levels. Furthermore, the prevention of violence was a prerequisite for the safety and health of human beings.

Cuba had set up a multisectoral working group, in 1997, coordinated by the Federation of Cuban Women and involving the public and private sectors, nongovernmental organizations and the media, to draw up a joint action plan for the prevention and treatment of domestic violence and to draft proposals where necessary. That action plan was being implemented and monitored. Furthermore, the Ministry of Public Health had set up a national commission on violence prevention under the Deputy Minister of Medical Assistance that would work through the National Maternal and Child Health Department and with new services.

Cuba supported the draft resolution.

Mrs BENAVIDES COTES (Colombia) said that the conclusions and recommendations of the report would be invaluable in developing in-country programmes. To ensure a universal, integrated approach to violence, WHO should collaborate more closely with Member States on the adoption of appropriate measures. Multisectoral activities that included nongovernmental organizations and civil society would be essential. The activities mentioned in document A56/24 deserved full support. Colombia was committed to comprehensive responses based on public health, primary care and treatment for the victims of violence.

Her delegation supported the draft resolution in resolution EB111.R7 as it stood. The proposed amendments to paragraphs 3 and 4 were unacceptable: the one-year period should be maintained.

Mr JHA (India) said that the scope of the topic was so vast and its ramifications so far-reaching that it would take some time to study the recommendations and prepare national responses. He therefore proposed that paragraph 4 be deleted.

Dr AHMED (Ghana) endorsed the comments made by the delegate of India on the scope of the subject. Violence relating to armed conflict was pertinent to his subregion, where conflicts affected many civilians, including women, children and the elderly.

With regard to harsh parental discipline, referred to in paragraph 2 of document A56/24, he noted the thin line between parental discipline and violence. Violence was becoming a major public health problem in Ghana, particularly in urban areas owing to rural-urban migration. Such migration flows stemmed from poor socioeconomic conditions and unmet expectations and led to other social vices such as alcohol abuse. That, in turn, resulted in domestic violence. Rape of defenceless women and children living in harsh socioeconomic conditions was also a major concern, and problems were exacerbated by the persistence of taboos. Education was particularly important in that regard.

Ghana had responded to the growing public health problem of violence by creating a Ministry of Women's and Children's Affairs which, among its various functions, addressed cases of abuse. The establishment of a women's and juvenile unit in the police service to deal with complaints of abuse was another major step that had been taken to combat violence. Nongovernmental organizations were also responding to the problem of violence against women. The Government had set up an intensive information and education campaign via the print and electronic media, including cartoons for schools. Bodies such as UNICEF and several local nongovernmental organizations also supported Ghana in its efforts to combat violence.

Ghana supported the conclusions and recommendations of the report.

Dr AL-HOSANI (United Arab Emirates) observed that the report underscored the need both for WHO to continue to lead work on the prevention of violence and for increased political and technical support to national, regional and international organizations.

Her country was opposed to violence in all its forms, particularly that resulting from armed conflicts, destruction caused by the use of internationally prohibited weapons and the random use of traditional weapons. Multisectoral partnerships should therefore be encouraged and resources

allocated to violence prevention. WHO should encourage Member States to provide treatment to victims of violence at all health institutions and develop appropriate preventive measures.

Violence was not a priority issue in her country, most cases being accident-related, particularly road traffic accidents, as reflected in the world report. No effort would be spared in developing accident-reduction programmes in collaboration with all relevant sectors.

Dr BALACHANDRAN (Malaysia) admitted that, although there was not a high incidence of violence in his country, it was nevertheless a problem. Preventive measures should target individual, societal and community levels. Much needed to be done on collaboration between governments and nongovernmental organizations. WHO should continue to play a central role in combating violence.

He expressed his support for the draft resolution in resolution EB111.R7 with the amendments proposed by the delegate of Greece to paragraph 4.

Dr AHSAN (Bangladesh), commenting that women and children were most often the victims, said that acid burns and rape were common forms of violence. Her Government was committed to the prevention of all forms of violence and had recently introduced the death penalty for those convicted of inflicting acid burns on victims. There needed to be agreement globally on ways of combating violence. There was also a need to increase awareness both through the media and through education of the repercussions of violence on health, particularly among the weaker members of society. The inclusion of violence and health on the Health Assembly agenda was commendable.

Dr LETSIE (Lesotho) supported the draft resolution contained in resolution EB111.R7. Violence was recognized as a serious public health problem by the Government of Lesotho, especially against women and children, in the form of physical assaults and rape, and road traffic accidents. With WHO's support, it had conducted studies into particular aspects of the problem, including violence against women, substance abuse among children and adolescents, rape, the impact of HIV/AIDS on girls, and the prevalence of abortions. Recommendations arising from the studies were being implemented: awareness campaigns on violence were conducted; laws and programmes relating to children and the management of rape victims were being reviewed; and special equipment was being installed in children's courts.

Mr YANG Qing (China) said that China endorsed the recommendations contained in the *World report on violence and health*. By making violence, in particular that within families, a public health issue, it should attract the attention of all countries. He encouraged Member States to participate in preventing and countering violence. Given that developing countries were only just beginning to introduce violence-prevention activities, and that their resources were limited, there was a need for capacity building among Member States. With the recognition of the public health and social implications of violence, the problem would most effectively be dealt with through multisectoral and multilateral cooperation at the international level. Violence itself and the measures taken to combat it could both be very damaging. Member States would need to determine which bodies were competent to deal with it.

Dr YACH (Executive Director), responding to comments made, said that violence was clearly recognized as a public health issue, but it was preventable. Several delegates had underlined the importance of political support and multisectoral approaches for sustained success. The delegate of Colombia had also highlighted the need to involve civil society. More than 30 Member States had already launched the *World report on violence and health* and many others were planning to do so. Speakers had focused on a wide variety of innovative interventions in specific areas, including a crisis centre for women and children in Thailand, support for victims of violence in Morocco and a family violence programme in Mexico. Some had focused on the elderly and the issue of alcohol as a cause of domestic violence. Others had mentioned violence against women and the importance of the role of parents and families. All the innovative ideas that had been discussed would be synthesized and those

that were found to be science-based would be incorporated into WHO's guidelines and best practices for violence prevention. Several Member States had emphasized the importance of having adequate financial resources to carry the recommendations forward at country level. Finally, the delegate of China had highlighted the role of international collaboration in violence prevention. WHO had already hosted a meeting of 15 United Nations agencies to define unique and complementary roles in violence prevention; a further meeting would be held during the second half of 2003.

Dr BERNES (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, commended the *World report on violence and health* and endorsed its recommendations. Adoption of the draft resolution contained in resolution EB111.R7 would serve to strengthen the ability of countries to prevent violence and mitigate its consequences at all levels of society. The recommendation that responses for victims of violence should be strengthened was particularly welcome. The health, social and legal services provided to victims of violence ought to be improved in all countries. Victims of violence required rapid access to effective health care, from the pre-hospital phase to ongoing medical management in cases of severe disability. The impact of violence on psychological well-being and social support networks should be managed through caregivers, communities and social services providing victim support. Legal services, including the police and justice sectors, required reform to ensure that they avoided renewed victimization of victims and were effective in deterring perpetrators from re-offending.

In strengthening the health component of responses for victims of violence, the Federation highlighted the vital, but as yet underdeveloped, services that nonprofessionals could immediately offer victims of violent injury; they often provided the initial response and could even save lives, for example, in the case of neighbourhood shooting or stabbing incidents, and in crisis situations, such as armed conflicts, arson attacks and mass shootings. Local first-aid programmes such as those of the Red Cross and Red Crescent Societies, were a means of empowering non-health professionals who had regular contact with victims of violence, such as policemen, bus and taxi drivers and teachers, to provide immediate pre-hospital care. The Societies were also engaged in building first-aid capacity among UNHCR staff through a global memorandum of understanding signed in 2003. In addition to helping to meet the needs of victims of violence for effective emergency health care, first-aid education also instilled an awareness and understanding of information-driven programmes for preventing violent injuries. First-aiders were often the first step in obtaining and recording accurate information about the causes and circumstances of violent incidents. Such information helped to place the violent incident in context. First-aiders, as the first responders to many violent situations, were powerful advocates for programmes to prevent such incidents from occurring. First-aid training also had a psychological and ethical dimension and its practitioners conveyed a warmth that helped to promote a more tolerant society.

In 2002, a cooperation framework on violence and injury prevention and management had been signed by the International Federation and WHO to support the dissemination of knowledge and skills related to violence and injury prevention and management, in particular to the most vulnerable. Both organizations had also committed themselves to ensuring that the related research, plans and services were relevant to local needs and capacities, and that those of individuals, families, communities, governments and organizations were strengthened. Other measures designed to protect more lives from the devastating consequences of violence were: the inclusion of first-aid training in school curriculums; provision of first-aid training at community level; and the formation of partnerships for violence and injury prevention and management programmes. The International Federation, in collaboration with WHO would promote such partnerships and ministers of health were urged to do likewise.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, observed that the *World report on violence and health* focused on critical public health issues generated by the increasing incidence of violence throughout society and the world. The International Council of Nurses supported the proposed global campaign on violence prevention.

Although the complete elimination of violence might not be a realistic aim, mechanisms needed to be introduced to facilitate confidential reporting, accurate data collection, sensitive victim management and appropriate follow-up, including disciplinary action against perpetrators. While the report specifically referred to workplace violence, it was regrettable that coverage of especially vulnerable settings where violence occurred was not more extensive. The growing incidence of workplace violence was a matter of great concern, particularly in connection with health sector data; while nearly all sectors and all categories of workers were affected, the health sector was particularly at risk: it was estimated that health care workers were 16 times more likely to be the victims of violence than service workers in other sectors. Violence in the health sector accounted for almost a quarter of all work-related violence and affected more than half of health care workers who were more likely to be attacked at work than prison guards, police officers, transport workers or retail or bank employees, and it had a destructive impact on the professional and personal lives of health care workers. It also affected the quality of care and the coverage provided and was increasingly being given as a major reason for staff leaving the health sector. At a time of critical nursing shortages, urgent action was required to improve working conditions in that sector. In the light of growing workplace violence, more resources and programmes to eliminate the contributing factors and eradicate the negative impact of violence on services and personnel were urgently required. During the past two years, WHO had worked with the International Council of Nurses, ILO, and Public Services International to create an international database on workplace violence in the health sector; the background documentation, research instruments and framework guidelines were available on the respective web sites. Health ministries worldwide should review the documentation, undertake their own research and monitoring, and apply the guidelines in their own workplaces. In many countries health ministries were major employees. It was important from both a public health and a labour perspective that the safety of employees and patients in the health sector was guaranteed. The International Council of Nurses was prepared, with WHO, ILO and Public Services International, to assist countries in combating workplace violence. The Health Assembly should provide WHO with the political backing to be a leading partner in the campaign against violence in all settings. He urged WHO and its Member States specifically to address issues related to workplace violence within the proposed global advocacy campaign.

Dr KARAM (Secretary) read out the amendment to the draft resolution contained in resolution EB111.R7 proposed by the delegate of South Africa, and noted that the delegate of Greece, supported by the delegate of Malaysia, had proposed an amendment to the fourth preambular paragraph to which the delegate of the United States had raised an objection.

Ms VALDEZ (United States of America) said that, after conferring with the delegate of Greece, it had been agreed that the fourth preambular paragraph be amended by inserting the words "and dignity" between "security" and "and that urgent action".

Dr KARAM (Secretary) said that a proposal had been made to amend paragraph 2 by replacing the phrase "to hold national launches or policy discussions on" by "to promote". The delegate of Denmark had proposed the deletion of paragraph 3, to which the delegate of South Africa had objected on the ground that it was essential that the leading role of the public health sector in the prevention of violence be reflected in the resolution because of the emotional consequences of violence.

Mr THOMSEN (Denmark) agreed to withdraw his proposal.

Dr KARAM (Secretary) said that a proposal had been made by the delegate of Greece, supported by the delegate of Denmark, to replace the phrase "within one year" with "in due time" in paragraph 4. The delegate of South Africa had proposed the insertion of the word "family" between "individual" and "and societal" in paragraph 5(2).

The CHAIRMAN said that he took it that the Committee wished to approve the draft resolution with those amendments.

**The draft resolution, as amended, was approved.**[1]

**Strengthening health systems in developing countries:** Item 14.13 of the Agenda (Resolution EB109.R10; Documents A56/21 and A56/22)

Dr HUERTA MONTALVO (Ecuador) said that the draft resolution in resolution EB109.R10 seemed only to refer to contractual arrangements, and did not reflect the need for accreditation, although there was a WHO framework for assessing health systems' performance, intended to ensure responsible management after decentralization and promote the development of services at district and local levels. Moreover, WHO served as the secretariat for the Alliance for Health Policy and Systems Research, a matter that should also be reflected in the draft resolution. To refer solely to contractual arrangements was incompatible with the topic's importance; the strengthening of health systems was a key issue, and had been viewed as such at the Fiftieth World Health Assembly.

His delegation therefore proposed that paragraph 2(4) should be amended by the addition, after the words "in which contractual arrangements", of the words "and other strategies to strengthen health systems".

Dr BAHAUDIN (Indonesia) said that Indonesia welcomed the progress in WHO's work to strengthen health systems in developing countries. Good health, fundamental to human development and national prosperity, was a main feature of Indonesia's national development system. Indonesia's health systems provided care to people at all levels, in line with the referral system, and used the latter to promote equitable access to care, especially for the poor. The system was doubly burdened, however, by communicable and noncommunicable diseases, and was therefore being reformed through decentralization, giving more authority to local systems, which made services more cost-effective. Indonesia's health strategies included the use of WHO-CHOICE guidelines, a reform of the financing system involving pre-payment, community financing and generally improved efficiency, as well as training and further education for health professionals, especially nurses and midwives. In order to ensure accessibility, safety and quality of care, however, Indonesia needed WHO's continued support in areas such as finance strategy, the strengthening of research capacity and the training of health professionals. Indonesia therefore supported the draft resolution in resolution EB109.R10.

Ms BUIJS (Netherlands) said that, as stated in the reports, health was essential to development, and poverty alleviation an essential aspect of health improvement. However, reaching the poor remained an enormous challenge in many countries. WHO took as a point of departure that health systems needed to deliver effective, responsive and fairly financed services focused on improved access for the entire population. In that regard, the country focus initiative was welcome. The challenge was to match the available knowledge with health system needs and capabilities at country level, and to support countries' efforts to reach the whole population, especially the poor and, very often, poor women. The challenge required an open attitude and WHO's preparedness to build on existing capacities at country level.

Her delegation endorsed the concern voiced by many Member States during the current Health Assembly that the constraints placed on human resources for health required urgent attention, particularly in countries badly affected by HIV/AIDS, because health workers were at the core of service delivery. The Netherlands recognized the role and responsibility of civil society organizations and the private sector. Strong pro-poor health policies were needed, particularly for groups with the poorest health outcomes. Contractual arrangements must therefore be in line with relevant policies in

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA56.24.

order to guarantee equity of access to health services. The Netherlands welcomed the draft resolution in resolution EB109.R10.

Mr RYAZANTSEV (Russian Federation) said that his delegation noted with satisfaction WHO's efforts to improve the delivery of health services during the past two years, with the emphasis not on importing developed countries' systems but rather on making effective use of health care mechanisms in the developing countries, with a view to enabling them to operate their own stable systems. The degree of economic development was bound to have an influence, and the guiding principles developed by WHO and its Commission on Macroeconomics and Health were useful in that regard. Of particular importance was the assessment of health reforms, with a view to providing reliable indicators and focusing on issues such as ensuring health services, a proper financial framework, availability of drugs and medicines and the effectiveness of health care. His delegation supported the basic points raised in the report, and was glad to see that it addressed the role of contractual arrangements with a view to improving relations with the private sector. Work in that field had shown that harmonizing of government and private-sector efforts was possible. WHO should continue such work and draw up recommendations for Member States.

Dr NGUYEN HOANG LONG (Viet Nam) said that the role of health in socioeconomic development and poverty reduction should be more strongly stated. The Government of Viet Nam, in developing its comprehensive poverty reduction and growth strategy, had found it was not always easy, although very important, to convince other ministries and sectors of the need to give health high priority in poverty reduction. Although a low-income country, Viet Nam had made considerable efforts to ensure basic health services to the poor. There was a wide basic health network, and many programmes had been implemented to address the health problems common to the poor, such as tuberculosis, malaria, leprosy and goitre. Free health insurance and the provision of free hospital services for the poor had been expanded, and the Government had recently decided to create a health fund for the poor, in all 61 provinces, by means of which some 14.6 million poor people, roughly 18% of the population, were to receive free health services. It was planned to increase public health spending and other measures with the aim of avoiding the so-called "medical poverty trap". The Ministry of Health and the WHO Office in Hanoi were together studying different models to support health care programmes for the poor, with reference to the WHO framework for assessing health systems' performance. The support provided by WHO and international organizations in developing Viet Nam's health system was highly appreciated.

Mr KAMAL (Canada) said that Canada supported the emphasis on involving civil society groups and the private sector in strengthening health systems. Efforts, however, must be measured in terms of equity and pro-poor strategies. The 10/90 gap in research should be further addressed, with the Global Forum for Health Research taking a leading role. All efforts to strengthen the developing countries' health systems must be guided by the goals of reaching the poor and promoting gender equality.

Formal and informal contractual arrangements were essential components of the Canadian health system and existed at all levels, from relations between federal and provincial/territorial governments to those between regulating bodies and health care establishments. They were almost always public and subject to open scrutiny, reflecting a common vision of health care. Canada supported the work of WHO and the World Bank to expand the evidence base on contractual arrangements with health sector providers. His delegation supported the draft resolution in resolution EB109.R10.

Dr MOETI (Botswana) commended the reports, which summarized WHO's achievements since the Fifty-fourth World Health Assembly in putting health at the centre of sustainable development. The report of the Commission on Macroeconomics and Health showed the magnitude of the resources required to make an impact on the health of the poor, and emphasized the importance of strong health

components in national poverty reduction strategy papers. Strengthening health systems was therefore important in addressing the links between poverty and health. Although detailed information had been provided on low-income countries' resource requirements, it might be beneficial for middle-income and lower-middle-income economies to have similar data to help to assess the resource commitment required for the growing number of Member States in that category. He welcomed, in that regard, WHO's initiatives in providing health finance information to assist countries in undertaking the often difficult task of ensuring fairly financed health systems able to provide sustainable health services, while ensuring that the poor had equitable access to care.

Botswana had recently made progress in respect of contractual arrangements, having contracted mine hospitals to improve access to antiretroviral drugs as part of the national HIV care programme. It appreciated WHO's support for a consultancy to assess ways in which the private sector might collaborate with public services in providing antiretroviral treatment. De facto contracted-out services were provided by religious missions, largely government-funded, which had long been a feature in Botswana. The increasing outsourcing of core and non-core services would be carried out in compliance with national health and development policies, as stated in the draft resolution. Considerable capacity would have to be created for monitoring, evaluating and coordinating such processes. His delegation therefore supported the draft resolution in resolution EB109.R10, which called on the Director-General to provide technical support in that area.

Professor ANDOH (Côte d'Ivoire) said that the Commission on Macroeconomics and Health, and the World Summit on Sustainable Development had highlighted the undeniable link between good health and development. The systems performance indicators in developing countries were unsatisfactory because those countries lacked the means to provide quality health services to all, especially to the most vulnerable groups. The challenges faced included problems such as communicable and noncommunicable diseases, nutritional problems, poor economic performance and infrastructures and lack of medicines and skilled workers, a situation often aggravated by civil conflict, war and HIV/AIDS, as in his country. Difficult choices of priorities had to be made, and resources carefully reallocated. The requisite financing was a complex issue. His country was currently developing a basic obligatory health insurance scheme with a view to providing nationals and non-nationals in the country with access to health care.

His delegation supported the draft resolution in resolution EB109.R10.

Dr NDOUR (Senegal) said that his delegation welcomed especially the fact that WHO had taken up the subject of decentralization in health service provision. During the past five years, his country had been involved in many health reforms, including decentralization and financing of health care, and activities to reform and develop the provision of medicines and other health services. There had been many participants, and relations with them had become increasingly complex. In that context, contracting was a vitally important means of regulating relationships between the players. His delegation suggested the addition of a new paragraph 2(4), that would read: "to facilitate the exchange of experience among Member States;", the existing paragraph 2(4) being renumbered 2(5).

Ms VALDEZ (United States of America) said that her delegation appreciated the clarity of document A56/21. The United States remained committed to working to build stronger health systems and services in developing countries, particularly through support for in-country capacity and the provision of information to guide future health policy. The President's Millennium Challenge Account reinforced that commitment. Her delegation appreciated the report's recognition of the critical role of research in addressing health disparities and promoting improvements. Research was fundamental to poverty alleviation and a key to the development of strong, sustainable health systems. As rightly pointed out, access to essential medicines and vaccines was one of the most cost-effective elements of health care and, hand in hand with physical infrastructure, was the critical mechanism and support structure for their delivery. Host country support, efforts to increase the number of and to retain

trained health care personnel, rational use of medicines and strengthened drug distribution systems were just some of the factors that could affect the quality of health care in the developing countries.

**The meeting rose at 12:00.**

## EIGHTH MEETING

**Tuesday, 27 May 2003, at 14:40**

**Chairman:** Dr R. CONSTANTINIU (Romania)

**TECHNICAL AND HEALTH MATTERS:** (Item 14 of the Agenda) (continued)

**Strengthening health systems in developing countries:** Item 14.13 of the Agenda (Resolution EB109.R10; Documents A56/21 and A56/22) (continued)

Mr LIEN (Norway), speaking on behalf of the Nordic countries, welcomed the initiative on contractual arrangements as a means of improving health systems' performance. However, little information was available about the results of contracting, and WHO could play an important role in developing an evidence base. When evaluating contracting efforts, account must be taken of the extent to which they were in harmony with national health policy, as urged in the resolution, since situations were specific to countries and would affect the implementation of reforms. Special attention should also be given to the transactional costs of contracting, which rose with the complexity of monitoring required. Where incentives were offered to improve the efficiency of health care delivery, it was essential to monitor the quality of the care provided; he welcomed an initiative to support Member States in establishing supervision systems.

In order to ensure that the solutions proposed were not understood as being the only quality-control mechanisms, he proposed that paragraph 2(3) of the resolution be amended to read: "to develop, in response to requests from Member States, methods and tools to provide support to Member States in establishing a system of supervision to ensure the provision of high-quality health services, for example by accreditation, licensing and registration of public and private sector and nongovernmental organizations in the health sector."

Success in strengthening health services delivery would be measured by the extent to which the challenges faced by developing countries in extending health services to all were met. With the proliferation of new vertical initiatives in those countries, coordination and horizontal strengthening of health systems were increasingly needed at country level. He strongly supported the country focus initiative, which had the potential to be a key instrument in addressing the challenges. WHO was better placed than any other agency to help Member States strengthen their health systems.

Mrs ROSSUKON KANGVALLERT (Thailand), welcoming the report on strengthening health services delivery, said that a policy of universal coverage, implemented in Thailand since 2001, had, together with a primary care unit initiative, increased accessibility to health services for all. Following public sector reforms, a Department of Health Services Support had been established in 2002. A task force had been set up to study and analyse matters raised by the report of the Commission on Macroeconomics and Health.

Implementation of contractual arrangements in developing countries would be difficult, and their implications for underprivileged groups would have to be taken into consideration. Successful contracts depended on accountability, and there was a lack of experience in imposing sanctions on unsatisfactory contractors. She expressed concern regarding the implications of the General Agreement on Trade in Services, and urged WHO to monitor those implications for health systems, particularly those of developing countries.

Dr MHLANGA (South Africa) said that health systems had to have the capacity to respond to the needs of the poor. To meet the need for human, material and financial resources, the South African Government had entered into several partnerships, including those with the private sector and with nongovernmental organizations. A unit had been established within the Treasury to support governmental departments entering into contracts with the private sector and to ensure that those contracts were designed to serve the public interest rather than private profit. The private sector had a role in training health workers, closely monitored by official health bodies, and in the procurement of equipment and the distribution of medical supplies.

Human resource requirements, however, presented the greatest challenge to health systems, since experienced and skilled personnel were leaving the public sector for a variety of reasons, not least the impact of HIV/AIDS. By improving working conditions for health workers, South Africa was attempting to reverse that trend, and it was grateful to countries such as Cuba for providing it with personnel. A code of conduct on the international recruitment of health professionals was needed, so that countries supplying such personnel could receive assistance from recipient countries.

Health systems performance would be measured by morbidity and mortality rates, for women and children in particular, and improvements in health care for them would mean improvements in health care for everyone. He supported the draft resolution contained in resolution EB109.R10.

Mr JANG Il Hun (Democratic People's Republic of Korea) said that the importance of strengthening health systems in developing countries, which suffered a lack of both financial and human resources, was well recognized. A transfer of financial and technical resources from developed to developing countries was needed if the latter were to enjoy health for all.

Dr RAO (India) said that the increased cost of health care and limited financial resources were obstacles to the provision of health care to the poor in developing countries, and initiatives such as WHO-CHOICE and the Global Tuberculosis Drug Facility were going some way towards remedying that situation. However, in countries where spending on public health was low, the poor were forced to use their own meagre resources for health care, thus accentuating the spiral of poverty. Measures to overcome the problem included accreditation of health care facilities, medical audits to avoid unnecessary treatment, establishment of modern well-equipped laboratories to ensure high-quality medicines, government-subsidized insurance policies for the very poor, and closely-monitored public-private partnerships. To broaden availability of health care services, especially in rural areas, certain health facilities could be transferred to private agencies and nongovernmental organizations. WHO might consider funding for such measures, notably the provision of affordable vaccines.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland), welcoming the explicit comments made in document A56/21 on the links between poverty reduction and a fully functioning health system, agreed that the country focus initiative could play a key role in that respect. With regard to human resources, migration was a major problem, and the strain placed on the management of efficient and equitable health services by HIV/AIDS ought to be given equal recognition. Issues relating to human resources needed to be urgently addressed.

Harmonization of procedures between countries and their donor partners could maximize benefits from funding in terms of outcomes and avoid further overburdening government systems.

She could support the amendment to the resolution proposed by the Nordic countries if its purpose was to emphasize the importance of tailoring methods used to country realities.

Mr MANSOUR (Tunisia), also commending the information provided, applauded WHO for its valuable contribution to the fight against diseases which threatened the health of all, particularly the poor, and stressed that poverty reduction was an essential element in any health-for-all strategy. He agreed with previous speakers on the importance of harmonization of programmes and mechanisms to create more efficient health services: the international community should make concerted efforts to achieve synergy. The new World Solidarity Fund, whose creation had been unanimously approved by

the United Nations General Assembly at its Fifty-seventh session, could provide effective support for action in the field as well as for research programmes, and should be taken into consideration in WHO strategies.

Dr NDONG (Gabon) said that since 1997 Gabon had taken various steps to strengthen its health services, including the introduction of three-year health plans, a national pharmaceutical policy and an integrated primary health care programme. Some regional hospitals had been rehabilitated to serve as focal points for intermediate health training. Two problems, however, were seriously hampering progress: shortage of drugs, particularly in rural areas, and lack of funding, which meant that part of the cost of health care had to be borne by the patients themselves.

He thanked WHO for its valuable assistance in the formulation of policy and for the work it was currently undertaking on financial protection mechanisms in regard to health spending, which constituted a major challenge for developing countries.

Mr MÄUSEZAHL (Switzerland) noted with satisfaction the importance accorded in document A56/21 to the delivery of effective services that focused on the needs of very poor people. It was only by developing and strengthening strategies in favour of the poor that equitable access to quality services could be achieved. He was also gratified to note the importance attached to the role of research in the development of effective health systems. It was vital to support the most disadvantaged countries in their efforts to strengthen their health systems, and to facilitate the emergence of national human resources capable of taking innovative measures. He supported the draft resolution as it stood.

Dr AHMED (Ghana), outlining developments in his country's health system since the reforms of the 1980s, said that it provided both primary and secondary health care, and included community health programmes administered through district and regional health centres. Teaching hospitals provided specialized services, training and research, and regulatory bodies had been set up to monitor quality of care. An annual health review was conducted with all development partners. Attempts had been made to address problems of accessibility to health services in rural areas by stationing health workers in isolated communities to provide services such as mother-and-child care and immunization.

One particular problem facing Ghana was the emigration of health workers, which hindered service delivery. Ghana had increased its output of health workers, in particular doctors, nurses and pharmacists, but unfortunately they were attracted to developed countries, and he therefore supported the South African proposal for a code of conduct on international recruitment of health professionals. In the meantime, Ghana had taken steps to curb migration by improving working conditions and upgrading equipment in health centres. In an effort to extend health services to rural areas, the Government had registered practitioners of traditional medicine and provided them with support and training. He supported the draft resolution.

Ms BALDICK (New Zealand) also supported the draft resolution contained in resolution EB109.R10. Her country's health service had undergone many changes over the previous 20 years. The current district health board structure emphasized improving health status, took a population health approach and focused on health services addressing inequality. New Zealand's experience was that cultural changes within a structure rather than multistructural adjustments could produce the desired shift in emphasis. She therefore requested the addition to the preamble of a paragraph reading: "Noting that cultural change within health services is often required to improve system performance, and that health system culture can be unaffected by structural change; examples of cultural change include a greater focus on patient needs, a population health approach and focus on health services addressing health inequalities".

Dr GONZÁLEZ FERNÁNDEZ (Cuba), commenting that documents A56/21 and A56/22 were complementary, said that health systems should be strengthened in order to make them more accessible to the most disadvantaged sections of the population that had the least health protection.

Although studies had demonstrated the existence of a wide variety of contractual arrangements for the provision of health care, ministries of health had to retain stewardship and to supervise, regulate and accredit service providers from the private sector and from nongovernmental organizations, because no institution should be permitted to provide health services that were not of the proper quality. Local government and civil society could also contribute to strengthening health systems and to the introduction of best practices for managing change in hospitals and care facilities. In that connection, WHO should help States to establish accreditation standards that would guarantee the quality of health services.

He supported the amendment proposed by the delegate of Ecuador, but wondered if the title should not be modified in view of the fact that the 115th session of the Executive Board and the Fifty-eighth World Health Assembly had been requested to ascertain in what way contractual arrangements had strengthened national health systems.

Dr EL TAYEB (Egypt) said that, in his country, in an endeavour to contain government expenditure, the ministry controlling financial resources had decided to purchase services rather than to provide them itself, and hospitals increasingly contracted out waste disposal and the supplying of meals. Health insurance was being reformed along similar lines to give the private sector a greater role. As there was still a considerable amount of work to be done with regard to contractual arrangements, he urged WHO to provide developing countries with assistance and technical support, especially with regard to the establishment of accreditation agencies, so as to ensure the quality of the services purchased and the effective delivery of those services to the public. With that reservation his Government supported the proposed resolution.

Dr ANTEZANA ARANÍBAR (Bolivia) endorsed the comments made by Ecuador and Cuba. He urged that mechanisms other than contractual arrangements be taken into account, because health system structures differed from country to country and included a wide variety of arrangements regulated by health ministries. When the follow-up to the Alma-Ata Conference was examined under agenda item 14.18, it would be advisable to consider a series of studies that had been conducted on the strengthening of health systems, as that was the only way to achieve universal access to health care.

Dr MURRAY (Executive Director) noted that capacity-building measures had been stepped up at both regional and national levels by means of national health accounts and improved health information systems using, for example, household survey instruments like the World Health Survey. Cost-effective options had been chosen, and the burden of disease had been analysed in specific regional and subregional initiatives. Efforts had likewise been made to select efficient health-financing instruments when policy was formulated.

WHO's activities to strengthen health systems were linked to the country focus initiative, one of whose central tasks was to enhance WHO's usefulness when assisting Member States in the formulation of national health policies designed to improve human resources policy and to consolidate health systems. Shortage of human resources could seriously constrain health systems, especially in the poorest countries. The causes were complex and included not only the emigration of health personnel, but also HIV/AIDS, poor working conditions and the problem of ensuring that resources were in the right place to deliver services to the poor.

Speakers had encouraged WHO to focus on evaluating evidence regarding contracting, and on the safeguards that ought to be put in place when contracting out services to different entities, in order to guarantee the quality of those services. Accreditation was just one of the many instruments for supervising service providers.

Paying due attention to the role of health systems in an era when vertical programmes might be fostered by certain global instruments was high on the Organization's agenda, as was shown by the fact that the focus of *The world health report 2003* was on health systems and achieving the Millennium Development Goals. The choice of that focus reflected recognition of the fact that highly effective interventions that could make a difference to poor people could only be delivered by health

systems capable of reaching them. The way in which the opportunities afforded by new resources could contribute to the general strengthening of health systems was one of the central issues that could be highlighted in *The world health report*.

Mrs TEN HOOPE-BENDER (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses, said that it was heartening to see the continued commitment of WHO and governments to strengthening health systems, particularly in developing countries. Without such strengthening, growing health demands arising from changing demographic factors and disease patterns and the ongoing threat of communicable diseases would overburden nurses and midwives and compromise achievement of the Millennium Development Goals for maternal and child health. As the training, deployment and retention of human resources formed the cornerstone of improving health systems, governments should give priority to the needs of health professionals, including the provision of a safe working environment, so as to encourage them to continue their work, promote recruitment and prevent mass migration. The organizations she represented were prepared to collaborate with WHO, other United Nations agencies and nongovernmental organizations in developing strategies for expanding human resources in order to strengthen health systems worldwide.

Dr KARAM (Secretary), responding to the CHAIRMAN's request, read out the amendments to the draft resolution proposed by the delegates of New Zealand and Senegal. The amendment to paragraph 2(3) proposed by Norway, as further amended by the United Kingdom, read: "to develop, in response to requests from Member States, methods and tools tailored to country realities to provide support to Member States in establishing a system of supervision to ensure the provision of high-quality health services, for example, by accreditation, licensing and registration of public and private sector and nongovernmental organizations in the health sector". In view of the amendment proposed by Ecuador, the new paragraph 2(5) should read: "to report to the Executive Board at its 115th session and to the Fifty-eighth World Health Assembly on the ways in which contractual arrangements and other strategies to strengthen health systems improve the performance of health systems in the Member States of the Organization".

**The resolution, as amended, was approved.**[1]

**Elimination of avoidable blindness:** Item 14.17 of the Agenda (Document A56/26)

The CHAIRMAN drew attention to the draft resolution contained in document A56/26.

Mr KINGDON (Australia), introducing the draft resolution on behalf of the Commonwealth group of nations, said that blindness and partial vision loss were a serious health problem affecting a significant number of people. Already there were 45 million blind people in the world and a further 135 million suffering from vision impairment and those numbers were expected to double over the next 20 years as a result of the ageing of the world population. Going blind had a huge impact on quality of life and on ability to participate in the community and in society, and could also lead to loss of independence or reduction in income-earning capacity which in turn could result in depression and poor mental health. Every member of society would at some stage of their life be affected by impairment of their own vision or that of a family member, friend or colleague. Vision loss on a wide scale could have an adverse impact on the economic well-being and development of entire countries: in his own country its cost was estimated to be more than US$ 1000 million a year. The burden of vision loss lay primarily on the most disadvantaged sectors of society, with the poorer countries of the world carrying a disproportionate share. There was therefore a global responsibility to ensure that

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA56.25.

100 million people would not needlessly go blind by the year 2020 because the urgent action needed to tackle the problem had not been taken. Appropriately targeted programmes and initiatives could reduce the impact of vision loss, and in Australia one particular programme had successfully improved capacity to deal with the eye health problems of indigenous people in a primary health care setting.

His country had played an international role in the research and development of artificial corneas, telemedicine and contact lenses, and its nongovernmental organizations were leaders in eye care and blindness prevention. Although national efforts had achieved much, a concerted international partnership would be required to harness the necessary resources to tackle such a colossal global problem over the next 20 years. Vision 2020 was a significant step forward in that respect, and Australia, the other Commonwealth nations, Bahrain, and Lebanon commended the draft resolution to the Health Assembly.

Mr DHAIF (Bahrain) said that his country had been one of the first to join the Global Initiative for the Elimination of Avoidable Blindness, and a national committee was preparing a comprehensive plan in that connection; his Government would be hosting the 7th General Assembly of the International Agency for the Prevention of Blindness (Manama, 28 September – 3 October 2003). He supported the draft resolution.

Mr BAILLY (France) said that his Government had supported the fight against avoidable blindness, as well as research and training to that end, for some 40 years, and WHO's Onchocerciasis Control Programme had been set up in West Africa on the basis of the work of French researchers. France and other donor States had helped countries to adopt a control strategy that had successfully eliminated the disease as a threat to public health in the region. The World Bank and WHO had played an essential role in coordinating the programme.

His country, along with many others, was participating in central Africa in another project, the African Programme for Onchocerciasis Control, the coordination of which by WHO augured well. The development of a partnership within the framework of Vision 2020 would ensure the meeting of targets. The action of each partner was complementary, and each should retain its specific role; given WHO's coordinatory role, he proposed amending paragraph 2(2) to read: "to provide support for strengthening national capability to coordinate, evaluate and prevent avoidable blindness".

Dr KASSAMA (Gambia) said that his Government wished to respond to the global call for a united stand to prevent the causes of avoidable blindness. A survey conducted in 1986 had shown that the main causes of blindness were cataract, trachoma and other corneal opacities mostly associated with childhood measles or harmful traditional eye medicines. His Government had therefore focused on a primary health care approach and on making services affordable, accessible and appropriate. Five-year plans of action had been worked out to meet the eye-health needs of the Gambian population, bringing eye care closer to communities and obviating the need for patients to travel long distances. Cataract surgery had been brought to communities throughout the country, and the national eye-care programme had markedly reduced the prevalence of blindness. That remarkable achievement could be ascribed to governmental commitment and partnership with nongovernmental organizations providing community-based eye-care services.

His delegation therefore endorsed the Vision 2020 initiative, especially as most of the causes of blindness were avoidable and the treatments available were among the most successful and cost-effective of all health interventions. He requested the Director-General to ensure that WHO collaborated with Member States and partners in the Global Initiative for the Elimination of Avoidable Blindness, and appealed to other countries to support that initiative.

Dr NDOUR (Senegal) praised the quality of the report. He said that he appreciated the importance of the Vision 2020 initiative, which needed to be translated into operational programmes. It was unacceptable that trachoma, trichiasis and cataracts should still be causing blindness in the twenty-first century. He therefore supported unreservedly the draft resolution.

Dr MAHJOUR (Morocco) praised the work of WHO to combat blindness through the Vision 2020 initiative. Effective strategies existed for the prevention of blindness caused by cataracts and trachoma, and it was most important that the international community make use of them. His country had had a national programme to combat blindness for the past 10 years. Its aims were to eliminate blindness caused by trachoma by the year 2005, to reduce blindness caused by cataract, and to develop programmes against glaucoma and retinal damage caused by diabetes. He strongly supported the draft resolution. To emphasize the coordinating role of WHO, he suggested amending the text of paragraph 1(1) after the words "a national Vision 2020 plan" to read: "in partnership with WHO and in collaboration with nongovernmental organizations and the private sector". In paragraph 2, he suggested including an additional subparagraph (3) reading: "to ensure coordinated implementation of the Vision 2020 initiative, in particular by setting up a monitoring committee that would bring together all the participants, including representatives of the Member States", and an additional subparagraph (4) reading: "to report to the Fifty-ninth World Health Assembly on the progress of the Vision 2020 initiative".

Professor FIŠER (Czech Republic) said that through careful planning his country had succeeded in reducing the backlog of patients visually impaired because of cataracts. As of 2002, there were 5300 cataract operations per million inhabitants.

He recommended that every country where eye care was a public health problem should consider developing a national plan for eye care, with measurable targets. The new Lions International Educational Center of Ophthalmology, in Prague, serving eye care professionals from eastern Europe, illustrated the impact of international cooperation in health care on the development of human resources. It had been made possible through partnership between WHO, Lions Club International, Christoffel-Blindenmission and the Czech Government. He acknowledged the technical contribution of WHO and its coordinating function.

Dr EL TAYEB (Egypt) said that in 2000 the Ministry of Health and Population in his country had set up a High Commission on Combating Blindness, which would be working with WHO to prepare a national programme for the prevention of blindness based on the Vision 2020 initiative, and for related capacity-building at national level. There was also a project to test the sight of schoolchildren. Ophthalmologists were given training in the surgical treatment of cataracts, and doctors in local medical units in some governorates were trained in ophthalmology, and the early detection of vision impairment and of trachoma. He supported the draft resolution.

Dr WATANEE JENCHITR (Thailand) said a national programme had been in place in her country since 1978 to prevent avoidable blindness and to improve eye care and access to care. In 2000, the Ministry of Public Health had adopted a national version of Vision 2020. Countries should be encouraged to identify their own problems and key priority areas in blindness prevention and care. Effective eye-care systems depended on adequate information and planning. Thailand had a good system of blindness prevention and care, with routine hospital registration systems, and had conducted a national survey on blindness.

Especially in developing countries, primary eye care should be integrated into the existing primary health care system. Primary health care workers and mid-level personnel should be trained to provide primary eye care, blindness prevention and promotion of eye health. The nongovernmental sector and civil society could be involved, particularly in providing information, education and communication. Community care should be included in the core curriculum for ophthalmologists. Eye-care networks should be set up as an integral part of national health care systems, and the national health plan should cover eye health and blindness prevention. Eye care should be made available to the poor and those in rural areas, through adequate health financing and exemptions from the payment of fees.

She proposed four amendments to the draft resolution. In paragraph 1(2) after "prevention committee" the following words should be inserted ", which may include representative(s) from

consumer or patient groups,". In operative paragraph 1(4), the words ", effective information systems with," should be inserted after "such plans". In operative paragraph 2(2), the words ", especially human resource development," should be inserted after "national capability". A new operative paragraph 2(3) should be added, as follows: "to document, from countries with a successful blindness prevention programme, good practices and blindness prevention systems or models that could be modified or applied in other developing countries".

Mrs BELLA ASSUMPTA (Cameroon), expressing her delegation's support for the draft resolution, said that her country had committed itself to the Vision 2020 initiative in October 2001. In January 2003, it had set up a national committee to combat blindness and a national programme comprising regional plans for cataract surgery, the distribution of vitamin A to children, and free supplies of ivermectin under the African Programme for Onchocerciasis Control. Glaucoma was the third cause of blindness in Cameroon and was an important part of the national programme, although it did not feature in Vision 2020. The assistance of WHO was needed to fill the gaps in epidemiological data and in the availability of specialist nurses and optometrists.

Mr RYAZANTSEV (Russian Federation) said that his delegation shared the concern reflected in the report about the global increase in blindness, and supported the Vision 2020 aim of eliminating preventable blindness by 2020 through scientifically sound and cost-effective measures. The effectiveness of that approach was illustrated by the experience of his country where, until the 1950s in some areas, 20% to 50% of the population had suffered from trachoma. Preventive measures and treatment had reduced the incidence of active trachoma dramatically over a period of six to eight years, and had finally eliminated it.

During a Russian interregional symposium on the Global Initiative, held with the participation of WHO in April 2003, plans had been made to develop a national action plan, to raise public awareness, to mobilize resources, and to improve training of personnel and ophthalmological services for the community. He supported the draft resolution.

Dr MOETI (Botswana) said that, although there were no survey data in Botswana, most blindness was due to cataracts and therefore treatable. Other causes included glaucoma, diabetes and traumatic injury. The national blindness prevention programme had adopted the principles of the Global Initiative, and was integrated into the primary health care service. In a population of 1.7 million, more than 4000 patients had been identified as needing cataract surgery, but could not be readily treated because of staff shortages. He requested WHO to step up its support to national capacity building, and to help Member countries to obtain support from other agencies to combat cataract blindness. Botswana had endeavoured to form links with the Bureau for the Prevention of Blindness of Southern Africa. WHO should play a greater coordinating role in that regard at country level. He supported the draft resolution.

Mrs RIZZO (Italy), welcoming the report, noted that 90% of the estimated 45 million blind people lived in the poorest countries of the world. She pointed to the human and socioeconomic consequences of blindness and the availability of safe, efficient and cost-effective methods to prevent and treat it. She supported the draft resolution and the amendments proposed by the delegates of France and Morocco for strengthening the role of WHO, and expressed her appreciation of the efforts of WHO, the International Agency for the Prevention of Blindness and nongovernmental organizations.

Dr SADRIZADEH (Islamic Republic of Iran) said that blindness was a serious global health problem that mostly affected developing countries. As most of its causes were preventable or treatable, WHO should give high priority to its elimination. His country had adopted the Vision 2020 initiative in 2002, in close collaboration with the Regional Office for the Eastern Mediterranean. A national plan

had been prepared for the prevention of blindness, and was being implemented in the framework of primary health care. He expressed support for the draft resolution.

Dr MZIGE (United Republic of Tanzania) said that trachoma was a leading cause of preventable blindness in his country, with more than 12 million people at risk of infection and more than two million children actively infected. Trichiasis was another major problem, affecting 45 000 people already blinded and 60 000 people in need of immediate surgery to preserve their sight.

Eye care had been included as a priority within comprehensive district health plans. Funds were being allocated to eye care activities for the first time, so that districts no longer depended solely on donor support. Trachoma control had advanced significantly in the preceding four years through the International Trachoma Initiative. Implementation of the SAFE strategy had enabled Tanzania to offer surgery to 5500 people, to provide antibiotic treatment with azithromycin to more than one million people, and to create significant community awareness of the importance of sanitation and face washing for trachoma control. In May 2003, Tanzania had launched its own Vision 2020 plan. It would continue to support efforts to control major diseases causing blindness and to build effective public-private partnerships for the purpose.

Ms GIBB (United States of America) welcomed the collaboration between WHO and the International Agency for the Prevention of Blindness. Another example of public-private partnership was WHO's partnership with the pharmaceutical company Merck in combating onchocerciasis in West Africa. Trachoma, onchocerciasis and xerophthalmia were serious challenges in many countries. Cataracts affected the ageing population in developed and developing countries alike. Since 1979, the United States had collaborated through its technical agencies with WHO in work to eliminate avoidable blindness, and would continue to do so. She supported the draft resolution.

Dr MOHAMMAD (Oman) said that national efforts to counter the causes of blindness should be stepped up and supported, especially where the causes, such as trachoma, could be prevented at low cost. Developing countries needed to formulate appropriate strategies, based on primary health care and technology transfer, for tackling other causes such as diabetes. He supported Vision 2020 and the draft resolution, with the amendments proposed by the delegation of Morocco. The Eastern Mediterranean Region had been the first WHO Region to adopt Vision 2020 which was supported by all the countries of the Region.

Mr ASLAM (Pakistan) pointed out that, of the 45 million blind people in the world, most were either elderly people or young children, and that blindness mainly affected developing countries. The prevalence of blindness in Pakistan was about 1.8%, two-thirds of which was preventable. In response to WHO's Vision 2020 initiative, in March 2001 his Government had launched a national programme for blindness prevention, with the support of several international nongovernmental organizations. Vitamin A supplements were being given to children in conjunction with measles immunization. He supported the draft resolution.

Dr TENNAKOON (Sri Lanka) said that since 1980-1981 Sri Lanka had played an active role in programmes for the prevention of blindness, with the help of the Helen Keller International programme and WHO, and had had reasonable success in controlling the prevalence of blindness in the country. In 2001 the Government had launched a national programme for Vision 2020, and in the light of the Global Initiative had reviewed and reorganized its activities. He commended the practical and reasonable targets set in the draft resolution, which his delegation fully supported.

Dr AL-HOSANI (United Arab Emirates) said that his delegation fully supported the aims of the Vision 2020 initiative, which it had endorsed in 2002. It intended to implement national plans to protect eyesight and eliminate avoidable blindness. A national committee was being set up to evaluate action taken to protect children's sight in school and to involve school health care facilities in

providing eye care. His Government would continue to support the Global Initiative, in close cooperation with the Regional Office for the Eastern Mediterranean. He supported the amendments proposed by Morocco to the draft resolution.

Dr AL-JABER (Qatar) mentioned the importance of the worldwide assistance given to developing countries in their fight to eliminate blindness. Governmental and nongovernmental agencies must work together to reach that goal. In his region a former major cause of blindness had been smallpox, which had been eradicated, and cases of onchocerciasis had diminished. However, it was still necessary to combat glaucoma, cataracts and all other diseases that led to blindness. The Vision 2020 initiative had been adopted in Qatar. His delegation supported the draft resolution, together with the proposed amendments.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), drawing attention to the incalculable socioeconomic consequences of avoidable blindness, said that the Vision 2020 initiative was an appropriate strategy, but each country must evaluate its own situation and tackle it with the resources available. Investment was needed to combat the diseases leading to blindness, to improve human resources and to develop appropriate infrastructure and technology. The mobilization of resources in and between the developing countries most in need should be a priority area for assistance from WHO, which should also support health systems to implement the goals of the Initiative.

Cuba had 805 trained ophthalmologists, almost one to every 10 000 people. Eye-care services were available nationwide and were accessible to all. Teachers also engaged in preventive work in the schools. New treatments had been introduced for the treatment of cataracts, and intraocular lenses were available to all who needed them. There was a school for blind and visually impaired people, who had the opportunity to contribute to social and economic development and were not marginalized within society. Emphasis was placed on preventing blindness by mobilizing the efforts of general practitioners, specialists, social workers and civil society. Prevention and rehabilitation efforts were proving successful in spite of Cuba's material shortages. He welcomed the suggestion that developed countries could contribute resources to help eliminate blindness. Cuba would be willing to share its experience in that field. He supported the draft resolution.

Mr AL-FAKHIRI (Saudi Arabia) supported the draft resolution. Saudi Arabia had been among the first countries to adopt the Global Initiative. It was concerned not only for its own people, but also for those in other countries who would benefit from the Initiative. His Royal Highness Prince Abdul Aziz Ibn Fahd was chairman of the International Committee for the Prevention of Avoidable Blindness.

Dr AHMED (Ghana) said that blindness had caused severe economic loss to Ghana since the colonial era. The northern part of the country had been devastated by onchocerciasis until 1974 when, as a result of efforts by the World Bank, WHO and others, a control programme had been introduced. Prevalence was at that time 80% but had fallen to below 5%, and economic activity in the area along the Volta Basin was booming, owing to the distribution of ivermectin, which was continuing throughout the country, particularly in forest areas.

Cataracts were common, especially in the elderly, and health workers had been trained to carry out simple operations in outpatient clinics and district hospitals. Trachoma had recently been identified as a major problem, particularly in some of the northern regions of the country. The Ministry of Health had set up a control programme in association with development partners and nongovernmental organizations. In order to combat avoidable blindness in children, routine sight testing had been introduced in primary schools and day-care centres in order to detect those with sight problems and provide appropriate treatment. The Government had also set up schools of optometry around the country in order to augment the number of personnel providing simple eye-care services. Vitamin A was routinely given to children as part of public health programmes, particularly in conjunction with measles vaccinations. His Government was convinced that it was possible to eliminate blindness using

cheap, simple and cost-effective measures. He supported the draft resolution, and the proposed amendments.

Mr JHA (India) said that his Government had launched a plan of action for Vision 2020 as part of the national blindness control programme. The plan involved improving the quality of services, preventive eye care and the optimal utilization of human resources. Cataracts, refractive errors, childhood blindness, corneal blindness, glaucoma and diabetic retinopathy had all been identified as target diseases. Blindness due to vitamin A deficiency had already been significantly reduced as a result of a vitamin A supplement programme.

Dr ABU RAMADAN (Palestine) expressed appreciation of WHO's work in combating blindness or "visual impairment", the term he preferred since it covered a larger proportion of patients. Despite having inherited a crippled health system in 1994, the Palestinian National Authority had launched an active campaign for the prevention of blindness and to promote accessible and efficient ophthalmic services. As in most countries, awareness of eye diseases among general practitioners had been low, leading to a huge overload for the limited number of eye doctors. A primary eye care system had been set up, involving the training of general practitioners to screen and treat simple eye diseases at community level; it had enhanced accessibility, relieved the load on eye hospitals and improved economic efficiency. The system could be replicated in other countries with similar conditions. It had become even more important since October 2000, when accessibility to treatment was again limited by Israeli curfews and the reoccupation of Palestinian cities.

A change had been noted in the causes of avoidable blindness as Palestine moved from being an underdeveloped to a developing country. It was experiencing an increasing percentage of visual impairment as a result of diabetes and ocular trauma, which should be added to the list of common causes of blindness. He requested further assistance from WHO for the purpose of improving and promoting primary eye care.

Dr YACH (Executive Director) thanked Member States for their strong support of Vision 2020 and the programme on avoidable blindness. It was evident that blindness reflected a failure of prevention of communicable diseases, such as trachoma and onchocerciasis, and noncommunicable diseases and conditions such as diabetic retinopathy, traumatic injury and malnutrition. Vision 2020 addressed the consequences, needs and prevention of blindness, and had been successful thanks to strong partnerships between the private sector, nongovernmental organizations, consumer groups and governments. WHO planned to continue pioneering such partnerships, and was ready to enhance its coordination roles at global and national levels to make the goals of Vision 2020 a reality. He acknowledged the expressions of ongoing support from donor countries, and the requests by developing countries for such support.

Mr WHITLAM (International Agency for the Prevention of Blindness), speaking at the invitation of the CHAIRMAN, said that most cases of blindness in the world were either preventable or curable. The World Bank and WHO both recognized that solutions for avoidable blindness were among the most cost-effective public health programmes in the world. Political will and appropriate resources were needed to rid the world of blindness.

The results of an economic impact study had shown that an investment of US$ 2000 million over the next 20 years to curb blindness would lead to a saving of US$ 102 000 million in productivity. His agency was currently spending over US$ 150 million on the problem. If States supported the draft resolution, the Agency would do what it could to assist them with the development of expertise and resources.

Dr FAAL (Sight Savers International), speaking at the invitation of the CHAIRMAN, explained that her organization worked in partnership with governments, nongovernmental organizations and WHO in 25 countries to prevent and cure blindness. In 2002, it had supported nearly 200 000 cataract

operations, more than 600 000 treatments for trachoma and 8.8 million treatments for onchocerciasis. In many countries there was an acute shortage of trained eye care personnel; in 2002 her organization had supported the training of nearly one million eye-care workers worldwide. It was working with the West Africa Health Organization and the Health for Peace Initiative to support ophthalmology training in the region, and was helping Sierra Leone to re-establish its eye-care services. The reduction of visual disability and the prevention of new visual disability brought tremendous benefits. Since the launch of Vision 2020 in 1999, governments and their nongovernmental partners had increasingly recognized the importance of healthy eyes and good sight. The unique partnership between WHO, governments, nongovernmental organizations and the private sector at international level should be replicated at the national level. She supported the draft resolution.

Dr KARAM (Secretary) read out the proposed amendments to the draft resolution: Morocco had requested that paragraph 1(1) be amended to read "to commit themselves to supporting the Global Initiative for the Elimination of Avoidable Blindness by setting up, not later than 2005, a national Vision 2020 plan, in partnership with WHO and in collaboration with nongovernmental organizations and the private sector". Two new subparagraphs should be added to paragraph 2 as follows: "(3) to ensure coordinated implementation of the Vision 2020 initiative, in particular by setting up a monitoring committee which would involve all of the participants including representatives of the Member States" and "(4) to report to the Fifty-ninth World Health Assembly on the progress of the Vision 2020 initiative". France had proposed an amendment to paragraph 2(2) which would then read: "to provide support for strengthening national capability to coordinate, evaluate and prevent avoidable blindness". With the first amendment tabled by Thailand, paragraph 1(2) would read "to establish a national coordinating committee for Vision 2020 or a national prevention committee which may include representatives from consumer or patient groups to help develop and implement the plan". Paragraph 1(4) should be amended to read "to include in such plans effective information systems ..." with the rest of the paragraph unchanged. Paragraph 2(2) should read "to provide support for strengthening national capability, especially human resource development, to assess and prevent avoidable blindness". Thailand had also proposed adding a new paragraph 2(3) to read "to document from countries with successful blindness prevention programmes good practices and blindness prevention systems or models that could be modified or applied in other developing countries".

**The draft resolution, as amended, was approved.**[1]

**The meeting rose at 16:55.**

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA56.26.

## NINTH MEETING

**Wednesday, 28 May 2003, at 09:50**

**Chairman:** Mr L. ROKOVADA (Fiji)

### 1. FIFTH REPORT OF COMMITTEE B (Document A56/65)

Mrs VELÁSQUEZ DE VISBAL (Venezuela), Rapporteur, read out the draft fifth report of Committee B.

**The report was adopted.**[1]

**The meeting was suspended at 10:00 and resumed at 12:35.**

### 2. STAFFING MATTERS: Item 18 of the Agenda (continued)

**Representation of developing countries in the Secretariat:** Item 18.2 of the Agenda (Document A56/40) (continued from the fourth meeting, section 3)

The CHAIRMAN said that a working group, chaired by the delegate of Brazil, on representation of developing countries in the Secretariat had held extensive discussions and its recommendations had been circulated as a revised draft resolution which read:

> The Fifty-sixth World Health Assembly,
>
> Recalling resolution WHA55.24;
>
> Having considered the report by the Director-General on representation of developing countries in the Secretariat;[2]
>
> Guided by the Purposes and Principles of the Charter of the United Nations, in particular the principle of the sovereign equality of its member states;
>
> Reaffirming the principle of equitable participation of all Members of the Organization in its work, including the Secretariat and various committees and bodies;
>
> Bearing in mind the principle of gender balance;
>
> Bearing in mind Article 35 of the Constitution,
>
> 1. EXPRESSES CONCERN over existing imbalance in the distribution of posts in the WHO Secretariat between developing and the developed countries, and the continued underrepresentation and nonrepresentation of several countries in particular developing countries in the WHO Secretariat;
>
> 2. APPROVES the updating of the various elements of the WHO formula incorporating the latest information available on membership, contributions and population;

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[1] See page 344.

[2] Document A56/40.

3. APPROVES the following formula for appointment of staff at the WHO Secretariat:
(1) contribution 45%
(2) membership 45%
(3) population 10%
(4) the upper limit of the desirable range would be subject to a minimum figure based on population as follows:

| | |
|---|---|
| Up to 1 m | 0.379% of 1580 or an upper limit of 6 |
| Over 1 m and up to 25 m | 0.506% of 1580 or an upper limit of 8 |
| Over 25 m and up to 50 m | 0.632% of 1580 or an upper limit of 10 |
| Over 50 m and up to 100 m | 0.759% of 1580 or an upper limit of 12 |
| Over 100 m | 0.886% of 1580 or an upper limit of 14 |

4. SETS a target of 60% of all vacancies arising and posts created over the next two years in the professional and higher graded categories, irrespective of their source of funding, for the appointment of nationals of unrepresented and underrepresented countries in particular developing countries on the basis of the formula in paragraph 3 in all categories of posts particularly the posts in grades P-5 and above, taking into account geographical representation and gender balance;

5. REQUESTS the Director-General:
(1) to give preference to candidates from unrepresented and underrepresented countries in particular developing countries on the basis of the formula in paragraph 3 in all categories of posts particularly the posts in grades P-5 and above, taking into account geographical representation and gender balance;
(2) to submit a report to the Fifty-seventh World Health Assembly on implementation of this resolution.

Mr COSTI SANTAROSA (Brazil), speaking as Chairman of working group, said that the draft resolution was a compromise that had been agreed after long but constructive negotiations in the working group. Some delegations, however, had expressed reservations. Basically, it updated the formula used for calculating representation in the Secretariat, by incorporating new percentages for contribution, membership and population (currently 55%, 40% and 5%, respectively). In addition, in paragraphs 4 and 5, the Organization was requested, in implementing the formula, to give preference to candidates from unrepresented and underrepresented countries, particularly developing countries.

Mr CHERNIKOV (Russian Federation) said that his delegation found the draft resolution unsatisfactory on two counts. First, it failed to reflect more equitable geographical distribution, both of posts in general and in the proportion of posts at D.1 level and higher. He assumed that the level of representation – or nonrepresentation – was taken into account with regard to appointments to high-level posts. Secondly, there seemed to be a somewhat discriminatory element with regard to countries in transition since, as in the previous year, only two groups of countries were mentioned in the relevant paragraphs, thus running counter to the reference, in the preamble, to equality of Member States and to equitable participation. He wished to state for the record that his delegation utterly failed to understand the implicitly greater importance attached, for example, to nationals of Pakistan than to those of Kyrgyzstan, Tajikistan, Turkmenistan and other countries, or why citizens of Iran should take precedence over those of Azerbaijan. Should the Secretariat decide to adopt the controversial paragraphs concerned, he asked that the consistency of the methodology be ensured, and that, in considering the informal document on contribution adjustments, the number of industrially developed countries would not include those Member States that were not full members of OECD. His delegation reserved its position pending the plenary meeting. In that connection, he requested that the text be made available in Russian, which had the same status as English in the Organization.

His delegation was grateful for the help provided by members of the Secretariat during the preceding five months of discussions on grades, budget and posts.

Ms BLACKWOOD (United States of America) said that her delegation was unable to accept a change, as contained in paragraph 3 of the draft resolution, in the United Nations system-wide formula and considered that the issue needed to be solved in the context of the United Nations itself. She accordingly requested a roll-call vote on the draft resolution.

Mr HEMMI (Japan) said that Japan had hoped that it would be possible to achieve more equitable participation in the Secretariat. However, there was no need for haste in reaching a decision on the issue, in view of the fact that the WHO formula was based on the United Nations formula, which had been adopted by consensus after a lengthy discussion in the Fifth Committee. Given the difficulty of judging the impact of the change of formula on individual countries, his delegation was unable to support the resolution at the present time.

Mr SEADAT (Islamic Republic of Iran) asked whether any criteria adopted by the United Nations were automatically applicable to WHO, in the context of the present discussion.

Mr BOTZET (Germany) considered that the time was not yet ripe for a decision. His delegation had worked constructively within the working group and had defined its position. He consequently regretted that a decision was being called for at a time when many States were unclear as to the impact of the proposed changes. He further regretted that WHO was departing from the United Nations formula on an issue that should be considered on a system-wide basis. His delegation therefore associated itself with the statements made by the United States of America and Japan, and was unable to support the draft resolution.

Mr LEÓN GONZÁLEZ (Cuba) said that he would welcome a response to the question by Iran, concerning the automatic applicability to WHO of the United Nations formula. However, he agreed with the Russian Federation that the issue had been discussed over a period of many months and that it hinged on resolution WHA55.24, adopted by the Health Assembly in 2002, calling for a revision of the formula used for appointments in the Secretariat. Hence the purpose of the discussions at the present Health Assembly was to carry out the mandate conferred on it by that resolution. He failed to understand, therefore, why there were objections to the change of the formula proposed. His delegation supported the draft resolution.

Mr SAHA (India) said that his delegation, which had participated actively in the working group, had concluded that, although some delegations had reservations, they would not obstruct adoption of the draft resolution by consensus. The discussions in the working group had continued the discussions that had taken place in the Fifty-fifth World Health Assembly, which had culminated in the adoption of resolution WHA55.24. The draft resolution before the Committee had been prepared pursuant to that resolution. Some delegates had stated that the draft resolution departed from the United Nations formula, with the implication that WHO was deviating from the system. He requested clarification, therefore, as to whether a United Nations system-wide basis existed for the staffing of secretariats. India understood that there was no such basis and that it was therefore entirely appropriate for the Health Assembly periodically to discuss changes that would improve geographical representation. India strongly supported the draft resolution and urged other delegations to do likewise.

Mr M.A. KHAN (Pakistan) said that increased representation for developing countries in the WHO Secretariat and its expert advisory committees and expert panels had been on the agenda for a long time. In the light of resolution WHA55.24, document A56/40 addressed the need for increased representation of developing countries in the Secretariat and put forward some options. Extensive consultations and negotiations had taken place in that working group in April 2003. Areas of

divergence had emerged, but the debate had generally been constructive. The draft resolution proposed by Pakistan had been designed to accommodate the concerns of all countries that had participated in that working group. Further negotiations had thus taken place in the working group chaired by Brazil, at the end of which it had appeared that a compromise had been agreed by consensus. The package reflected concessions on issues that were extremely important to Pakistan. It was surprising that countries that had apparently indicated approval were asking for the draft resolution to be put to the vote. However, it was not clear whether they were referring to Pakistan's draft resolution or the compromise draft resolution that had just been introduced. A response to the question from Iran might clarify the situation.

Mr AITKEN (Chef de Cabinet) confirmed that the specialized agencies, funds and programmes of the United Nations system did not share a common method for calculating the representation of countries. Some funds and programmes had no methodology at all and did not use a representation system. Document A56/40 included some of the different formulas used by the United Nations and its specialized agencies. Generally speaking there was no consistency. WHO's current formula differed from that of the United Nations in that it included posts funded from extrabudgetary sources, as well as regular budget-funded posts. In past years, the Health Assembly had adopted its own resolution determining the formula to be used.

Mrs BENAVIDES COTES (Colombia) said that the discussions in the working group had begun with the intention of finding a better representational balance for developing countries in the Secretariat. The current formula had led to those countries being underrepresented and resolution WHA55.24 had addressed that imbalance. The working group had shown a willingness to find a consensus-based formula and most countries had adjusted their positions in the interests of reaching an agreement. It was therefore surprising that a vote had been requested. Her country would vote in support of the draft resolution. Some delegations had expressed concern about the impact that the proposed changes in the formula would have. In her view what mattered was that more posts should be filled by unrepresented, underrepresented and developing countries.

Mr SHA Zukang (China) noted that resolution WHA55.24 represented a unanimous decision by Member States. The desire for progress reflected in that resolution had been taken up and incorporated in the draft resolution before the Committee which, it was to be hoped, would be adopted by consensus. If a vote were decided on, the Chinese delegation would vote in favour.

Ms MAFUBELU (South Africa), commenting that her delegation had actively participated in the discussions of the working group, said that she had understood that the compromise package had been accepted. South Africa had willingly withdrawn its own proposal in exchange for a consensus decision, and it was disappointing that some delegations were requesting a vote.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) said that she had pointed out in the working group that her instructions did not allow her to join a consensus on the issue of the formula. Although the Secretariat had stated that formulas used by the specialized agencies varied, in the United Kingdom's view, WHO had rightly based itself on the United Nations formula as representing the most equitable basis. The issue was not a suitable one for discussion by non-experts. Although some countries would be adversely affected by the proposed new formula, that did not apply to the United Kingdom. Juggling formulas and amendments in a working group was not the right way to proceed. The delegate of China had stated that resolution WHA55.24 represented a unanimous decision. That was not the case since many countries had voted against it.

Mr BASSE (Senegal) recalled that the working group had devoted much time to considering a sensitive issue and it had seemed that a consensus had finally been reached. The request for a vote had therefore come as a surprise. He was still hopeful that consensus could be reached, bearing in mind

that Mr Aitken had confirmed that the United Nations approach allowed organizations some autonomy in devising their formulas. Furthermore, resolution WHA55.24 expressly recommended that there should be less emphasis on contributions, paving the way for a formula review. He called on Member States to adopt the draft resolution by consensus in the spirit of the working group and the interests of all developing countries.

Dr SONGANE (Mozambique) associated himself with the views expressed by South Africa and thanked Mr Aitken for removing any doubts about the legal implications of revising the formula. It was unfortunate that the consensus reached in the working group had evaporated in the Committee. Resolution WHA55.24 had been adopted and the time had come to agree on how its recommendations should be implemented.

Mr ARRIAGA (Mexico) said that his delegation had participated in the discussions with a view to redressing the imbalance and underrepresentation of countries, including developing countries, in the Secretariat. Mexico supported the draft resolution.

Mr M.A. KHAN (Pakistan), responding to the United Kingdom's point that countries had voted against adoption of resolution WHA55.24, asked whether that meant that countries that had not voted in favour of Heath Assembly resolutions were not bound by them. Member States needed to be clear about the sanctity of WHO resolutions, whether they were adopted by consensus or by a vote.

Professor CHURNRURTAI KARNCHANACHITRA (Thailand) welcomed the draft resolution proposed by the working group. It accurately reflected the recommendations contained in resolution WHA55.24, in particular paragraphs 4 and 8. In the spirit of constructive engagement, Thailand supported the draft resolution as it stood.

Dr PARIRENYATWA (Zimbabwe) expressed support for the position taken by South Africa. It was disappointing that the agreement reached in the working group had not been carried over into the Committee.

Mr M.A. KHAN (Pakistan), on a point of order, requested that the meeting be suspended to allow further discussion on the draft resolution.

**The meeting was suspended at 13:20 and resumed at 13:40.**

Dr PARIRENYATWA (Zimbabwe) said that his delegation was dismayed that the revised draft resolution before the Committee could not be approved by consensus. If the matter was put to a vote, his delegation would vote in favour of the text.

Mr M.A. KHAN (Pakistan) said that, if a vote were to be taken, it should be on the compromise text and not on Pakistan's original proposal.

Mr SAHA (India) suggested that some action should be taken to ensure that enough delegations were present to form a quorum for a vote.

Mr COSTI SANTAROSA (Brazil) said that his delegation, and many others, still hoped that the text could be adopted by consensus, and urged the United States delegation to withdraw its request for a roll-call vote.

Ms BLACKWOOD (United States of America) said that, although her delegation appreciated the efforts made in the working group to reach agreement, including the Brazilian delegate's work in

chairing the deliberations, it could not accept the text tabled and maintained its request for a roll-call vote.

Mr TOPPING (Legal Counsel), responding to a question by Mr LEÓN GONZÁLEZ (Cuba), confirmed that the requested roll-call vote related to the latest proposal tabled, namely, that of the working group. Abstentions were not counted in determining the number of votes required for a majority. On the question of a quorum, raised by the delegate of India and Ms BLACKWOOD (United States of America), he said that the number of credentials accepted for attendance at the current Health Assembly had been 187, giving a quorum figure of 94. Since, however, four delegations had not arrived, the number of participant delegations was 183, giving a quorum figure of 92; a count had shown that 107 delegations were present in the current meeting.

The following Member States would not be called because they had had their voting rights suspended in accordance with prior Health Assembly resolutions: Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Chad, Comoros, Djibouti, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kyrgyzstan, Liberia, Nauru, Niger, Nigeria, Republic of Moldova, Somalia, Suriname, Tajikistan, Togo, Turkmenistan and Ukraine. Nine Member States had not submitted credentials, and would not be called to vote. In addition, the following delegations, whose credentials for the current Health Assembly had been accepted but which had failed to attend, would likewise not be called to vote: Bahamas, Federated States of Micronesia, Saint Lucia, and Saint Vincent and the Grenadines.

**A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Gabon, the letter G having been determined by lot.**

**The result of the vote was as follows:**

**In favour:** Angola, Bangladesh, Belgium, Benin, Botswana, Brazil, Burkina Faso, Cameroon, China, Colombia, Costa Rica, Côte d'Ivoire, Cuba, Cyprus, Democratic People's Republic of Korea, Ecuador, Egypt, Ethiopia, Gabon, Ghana, Greece, India, Indonesia, Islamic Republic of Iran, Kenya, Kuwait, Lesotho, Madagascar, Malaysia, Mexico, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, Oman, Pakistan, Peru, Portugal, Qatar, Saudi Arabia, Senegal, Singapore, South Africa, Sri Lanka, Sudan, Sweden, Thailand, Tunisia, Uganda, United Arab Emirates, United Republic of Tanzania, Venezuela, Zambia, Zimbabwe.

**Against:** Belarus, Czech Republic, Germany, Ireland, Israel, Japan, Republic of Korea, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United States of America.

**Abstaining:** Australia, Austria, Canada, Croatia, Denmark, Fiji, Finland, France, Guatemala, Haiti, Honduras, Hungary, Iceland, Italy, Jamaica, Luxembourg, Monaco, New Zealand, Norway, Papua New Guinea, Paraguay, Philippines, Poland, Romania, San Marino, Serbia and Montenegro, Slovakia, Spain, Switzerland, Turkey, Uruguay.

**Absent:** Albania, Algeria, Andorra, Azerbaijan, Bahrain, Barbados, Belize, Bhutan, Bolivia, Bosnia and Herzegovina, Brunei Darussalam, Bulgaria, Burundi, Cambodia, Cape Verde, Chile, Congo, Cook Islands, Democratic Republic of the Congo, Dominica, El Salvador, Equatorial Guinea, Eritrea, Estonia, Gambia, Grenada, Guinea, Guyana, Jordan, Kazakhstan, Kiribati, Lao People's Democratic Republic, Latvia, Lebanon, Libyan Arab Jamahiriya, Lithuania, Malawi, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Nicaragua, Palau, Panama, Rwanda, Saint Kitts and Nevis, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Slovenia, Solomon Islands, Swaziland, Syrian Arab Republic, The former Yugoslav Republic of Macedonia, Timor-Leste, Tonga, Trinidad and Tobago, Tuvalu, Uzbekistan, Vanuatu, Viet Nam, Yemen.

**The draft resolution was therefore approved by 57 votes to 10, with 31 abstentions.**

Mr BÁRCIA (Portugal) said that Portugal had voted in favour of the resolution for reasons that went beyond the merits of the text itself. First, it could not have voted otherwise after having taken part in negotiations that had reached consensus despite certain reservations. Secondly, after the approval of the scale of assessments, Portugal had wished to help to end the excessive politicization and North-South tensions in WHO so that the Organization could concentrate on its fundamental purpose: health for all.

Mr M.A. KHAN (Pakistan) expressed his gratitude to all delegations that had taken part in the consultations on that important resolution, and in particular those who had made concessions to make compromise possible. The resolution that had been adopted was well-balanced and would enable WHO to move forward more effectively under the new Director-General.

Ms MAFUBELU (South Africa) said that South Africa remained convinced that the purpose of resolution WHA55.24 was to increase the representation of developing countries in the Secretariat and not of unrepresented or underrepresented countries in general. It was regrettable that what had been understood as a consensus package had turned out to be a compromise subjected to a vote. South Africa had withdrawn its proposal, which would have advanced the interests of developing countries in keeping with resolution WHA55.24, in good faith in order to facilitate consensus. In good faith, too, it relied on the Director-General to ensure that the representation of developing countries in the Secretariat and the principle of gender balance received the attention they deserved. South Africa looked forward to receiving the Director-General's report to the Fifty-seventh World Health Assembly on implementation of the resolution.

Mrs BERGER (Switzerland) said that the question of equitable representation of Member States in the Secretariat was important in enabling the Organization to discharge its numerous tasks in proper conditions. Switzerland had therefore taken an active part in the working group and had been ready to accept the compromise reached. Unfortunately, the positions earlier expressed had made it difficult for Switzerland to support the compromise and her delegation had received clear instructions to abstain. That situation had been unfortunate since Switzerland was always ready to explore ways of redressing recognized imbalance in the Secretariat. As the resolution had been approved, Member States should support the Secretariat in taking the appropriate measures to achieve a proper balance.

Dr PARIRENYATWA (Zimbabwe) said that the fact that the vote had not reflected a typical North-South divide would improve solidarity among Member States. He looked forward to the report to the Fifty-seventh World Health Assembly on implementation of the resolution.

Dr CHITUWO (Zambia) said that the principle of consensus was one of the hallmarks of the Health Assembly and was always preferable to a vote. A resolution like the one adopted had no winners or losers since its beneficiaries were the people who looked to WHO for leadership in public health issues. Such a spirit should continue to serve human beings in the field of health.

## 3. SIXTH REPORT OF COMMITTEE B (Document A56/67)

Mrs VELÁSQUEZ DE VISBAL (Venezuela), Rapporteur, read out the draft sixth report of Committee B.

**The report was adopted.**[1]

## 4. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

**The meeting rose at 14:35.**

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[1] See page 345.

# PART II

# SUMMARY RECORDS OF THE ROUND TABLES

**ROUND TABLES: HEALTHY ENVIRONMENTS FOR CHILDREN:** Item 10 of the Agenda (Document A56/DIV/4)

**Salle XII, Tuesday, 20 May 2003, at 15:30**

**Chairman:** Dr W. AL-MAANI (Jordan)

The CHAIRMAN, opening the round table, invited Dr H. Abouzaid, Regional Adviser, Supportive Environments for Health, Regional Office for the Eastern Mediterranean, to introduce the subject.

Dr ABOUZAID (Facilitator) said that the round table provided an opportunity to share experiences, identify constraints and obstacles to success and to examine the role of the health sector and how it worked with other sectors. Participants might discuss the role of local and national government, exchange examples of successful advocacy for children's environmental health, and suggest how WHO could facilitate action to ensure healthy environments.

The rationale for addressing environmental risks to children's health was based on several factors: the disproportionately high share of risk borne by children; their specific vulnerability; the lifelong ill-health and disability associated with early exposure to environmental hazards; and the high percentage of population under 15 years of age in many developing countries. Recent estimates of burden of disease pointed to six risk areas as global priorities: household water security; hygiene and sanitation; air pollution, including indoor air pollution and environmental tobacco smoke; vector-borne diseases; chemical hazards such as lead, mercury and unsafe use of pesticides; and unintentional injuries, although specific risk factors and issues might be a higher priority in certain communities or settings. Of particular importance was the frequent exposure of children to several such risk factors simultaneously. An integrated approach that tackled the multiple risks to children's health in various settings and involved children themselves was called for. Such an approach also underscored the importance of intersectoral action, such as supporting national and local movements, and establishing healthy environments for children's centres.

The representative of MYANMAR said that, despite a considerable reduction in infant and child mortality in the South-East Asia Region over the past decade, more could be done to ensure a healthy, safe and supportive environment for children. Socioeconomic changes, the epidemiological transition and technological advances had had a strong impact on children's lives, and both the physical and social environment had to be conducive to children's growth and development. Myanmar had adopted a life-cycle approach covering health from conception to adolescence and youth. The Ministry of Health had given priority to providing safe water and sanitation, and had promoted personal hygiene for children. For six successive years national sanitation weeks had focused on the construction of sanitary latrines, especially in rural areas, promotion of personal hygiene and measures to control disease vectors, especially mosquitos, through social mobilization and community participation. Measures included raising awareness to combat indoor air pollution from the use of biomass fuel and coal, and priority had been given to control of chemical hazards. The Health Promoting Schools programme, which included a strong environmental health element, had been implemented nationally. In collaboration with the Ministry of Education, school health weeks had been held; and for the unfortunate minority not in school, community-based sanitation, health and education programmes had been expanded through work with national nongovernmental organizations, particularly the

Myanmar Maternal and Child Welfare Association and the Myanmar Red Cross Association. Myanmar would do its utmost to fulfil the promises made at the World Summit for Children 1990.

The representative of SAUDI ARABIA said that his country had taken part in the international campaign for a healthy environment for children, the latter constituting some 45% of the population. Activities had included the holding of a symposium in April 2003 in relation to World Health Day; a year-long Ministry of Health programme on a healthy environment for children; and the creation of a national committee, under the aegis of the Ministry of Health, to promote better living conditions for children. Steps had also been taken to enhance environmental awareness among schoolchildren. Environmental protection programmes, including measures to improve health care and sanitation services, had been initiated in several regions.

The representative of ALGERIA said that the first task was to identify concrete measures that could be taken to improve the environment for children with results that could be verified and evaluated, and, secondly, to consider what means had to be made available. The primary focus should be on the range and coverage of vaccines available. Less advantaged countries, such as Algeria, which had a twofold burden of poverty and an ageing population, should be encouraged to look at the achievements of the wealthier countries and attention should be given to ways in which WHO could help countries to promote the Expanded Programme on Immunization. Other national programmes, such as school health, were also important. Algeria had more than 200 child health monitoring units which, in addition to screening, provided health education for the entire family. Strengthening the school health care system, therefore, was a valuable measure that should be promoted by all governments. Despite notable improvement in Algeria's health indicators, much remained to be done. Particular efforts were being made in the area of infant mortality for example, which had been dramatically reduced since 1962 to the current figure of 32 per 1000 live births. Attention to the environment was also important, particularly in relation to problems stemming from rural exodus and population movements caused by conflict. In that connection, the highest priority should be given to the provision of basic services such as water and sanitation. In Algeria, 85% of all households, including those in rural areas, had access to drinking-water and 65% to sanitation services. In all those areas, national health ministries had a regulatory and promotional role, which should enable them to exercise influence on other ministries. In Algeria the establishment of a Ministry of Environment had made legislative advances possible almost immediately; and children had been invited to participate in relevant discussions in the National Assembly. In environmental management, decentralization was the best way of promoting local awareness, community participation and the protection of children's rights.

The representative of ROMANIA said that her country considered a healthy environment for children to be a priority and had included it in the community public health programme of the Ministry of Health and Family, in order to monitor physical development, assess environmental conditions in educational facilities, conduct periodic examinations and epidemiological screening of schoolchildren and students, and monitor the behavioural risks to health. Results had shown the main risks to be overcrowding, inadequate water supply, microclimatic conditions, unsuitable lighting and old furniture. Early identification of risk factors such as pollution or behavioural risks such as an unhealthy diet, smoking, alcohol or drug consumption was crucial for children's health and well-being. An assessment of some 10% of Romania's educational facilities in 2002 had shown that about one-third of the buildings were unsuitable. In urban areas, schools had mains water for the most part, but in rural areas almost 10% of schools lacked their own supply. Major problems, such as inadequate furniture and the lack of gymnasium facilities, had contributed to an increase in various disorders such as lowered general resistance, spinal deformities and visual disorders. The task of improving educational environments involved not only the Ministry of Health and Family but also, in partnership, the Ministries of Education and Environment, local authorities and civil society.

The representative of ANGOLA, commenting that a healthy environment for children was essential to their stable growth and development, said that her Government gave priority to women and children in health care delivery. Of Angola's 13 million inhabitants, more than six million were under the age of five. The country was experiencing peace after three decades of devastating civil war which had destroyed the basic sanitation, education and health systems and had resulted in family disintegration, displaced persons and the problem of street children. Many children lived in an environment of permanent risk, where land mines, street violence, traffic hazards and domestic accidents were commonplace. The climate and inadequate sanitation facilitated the spread of waterborne and vector-borne diseases. The main causes of morbidity and mortality of children under five years of age were malaria, acute respiratory diseases and diarrhoea.

Governmental interventions focused on reducing risk factors, promoting strategies such as rolling back malaria, extending integrated management of children's infections, and implementing community initiatives relating to water sources, better latrines, garbage treatment, mine clearing and family identification and reunification. Such activities involved various partners such as the Ministries of Education and Social Reintegration, nongovernmental organizations, multilateral and bilateral partners as well as bodies in the United Nations system. Only through a multisectoral and intrasectoral approach and the adoption of oriented policies could health be improved. WHO had a fundamental role in mobilizing the requisite technical and financial resources.

The representative of BOTSWANA said that generations of children had faced basic environmental risks: unsafe drinking-water, poor sanitation, indoor air pollution, insufficient food hygiene, poor housing, and inadequate waste disposal. The percentage of rural households with access to a safe water supply had increased from 68% in 1993 to 98% in 2003, meeting one target of the National Programme of Action for Children. A national waste-management strategy, which included the relocation of rubbish dumps away from human settlements, had been drawn up. The Government continued to promote road safety, by regulating traffic, maintaining a speed limit of 120 km/h, and teaching road safety, especially in schools. Like other developing countries, Botswana continued to face modern risks, such as the unsafe use of poisonous chemicals, improper disposal of toxic wastes, noise, and industrial pollution. A chemical safety programme had been in place since 1998, and legislation was expected to be adopted soon to regulate industrial and household chemicals, and set standards for the labelling and classification of chemicals.

The representative of UZBEKISTAN said that his country fully supported the WHO initiative to create healthy environments for children. For several years a special programme had been in place to protect children's health in Uzbekistan, where more than 40% of the population was under 14 years of age. Its main objectives were to ensure that all children had access to medical care and to protect them from the harmful effects of the environment, in view of the many areas in Central Asia and Uzbekistan in particular, such as the Aral Sea region, where children's health was seriously at risk. Maternal health was also considered to be an important aspect of children's health and was promoted accordingly.

In recent years immunization coverage had been extended to 98% of the child population. Physical education and sport were also being encouraged, and a fund for the development of children's sport had been set up under the chairmanship of the President of Uzbekistan, reflecting the political importance attached to the issue. Education, both before and in school, about health was vital.

The representative of BENIN said that Africa was seriously affected by environmental problems; the child mortality rate due to diarrhoea and malaria, for example, both environment-related, was highest in developing countries. Benin had created a Ministry of the Environment that worked with the health sector, the Ministry of Agriculture and the Ministry of Education, which had its own environmental health education section for children. In common with many other countries, Benin's environmental problems, such as the pollution caused by thousands of motorcycle-taxis, persisted for economic reasons. The Healthy Environments for Children Alliance would enable funds

to be raised for tackling the many environmental problems that affected children's health, and deserved strong support.

The representative of MOROCCO emphasized the need for strong intersectoral synergy, including cooperation between the public and private sectors in tackling the environmental problems affecting the health of children. As well as promoting health and prevention and ensuring care services for children, the Ministry of Health should take the lead in sensitizing society to the link between children's health and the environment, so that all development activity prioritized health in general and children's health in particular. Morocco had adopted that approach and, in addition to extending and improving its immunization programmes, had formulated new integrated programmes to combat poverty, extend water and sanitation services to rural areas, and combat air pollution, among others. Morocco also had a national observatory of the rights of the child and a children's parliament, which enabled children to debate issues among themselves, with adult parliamentarians, and government ministers.

The representative of LATVIA said that a public health strategy had been approved in her country in 2001 to promote environmental health, with a particular focus on children and young people, and programmes were being prepared to implement that strategy. A national AIDS programme had already been approved. Legislation on hygiene requirements for kindergartens and schools had been passed, and standards for water, air, waste and vibration set. In 1996, Latvia and five other countries, with WHO support, had initiated national environmental health action plans in the European Region, and an international impact assessment would be presented at the ministerial conference on environment and health to be held in Budapest in June 2004. A new programme for children suffering from drug and substance abuse would be launched in Latvia on 1 July 2003. Under Latvia's national alcohol programme, drawn up in collaboration with WHO, a plan was being implemented to reduce consumption by teenagers. A project had been launched three years earlier by the public health promotion centre to eliminate tobacco smoke pollution and create a healthy and safe environment for children by reducing the levels of tobacco smoke in the home and indoor public places, and increasing knowledge and awareness among parents and health professionals. Other important activities included a breastfeeding programme in collaboration with hospitals, local authorities and health professionals, an agreement to promote health programmes in schools, signed on World Health Day 2003, a salt iodization programme and 10-year healthy food project that included a milk programme for schools.

The representative of the RUSSIAN FEDERATION said that the ecological and environmental changes brought about by the revolution in science and technology had had adverse effects on children and young people. In his country the effects were particularly noticeable in urban and industrial areas where air, water and soil pollution, accidents, infectious diseases, poor sanitation and hygiene, among other risks such as poor nutrition and noise, were common. Furthermore, more than 80% of children attended some form of educational establishment where some 20% of health problems originated. Not even the best-organized health systems could resolve these problems alone, as most were related to environment or lifestyle. The creation of a healthy environment for children was therefore the right approach to tackling childhood ill-health. That issue had been given great attention in his country in recent years, where environmental improvement for the benefit of children and young people was governed by a single unified policy, which had been based on the recommendations of the international community, including WHO, on scientific research and constant and rigorous environmental monitoring. A national environmental protection programme, developed in 2001 and which included legislation and standards, was being implemented in close cooperation with various ministries and WHO's Regional Office for Europe.

The representative of TURKEY said that the vulnerability of children to environmental hazards should be combated by creating awareness in the community that air, water and soil should be unpolluted. The role of government was paramount, and the health sector had to secure the

commitment of the education, environment and finance ministries to multisectoral action to improve the environment and thereby prevent ill-health. The role of civil society, involving nongovernmental organizations and the private sector, was also important. Nongovernmental organizations could effectively raise community awareness and demand action; in Turkey, for example, many already worked with schoolchildren to clean up the environment by collecting paper, plastic and bottles, and, in urban areas, a major community movement had developed to protect children and young people working in car-repair workshops from pollution and from long and difficult working conditions. It was the private sector's social responsibility to develop safe and inexpensive medicines, safer alternatives for pest control and alternative sources of energy.

There were obstacles, however, to organizing such initiatives in poor communities. A focused investment was needed on the part of political leaders, women's groups, professional societies and local officials. It was also essential to review environmental legislation, to ensure that local authorities gave priority to environmental action and for nongovernmental organizations, health workers, teachers and religious leaders to promote hygiene and healthy behaviour in the home and the community.

WHO's role was crucial to all those efforts. For example, it could help keep the issue high on the international health agenda and sensitize decision-makers and donors. It could create regional networks to assist in research and education. Finally, it could provide generic evidence-based guidelines to assist countries in tackling legislation, policy and service delivery.

The representative of COSTA RICA said that her country had demonstrated its commitment to children in many ways. The focus of health care had moved from illness to healthy lifestyles and to an emphasis on the rights of the child, and from an emphasis on the individual to a broader collective focus. School programmes aimed largely at creating healthy schools benefited children generally and in particular those in deprived urban and rural areas. The fortification of food with vitamin A, folic acid and iron had reduced infant mortality from neural tube defects; nevertheless, monitoring of infant mortality had shown that out of 700 infant deaths, most of which were related to the quality of delivery care, a large proportion had been caused by communicable diseases such as diarrhoea and acute respiratory infections, and could have been prevented with better health care.

One year after the adoption of a law on responsible paternity, the country's birth rate had fallen by 8%. In other words, a policy enforcing adult responsibility for children had led to a change in sexual behaviour particularly among men.

The progress made was undoubtedly due to intersectoral and multidisciplinary action, on the one hand, and to making children and young people a priority at the national level, on the other.

Costa Rica recognized the importance of the Health Assembly as a forum for the exchange of experience and congratulated Taiwan on its health achievements and constant efforts to achieve observer status for the sake of its children.

The representative of RWANDA said that major efforts had to be made to ensure that children would grow into healthy, responsible and productive adults. Children formed a vulnerable group and needed well-defined protection mechanisms that would permit balanced development, the greatest threats to which came from their family, school and community environments. Environmental risks varied from place to place. Whereas in the industrialized world constant stress was a risk, in the developing world the greatest risks, for malaria, diarrhoeal disease, tuberculosis, intestinal parasitoses, AIDS and atypical pneumonia, were related to the environment or socioeconomic conditions. Solutions could come only through improved sanitation and hygiene. Mass population movements in response to natural catastrophes and armed conflict also had a particularly harmful effect on children.

Governments of all countries needed to have the will to reduce morbidity and mortality in children. In developing countries, that will was thwarted by the lack of resources, hence the need for joint action and intercountry strategies within the framework of south-south and north-south cooperation.

Following the 1994 genocides in Rwanda that had created a new generation of street children, the government had taken several measures to improve the environment, including the creation of a

Ministry of the Environment, a national catastrophe management committee, a school medical service and a nutrition department. It was also setting up a system of waste collection and treatment and was drafting a law on the production, advertising and sale of tobacco. Creating a healthier environment was an ambitious objective but one that, if achieved, could help control most childhood diseases.

The representative of EGYPT said that the priorities of the Ministry of Health and Population of her country included environmental improvement, disease prevention and nutritional programmes for children. Its "Healthy Egyptians 2010" initiative, an integrated public health programme involving ministries, associations and communities, aimed at optimizing health and minimizing environmental hazards, particularly those that affected the health of mothers and children. A national committee for disease prevention included representatives of all major bodies involved in the different aspects of the issue and in the preparation of a national action programme to tackle the causes of disease. Egypt also had a tobacco-control initiative and a special initiative on prenatal care and maternal health that was designed to reduce maternal and child mortality, improve the nutritional health of both mother and child and promote reproductive health.

The Ministry was also taking steps to ensure equality of access to high-quality health care through the application of health insurance for all neonates. Coverage had reached 85% in 2002. Intensive neonatal care, provided through some 200 units in public hospitals and educational institutions throughout the country, had reduced neonatal mortality to just over 15 per 1000 live births in 2002. As part of a comprehensive programme to prevent communicable diseases in children, the State had allocated 500 000 Egyptian pounds per year for vaccines and personnel to protect children from nine diseases. As a result, the death rate from measles had fallen and no cases of pertussis, diphtheria and neonatal tetanus were seen. Vaccination coverage already extended to 92% of children up to two years of age.

Egypt was also carrying out a disability-reduction programme based on early warning of the causes of disability and on the prevention of diseases and their sequelae. An early warning system operated in 15 governorates to detect thyroid disorders and prevent mental retardation. A strategy had been formulated to provide health services through specialized services for homeless children and children with special needs, and, in collaboration with WHO, programmes aimed at promoting community participation and behaviour change were being implemented and were already showing positive results.

The representative of MALI said that her country appreciated WHO's support and the initiative taken to link child health with the environment. Her Government had used that as an opportunity to carry out an awareness-raising campaign throughout the country. Environmental risks to child health were all too real. Only 42% of the population had access to clean drinking-water, and even fewer to basic sanitation services, including the disposal of solid and liquid waste which encouraged proliferation of mosquitos and hence the spread of malaria. With little electric power being produced, wood was burned to meet energy needs, resulting in widespread smoke pollution in kitchens and communities alike. Urban air pollution was also at a high level.

The Ministry of Health was collaborating with other ministries and departments in programmes to provide safe drinking-water, to improve hygiene and to introduce life-style education with a focus on family life. Mali had also created an agency for food safety and promulgated anti-pollution legislation on waste disposal. A "Health City" initiative involved clean-up operations and the supply of water to markets, schools and other public places. However, those programmes and actions were beset by obstacles: sanitation was given little attention in health programmes; it received inadequate financial and human resources, and the institutional, legislative and regulatory framework was also inadequate. The solutions proposed were to make sanitation a priority of the health development programme and to establish a health/environment policy under the Ministry of Health. The support of WHO in mobilizing financial and human resources and developing policies and programmes would be invaluable.

The representative of QATAR said that his country was small with an infant mortality rate of 8.2 per 1000 live births. Immunization coverage for infants up to the age of one year was 97%; 100% of the population had safe drinking-water; and 80% had mains sewerage, with only 20% needing septic tanks. Qatar was in the process of rebuilding old schools to meet environmental requirements, including proper ventilation and safe playgrounds. Food inspection was compulsory for all schools. Flour was fortified with iron and folate, and salt was iodized. Qatar was also a signatory to the United Nations Convention on the Rights of the Child.

The country's main problem as far as child health was concerned was accidents. Plans were being made to reduce their incidence.

The representative of GRENADA said that many factors affecting child health could be controlled or prevented. Various perinatal diseases had their root causes in the environment. Among the main concerns were maternal exposures and poor nutrition during the prenatal period, and adverse conditions in the home in the days following birth. Acute respiratory infections were of great concern in the Caribbean, and chronic respiratory illness was a growing problem. Children under five were especially susceptible to diarrhoeal diseases, a problem to which poor domestic sanitation, lack of safe drinking-water and exposure to liquid and solid waste were important contributing factors. Among the most pernicious problems were physical injuries to children; at best they were the result of neglect and at worst the product of deliberate abuse.

Improving the environment in which children lived required both political will and community participation. The major problems to be tackled at the national and international levels were poverty and ignorance. Ignorance could be overcome by public education, an inexpensive but extremely effective initiative. Poverty-eradication programmes must be undertaken because the children of the poor were always the most vulnerable. The resources invested in children would yield great benefits in the future.

The representative of CÔTE D'IVOIRE said that diverse communicable diseases were prevalent in children and resulted in a high mortality rate. Moreover, lack of proper sanitation, the poor quality of drinking-water and waste management, road traffic, industrial and other accidents, careless personal hygiene, the sale of medicines in the street, and tobacco consumption were among the causes of environment-related diseases that also took their toll. In addition, a particular problem was caused by armed conflicts, with particularly serious effects on young children because of their vulnerability. Under that category he included a range of factors, from the images of war disseminated by the media, pollution of the environment, and witnessing of shocking events to the consequences of sexual violence suffered by women and children. Clearly, preventive action was required to counter such diseases and situations. Education and health promotion in schools could be an effective tool in that regard.

In his country programmes had been established to improve children's health; they included infant, school and university health activities and programmes. National programmes were also in place to improve water and sanitation services and to combat specific diseases, including malaria, which could be prevented only through appropriate environmental control. Training of health professionals to encourage changes in people's habits was essential, and he called for global partnership in the effort to ensure that sustainable development took place.

The representative of the COOK ISLANDS said that his country's Ministry of Health, in collaboration with the Ministry of Education, was implementing a school physical education programme focusing on different sporting activities during each of the four school terms. Having achieved 100% access to safe drinking-water, the Cook Islands was trying to maintain that situation, in the face of difficulties due to development, by stringent and regular monitoring. Changes in diet and the ready availability of fast and high-fat foods were slowly gaining a foothold in many Pacific island countries; it was forecast that coping with noncommunicable diseases take a greater part of the national budget if proposed action plans were not successful. Legislation on the quality of imported

food might reduce the incidence of those diseases. His country was focusing on education, not only for children but also their families, as a primary means of ensuring that children enjoyed a healthy living environment.

The representative of CAPE VERDE said that, as a small island country, Cape Verde suffered from serious environmental imbalances which had serious effects on health, particularly for children. Nevertheless, thanks to the efforts of the people and with support from WHO and other international organizations, it had succeeded in improving health indicators significantly, particularly in the case of children. There had been a significant reduction in the infant mortality rate since independence in 1975, and vaccination coverage had increased. Further efforts were needed, however, to increase access to clean drinking-water, to raise immunization rates, and to improve sewerage systems. In particular, all the actors involved such as parents, teachers, the Government and United Nations organizations must be encouraged to participate keenly in order to improve the health of children in Cape Verde.

The representative of FINLAND, commenting that his country was in the privileged position of being a rich one in which children enjoyed good health and which had an excellent public health record, said that the topic under discussion was extremely important irrespective of the level of development of a country since the most important determinants of health were those that affected the most vulnerable people, including children. He stressed the positive side of the information he had heard from some of the poorest countries in the world and emphasized that, whatever the stage of development, there was always room for progress. The history of public health had shown that, once the right policies were in place, children were always the ones to benefit the most. There was a tremendous potential that could be tapped quickly and could produce excellent results.

From the perspective of the highly industrialized countries, he pointed out that the nature of environmental risks had changed but that they were constantly present. Although the physical man-made environment had been controlled up to a point, other serious threats to children had to be faced, in particular, the growing importance of the psychosocial environment in which children grew up, learned and played, the influence of the media, and changes in family patterns. The problems of violence, including the taboo topic of domestic violence, alcohol and drug abuse also had an impact on mental health. The international community must act together and provide a response by taking greater measures such as enacting legislation to counter the problem.

The CHAIRMAN, emphasizing the common features that had emerged from the interventions, the high level of recognition of problems, old and new, and the great strides that had been made to rectify matters, said that greater efforts were needed to improve children's health further, especially in terms of a wider definition of the word environment.

Speaking as the representative of JORDAN, he said that it was most important that bodies be established and legislation enacted to influence the behaviour of people and of governments, with the aim of making the environment safer for children. Jordan had taken positive action on ratifying the Convention on the Rights of the Child in 1991, forming national teams for early childhood development and family safety in 1999 and more recently setting up a national council for family affairs. The purpose was to prepare the plans required for ensuring the health of family members, supporting the family entity and fostering its empowerment, supporting various social institutions for the family, and raising public awareness of relevant issues. The maintenance of family unity, stability and self-sufficiency was seen as an important protective endeavour. A further project was the establishment of a national fund for protection of the family which would advise on human rights of children, ensure a proper approach towards children in the judicial system, and develop counselling and health services for mothers when there was abuse in the family, as well as preventive and therapeutic services for children. His country considered as very important the early detection of thyroid disorders in infants and diagnosis of diabetes at an early stage in pregnancy in order to avoid

negative effects on the child. It had recently begun giving a vitamin pill to every school child, at small cost. The project was being monitored and WHO would be informed of the findings.

Dr ABOUZAID (Facilitator) confirmed that the session had covered much common ground, especially as regards problems relating to nutrition and food safety, environmental concerns and substance abuse involving tobacco, drugs and alcohol. Three other important aspects had been mentioned: the psychosocial environment; war and conflicts; and natural disasters. The speakers who had mentioned settings had concentrated on the home and schools, and the effects of urbanization had been underlined. Many representatives had referred to the role of the health of mothers in the creation of a healthy environment for children.

On the question of national institutions, the importance of a committee or similar body on a healthy environment for children had been mentioned. In that context, intersectoral collaboration involving the ministries of health education and the environment was essential with strong leadership advocacy.

Some speakers had also referred to children's parliaments or similar institutions and, again, it was essential that the ministries of health should play a leading role in such matters. Many experiences or suggestions had been reported in the context of policies, including the importance of legislation and standard-setting, as well as community participation. The strengthening of expanded immunization campaigns had been highlighted and many speakers had mentioned the prominent role of education, the importance of poverty alleviation, and the monitoring of health risks.

WHO had been requested to provide evidence on the need for a healthy environment for children and to mobilize technical and financial support to countries. Great hopes had been expressed in relation to the Healthy Environments for Children Alliance and the possibility that it might promote south-south cooperation.

**The meeting rose at 17:30.**

## Salle XVI, Tuesday, 20 May 2003, at 15:30

**Chairman:** Mrs S. SWARAJ (India)

The CHAIRMAN opening the round table, introduced the facilitator, Dr J. Pronczuk, a toxicologist specializing in children's health and environment from WHO's department on the protection of the human environment.

Dr PRONCZUK (Facilitator) said that the purpose of the round table was to share experience on ways of offering children a healthier environment, to identify the main problems, to consider the role of the health sector and how it should interact with other sectors and, above all, to suggest how WHO could facilitate action to improve children's environmental health.

Children bore a disproportionately large share of the burden of global morbidity attributable to environmental factors. They were particularly vulnerable to environmental hazards, especially during "windows of susceptibility", when chemical or physical agents could have serious consequences for their development. Early exposure to such risks could have a long-term impact on health, or result in disability in adult life. In many developing countries, the under-15s made up a substantial proportion of the population.

Document A56/DIV/4 identified the leading environmental risks worldwide. Other types of risk might predominate in particular communities or environments. Because children were frequently exposed simultaneously to several risk factors at home, at school, at play and at work, an integrated holistic approach covering health in every setting was vital, with intersectoral action to keep those environments healthy, for example by supporting national or local movements or setting up children's environmental health centres.

She invited brief, focused comments that could form the basis for recommendations on how to create healthy environments for children, and that would identify promising and feasible action or strategies, secure a stronger commitment to the Healthy Environments for Children Alliance, and encourage more countries to launch national and local movements militating in favour of healthy environments for children, at both domestic and global levels.

The representative of BHUTAN said that his Government had invited children to participate in World Health Day 2003 and to express their views on the topic of a healthy environment for children. In order to get their message across, the hundreds of children who had taken part had sung a song composed by themselves, which he read out in translation. His Government was endeavouring to translate into policy the aspirations so expressed, such as availability of clean air and water, organic food, immunization programmes, safe families and communities, education, and protected biodiversity. It was committed to providing children in Bhutan with safe water and sanitation. It aimed to protect children against micronutrient deficiencies, to provide them with a less polluted indoor atmosphere so that acute respiratory tract infections could be reduced, and to prevent diarrhoreal diseases, a leading cause of child deaths. His Government was determined to obtain results in all those areas within four years.

The representative of NORWAY said that the treatment given by health ministries to the weakest members of society was a measure of human dignity. The Millennium Development Goals were relevant to children, since health targets were prominent among them, and environment and health were closely linked. Five million children died every year because of diseases caused by bad environments. Priorities for achieving healthy environments for children differed between countries; his Government was endeavouring to lower children's sugar consumption, and many other countries were struggling with malnutrition and food scarcity. In many countries, respiratory disease was caused by fumes from fuel used for cooking stoves, whereas in Norway respiratory health was threatened by tobacco smoke and air pollution.

National priorities might vary, but certain common principles held good everywhere. Children had rights, and action for them should be based on the Convention on the Rights of the Child, especially, Article 24. His Government had signed the Convention in 1991, and since 1981 his country had had an Ombudsman for Children, whose primary task was to advocate and protect children's rights. His Government would be pleased to pass on its experiences with that institution.

Alliances should be built between the health sector and other key actors. In Norway, the building of such alliances between public authorities at various levels, nongovernmental organizations, the private sector and individuals, had been given prominence in the health strategies set out in a White Paper presented to Parliament in January 2003. Since 1992, Norway had participated in the European Network of Health Promoting Schools, geared to improving the physical and social environment in schools. Involvement of pupils had been the key to success, because they had not only influenced the school environment, but had learned from other countries as well. His Government had also implemented an action plan, based on WHO's Safe Community Concept, to prevent injuries at home, in schools and in kindergartens. The way in which local authorities and the health sector had executed the activities and established alliances might be a useful guide for other countries. The evidence base was extremely important; people needed knowledge in order to protect children from environmental hazards. It was also essential to extend and improve existing knowledge and tools. A healthy environment would shape the future, and children were the future. Participants in the round table should be as imaginative as children in seeking solutions to current challenges.

The representative of PAKISTAN agreed with the representative of Bhutan that it was vital to listen to what children had to say. Children needed parents, a healthy environment and love, not hate, bombs, murders or killing. A basic cause of disease was the lack of peace in the world. A five-year-old Pakistani girl had said during an interview that neither children nor adults should fight. Politicians and other adults should learn from her words. No politician was elected to start a war. What was the point of a university education if people were unable to talk peacefully to one another and to resolve conflicts? Two million refugee children from Afghanistan had been living in Pakistan for almost 20 years. They, like other children from war-torn countries, had been terrorized by bombs. The media should show the effect of so-called "smart bombs" on children who had witnessed the deaths of their mothers and siblings. The biggest killer and destabilizing force in the world was war. Politicians should work for peace, as the world could not cope with conflicts on top of the host of existing health problems. Nothing could be achieved without peace.

The representative of THAILAND said that his Government had always been committed to the health and well-being of children. Since 1992 it had been a Party to the Convention on the Rights of the Child. Princess Chulabhorn had taken an interest in promoting a healthy environment for children, and had attended the ceremony in Johannesburg (South Africa) to launch the Healthy Environments for Children Alliance. A healthy environment was necessary for infants in the womb and throughout childhood. His Government's efforts, combined with those of nongovernmental organizations and local communities, centred on promoting a healthy environment at home, in day-care centres and in schools. Some 80% of schools were covered by health-promoting programmes. He concluded by showing a video film about activities in schools to promote children's health.

The representative of SOUTH AFRICA said that her Government supported the initiative on healthy environments for children. It was convinced that a better environment could contribute greatly to the health and development of children; all the relevant stakeholders in her country had signed a pledge of commitment in that respect.

The best way to involve children and communities in the Healthy Environments for Children Alliance would be to persuade adults to listen to children, to provide access to resources, to enhance technical skills and capacity, and to draw upon cultural systems and indigenous knowledge in order to build resilience. Although the health sector was taking the lead in tackling risks to children's health, it should collaborate closely with other sectors and children themselves in the process of identifying and solving problems. It should provide evidence-based information on children, environment and health to other stakeholders; facilitate cooperative governance and joint development planning; establish a resource centre to provide ready access to information; initiate standard-setting, for instance for lead in paints; identify indicators for the initiative; conduct research; and monitor and evaluate the programmes of the Alliance.

Her Government had initiated a wide range of cross-cutting policies and intervention strategies on children's health and environmental issues. It had adopted a cluster approach that had not only brought together the leadership of several sectors, but facilitated the introduction of a common mechanism for integrated programmes relating to the management of childhood illnesses and health promotion, such as the prevention of mother-to-child transmission of HIV and of violence in schools. Other strategies included an initiative to declare all schools in South Africa tobacco-free zones, a decision by Parliament to phase out the use of leaded petrol by 2006, a national accelerated electrification programme to reduce indoor air pollution, the provision of housing and water, education in personal hygiene, food security programmes, and programmes for refugee children. WHO and the Healthy Environments for Children Alliance could help countries by offering financial and technical support together with information, education and communication materials, by assisting intercountry networking and information-sharing and by establishing a set of core indicators on healthy environments for children.

The representative of CYPRUS stressed the need to develop child-focused environments and to integrate a child-protection policy within national environmental health action plans, with the active participation of all sectors of society and on the basis of valid data and appropriate indicators.

Cyprus had developed multipurpose, integrated, and prevention-oriented programmes, designed and implemented by the Ministry of Health in close cooperation with other ministries, voluntary organizations and local authorities. Integrated plans had been developed for early response to accidental pollution of the water supply system, and for the early detection of new emerging threats of pollution in water resources. Food hygiene and safety were promoted by action at the most critical control points of the food chain and the foods that featured prominently in children's diets. Cyprus had implemented preventive actions to reduce environmental hazards, based on legislation in line with European Union directives. Those measures included enforcing safety standards for contaminants in food, water, and air; microbiological control and the monitoring of food and water; policies to reduce traffic pollution and point and nonpoint contamination; periodic safety checks on schools and day-care centres; measures to increase safety and reduce average speeds on the roads; and enforcing safety standards for toys and other articles which could expose children to pollutants.

The Ministry of Health would in future take a more focused and integrated approach and formulate policies to tackle and prevent risks to children in an explicit and consistent manner. It would seek to build national capacities in children's environmental health protection, and to raise awareness by increasing the ability of health professionals to identify, prevent and reduce environmental health threats to children. It would develop programmes to deal with children's environmental health issues, take account of children in risk assessment and the setting of national standards, provide information and tools to the public, support European Union and international action to protect children, and provide mechanisms to enable parents, professionals and communities to make informed decisions and contribute to effective policies and interventions. The Ministry of Health would establish a multisectoral scientific advisory committee on environmental risks to children, with members from both the public and private sectors, to strengthen coordination at national level. Cyprus would collaborate with WHO and existing networks and would create links with similar structures at the international and European levels for the effective communication and prompt transfer of new developments. A healthy environment was not a privilege, but a basic human right, and was the most precious heritage for children and future generations.

The representative of BANGLADESH said that every child had the right to grow up, live, learn and play in healthy places. However, environmental degradation, disasters, events triggered by natural hazards, related technological and environmental events, as well as protracted social conflicts and wars, continued to imperil the vision of a safer, healthier world for children in all countries. Environmental risks to children's health were aggravated by persistent poverty and social inequalities. Moreover, recent armed conflicts had demonstrated that children were increasingly the targets of some of the most serious crimes known to humanity. Impunity for crimes committed against children adversely affected not only the individual victims but also a whole generation of children, undermining their development and the formation of their identity and values. That in turn had far-reaching effects on their ability to function as leaders and decision-makers in the future, with negative implications for future peace and stability.

World Health Day 2003 had highlighted the fact that children throughout the world were born with the fundamental freedoms and inherent rights of all human beings. If human rights were seen as a foundation for sustainable human development, the vision of a society with economic, political, social, environmental and cultural dimensions to its development would remain unrealized unless children's rights were promoted, preserved and defended.

The well-being of children called for political action at the highest level. Bangladesh was determined to protect children from all threats, including environmental risk. In 1994 it had adopted a national children's policy, aimed at assisting children in difficult circumstances, and was one of the 46 States that had ratified the optional protocols to the Convention on the Rights of the Child, on the involvement of children in armed conflicts and on the sale of children, child prostitution and child

pornography. However, ensuring a health environment for children should be everybody's concern. The environmental health risks to which children were often exposed had become transnational, and must be combated through global cooperation and intensive effort.

Improvements in science and public health that had enabled more children to survive their first years brought with them the responsibility of ensuring a healthy and stimulating childhood. The global community was aware of the value of investing in childhood and protecting children from environmental risks. Enhancing the cognitive and intellectual development of children by bringing children's needs into the mainstream of long-term health programmes that also protected them from environmental hazards was among the principal challenges of the new century. The international community agreed that children's rights should be respected and promoted, as was evident from the near-universal ratification of the Convention on the Rights of the Child, but that commitment should be translated into practice by the global community working together and sharing resources to safeguard a healthy and favourable environment for children.

The representative of SENEGAL said that in her country 54% of the population was under 15 years of age and 30% under five. It faced the same environmental problems that impacted on child health as other countries, but as a developing country it also had a problem with waste disposal, particularly in suburban and rural areas where children played in the rubbish heaps or sifted them for items to sell. There were also risks linked to pesticides: especially in rural areas, children were often poisoned by consuming pesticides stored next to foodstuffs. Thirdly, the social environment, blighted by poverty, the exodus from the countryside, parental unemployment and illiteracy, and harmful traditional practices, had a negative effect on children's health. The social environment underlay begging by children, sexual abuse of children and the exploitation of child labour, as well as deviant behaviour, such as smoking at a very young age and drug and substance abuse. The health of young girls in particular was affected by the practice of female genital mutilation.

Senegal had taken certain steps to protect children. The President of the Republic himself had decided that educational centres ought to be created for underprivileged children under five years of age in suburban and rural areas in order to provide teaching in health, nutrition and hygiene, with some formal education and instruction in new technology. The centres were staffed by volunteers and specialist teachers. A separate ministry had been set up to oversee the centres. The protection and promotion of children's rights was a government priority. Mobile medical and social services were provided for street children. There were advice centres for young offenders, and even a children's parliament, where children raised their own health issues.

The health sector in Senegal gave top priority to children, with a special department dealing with child nutrition and survival needs. There was also a multisectoral initiative to handle environmental problems, with the health minister playing a leading role, and a national commission on sustainable development involving all sectors with an impact on the environment. The education sector worked to combat smoking in schools. Some nongovernmental organizations were active in campaigning against smoking and female genital mutilation, and ran workshops for children on health issues.

WHO should help countries to evaluate their situation in respect of child health and the environment, and to identify appropriate indicators to enable them to follow up the strategies and actions to be implemented, regionally or internationally, to secure a healthy environment for children.

The representative of CAMBODIA welcomed the attention paid to children's health through the initiative on healthy environments for children and World Health Day 2003. The health of Cambodia's children was of great concern to its Government, and the reduction of early child mortality was one of the priorities of its health sector strategic plan for 2003-2007; the country had some of the highest rates in South-East Asia – an infant mortality rate of 95 deaths per 1000 live births and an under-five mortality rate of 124 deaths per 1000 live births. Since the dark years in the 1970s, under-five mortality had fallen steeply, from over 400 deaths per 1000 live births to about 150 by the early 1990s. Subsequent progress had been much slower than expected. The main causes of death for children were

perinatal conditions, acute respiratory infections, diarrhoea, malnutrition, vaccine-preventable diseases, malaria and dengue fever. All such conditions were linked to environmental factors, such as poor housing and lack of access to clean drinking-water and sanitation; poor family practices, in respect of infant and young child feeding; care-seeking behaviours; food insecurity; and access to preventive and curative health services. They were also linked to general environmental factors, such as climate change, deforestation and increasing urbanization.

Healthy environments for children was a broad concept. It ranged from environmentally-related asthma and allergies, an increasing concern in high- and middle-income countries, to poverty-related conditions in low-income developing countries. There was a risk of losing focus. The world should concentrate on a number of achievable results. At the Millennium Summit, the international community had committed itself to reducing child mortality and eliminating malnutrition. In low-income countries, the focus should remain on basic interventions to provide better living conditions for the poor, increase access to safe water and sanitation and promote good family and community practices related to personal hygiene, infant and young child feeding and the use of preventive health services.

The only healthy environment for children was one in which no easily preventable child death occurred. In a number of countries such as Cambodia, the target set for 2000 at the World Summit for Children had not been achieved. More attention should be given to the reduction of child mortality.

The representative of the NETHERLANDS said that the safety of children was a matter of particular concern for both the Netherlands and the Netherlands Antilles. Healthy children were the key to a healthy nation. Providing a healthy physical, mental, social and developmental environment for children called for special attention. Her Government had focused on healthy schools, safe and healthy living environments for playing and development, and safe and healthy housing. However, government efforts alone did not suffice: a multisectoral approach involving parents had to be adopted because a safe environment for children began in the home. She concluded by showing a video film about accidents to children that happened while they were supervised.

The representative of BOLIVIA said that his country's population was young: 35% were under 15 years of age. The infant mortality rate was 67 per 1000 live births, the main causes of death being diarrhoea and acute respiratory infections. Among children under the age of one, 78% of the deaths were due to diarrhoea and 22% to pneumonia. Among children under four, deaths from diarrhoea were also common, and 19% of deaths were due to pneumonia. For children of all ages diarrhoea continued to be a major problem. Childhood diseases and mortality owed largely to contaminated water and the lack of sanitation. Only 40% of Bolivia's population had access to water, of which only 25% had a domestic supply; the rest used a common source. Health problems must be tackled through water purification and supply. Food contaminated by pesticides and other agrochemical products was also a significant cause of morbidity and mortality. Only 25% of children in Bolivia enjoyed pure, safe and adequate food. The Ministry of Agriculture and the Ministry of Economic Development had been working together, focusing on food-production areas, to provide adequate food supplies for children and to improve the quality of life for the public.

Poverty and the environment interacted to impair the health of children. Accordingly, it was not enough for health programmes to focus on treating illness or the use of medicines; the environmental problem must be solved as well. In that light, Bolivia had developed a health programme providing blanket coverage for mothers, infants and pregnant women.

The representative of AUSTRALIA said that environmental risk factors contributed significantly to child morbidity and mortality. In Australia, childhood injuries, including poisoning, were the leading cause of child mortality and one of the main causes of ill-health. Type 2 diabetes among children was increasing; 20% to 25% of children were overweight or obese; and one in five school-aged children suffered from asthma as a long-term health condition. The situation was even

worse for aboriginal and Torres Strait Islands children; the disparities in health outcomes between indigenous and non-indigenous children were of particular concern.

Giving children a healthy start in life had to be a high priority in health and other systems. The best way to engage communities was through movements that ensured the participation of children and communities, which in turn called for good local-level involvement and meant listening to the views of the public.

The health sector should identify risks to child health and quantify potential harm. It should help to provide advice and education to the public about risks and strategies for avoiding or reducing them, using every means of communication, such as public statements, the media, role models and legislation. It should work with health educators, parents and youth groups to raise awareness about risks and their management. All relevant agencies, including ministries of education, social security and employment, should be mobilized. Governmental agencies should work alongside the nongovernmental sector, civil society and communities. The private sector should also be involved; the food industry, for example, should be encouraged to provide healthy choices.

Australia had developed guidelines to assess risks to human health arising from environmental hazards and the health impact of an activity or development. It had also published a guide on indoor air pollutants and ways to minimize them. Another publication set out the non-auditory effects of chronic noise exposure, such as from traffic or aircraft, on children's health and performance. Most Australian states and territories had implemented, or were planning to introduce, universal screening programmes to test the hearing of newborn babies.

Major road-safety initiatives, including mandatory child-restraint systems, had had a major impact on child death rates in Australia. Among the child-safety measures introduced were swimming pool fencing, child-resistant closures on pharmaceutical and household poison containers, and safety standards for children's toys and playgrounds. Numerous national and cross-jurisdiction measures had been set up to prevent childhood burns and scalding, including compulsory smoke alarms in all new homes, hot-water temperature gauges, and a range of standards to ensure that products used by children, such as nightwear, were fire-resistant. An environmental health initiative developed by an aboriginal council had been adopted in many parts of urban, rural and remote Australia. It promoted nine healthy living practices: personal washing; washing clothes and bedding; removing waste safely; improving nutrition; reducing overcrowding; separating people from animals, vermin and insects; reducing dust; controlling temperature; and reducing trauma.

The representative of the UNITED REPUBLIC OF TANZANIA said that systems safeguarding the environment had to be put in place from the time of a child's conception. That could only be achieved through an intersectoral, multisectoral and integrated approach, involving ministries of health, families, communities and health and other systems. The problems affecting children should be addressed comprehensively, rather than by segmented age groups.

Tanzania's ability to meet the health and other needs of all age groups was hampered by its limited resources, a problem that warranted critical examination by its development partners. Infant and mortality rates were still high. Infections and neonatal deaths resulted from malnutrition and unhealthy environments, and from lack of access to good-quality health services. Knowledge of the management of childhood diseases and injuries had improved, but the reach of essential interventions was still inadequate. Poverty continued to be the main common factor impairing the health of children. Poverty and gender inequities should be tackled together.

In Tanzania, the home remained a hazardous place. Many houses lacked proper ventilation and sanitation, schools were overcrowded, and some schools had very limited sanitary facilities. Cultural and traditional mechanisms of community control were being eroded by rapid methods of communication, such as television. Children were often innocent victims in traffic accidents. While active and viable policies had resulted in improved immunization of mothers and children, thus reducing the infant mortality rate, much had still to be done.

In addition to the ministry of health, other government sectors, including planning, finance, water, education, community development and agriculture, should play a part in ensuring healthy

environments for children. Voluntary and nongovernmental organizations should also be involved. An effective public-private partnership was extremely important.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND drew attention to five themes for action. The health and protection of children should be at the heart of policy, not only in the ministry of health, but also in the ministries of education, transport, trade, the environment and even finance. His country had in place several important cross-cutting policies.

An uncompromising quest was needed to root out health inequalities as they affected children. For example, the rate of pedestrian road accident deaths in the United Kingdom was five times higher among children from the poorest section of society than among those from affluent professional families. The health divide was common to many aspects of children's health. The gap must be narrowed if children's health was to be improved. High-quality local services must be available to protect children's health. His country was implementing a national service framework of standards for children's services, which were being inspected at local level.

Good information must be provided in order to track progress. It was vital to identify failure and to highlight and spread success. Where children were valued and their interests reflected in all the structures and laws of society, the path to good health would be smoother.

The representative of MALAYSIA said that the home, school and local community should be healthy places where children could thrive and be protected from disease. Health, environment and children were the three valuable assets in life; they were so entwined if one was unprotected it would affect the others. Malaysia had been advocating a "healthy settings" approach, using the five principles for health promotion enshrined in the Ottawa Charter. Malaysia had designated 180 healthy settings in 2002, all focused on children and the environment.

Although many problems had been solved over the years, new challenges had to be addressed. Improvements in health over the years had begun through the improvement of basic amenities, especially by providing safe water and proper sanitation. The data for 2001 showed that 92% of the population was supplied with safe water, and 99% of the rural population had adequate toilets. A rural environment sanitation programme, begun in the 1960s, had contributed to the good standard of sanitation. Malaysia had plenty of water all year round. However, the emergence of new viral diseases such as hand-foot-and-mouth disease, made it necessary to instil intensive hygiene practices, such as frequent hand-washing by children. That need was being met through a healthy-lifestyle campaign focused on schoolchildren. While impressive progress had been made in terms of vector control and reducing the incidence of malaria and filariasis, dengue fever was still a problem. Malaysia was committed, however, to good surveillance, law enforcement and interagency cooperation, to be able to cope with dengue as well.

Smoking contributed 80% of all indoor pollution, and almost 25% of adults and 17% of under-18s smoked. Efforts to control tobacco use were being constantly stepped up. Children were often the victims of unintentional injury, which was one of the leading causes of mortality and morbidity in Malaysia. A 1996 study had shown that road accidents accounted for 42% of all accidents, compared with 29% in the home, 18% in the workplace, 7% in recreational areas and 4% in schools. Interagency collaboration was vital to reducing unintentional injuries by generating better public information and education and bringing about law enforcement and environmental modification.

While the importance of ensuring children had access to adequate safe food was paramount, Malaysia was facing a problem of over-nutrition among children living in cities. It was hoped that by persuading major food manufacturers to produce healthier products and providing community education and legislation, the problem could be controlled.

The representative of FIJI said that the environmental health risks that contributed to increased morbidity and mortality in children were compounded by other socioeconomic factors, such as

poverty, unemployment, poor water supply and sanitation. Pneumonia and acute respiratory infections were the commonest causes of morbidity and mortality in children, in Fiji, and in 2000-2001 accounted for up to 40% of hospital admissions of children under five. To combat those and other major sources of disease and injury, Fiji had set up a Children's Coordinating Committee. Its brief was to set policy directions and to coordinate, monitor and evaluate all children's issues, programmes and activities implemented by government agencies. Specific measures to improve the conditions of children in Fiji included the integrated management of childhood illness and capacity building for service providers; the introduction of new combination vaccines; strengthening the adolescent reproductive health programme and introducing other sociobehavioural measures; implementing nutritional programmes, such as the fortification of flour; providing antiretroviral drugs to prevent mother-to-child transmission of HIV; and facilitating more baby-friendly hospitals and strengthening breastfeeding initiatives. Other measures included basic formal and informal educational programmes, strengthened child protection, the encouragement of interagency initiatives, improvements to water supply, sanitation and refuse disposal; enhanced community participation in public programmes; and meeting special needs of children.

The representative of KYRGYZSTAN noted that the problems were the same in many countries, but the solutions differed. Among several measures, Kyrgyzstan had adopted a national "New generation" programme and a law on family planning. Its national programme covered *inter alia* the environment, air pollution, clean water and the soil. All measures in favour of children were taken jointly by the different ministries concerned. But it was also important that schools and other group institutions should be enabled to develop their own programmes. He would like to see centres set up to protect the environment. Information on successful national experiments should be disseminated widely, with ministries of health and WHO doing more in that regard.

The representative of the MARSHALL ISLANDS said that his country's health care systems were based on the concept of primary health care as defined at Alma Ata. In 1995, the Yanuca Island Declaration for Health in the Pacific in the 21st Century had introduced the term "Healthy Islands" as a unifying theme for enhancing the health and quality of life of Pacific peoples. The Marshall Islands strongly supported the efforts of WHO to promote healthy environments for children, which would go far to address the unique challenges in providing health care to children, and to expand discussion on ways to improve the health of children everywhere.

The representative of BRUNEI DARUSSALAM said that, although most children in his country had access to good health care, hygiene, sanitation and safe drinking-water, several environment-related health risks to children remained, such as unintentional injuries, road-traffic accidents, and food poisoning in schools. Cross-border air pollution was also worrying, but measures were being taken to mitigate its effects. Legislation, including special protective measures for children, was being formulated to deal with pollution caused by tobacco smoke.

The health sector alone could not deal with all environment-related health risks. It had a three-part role: formulating legislation and policies to protect the public and consumers; designating other relevant agencies to participate in collaborative action; and educating the public, local communities, target groups and key stakeholders about environment-related issues.

In 2002, a national committee on health promotion had been set up, comprising six governmental agencies, a nongovernmental organization and a representative of the private sector. Seven main programme areas had been identified including environmental health, and action was specifically targeted at the settings approach. However, implementation of the programmes was hindered by the need for dedicated manpower, capacity-building and training. Where multisectoral involvement existed, a single leader was required to create momentum for the project, as well as effective coordination of the other members.

WHO should continue to play a facilitating role and to provide technical support to countries to help them build national and local capacities for implementing relevant programmes. His country supported the Healthy Environments for Children Alliance.

The representative of UKRAINE, observing that children's health had always been a priority for his country, focused on three areas of activity. The Ministry of Health had devised an intersectoral programme entitled "The health of the nation" to create healthy settings for children at school, at home and on holiday; it had been particularly useful in a heatwave. Doctors, teachers and psychologists were, however, concerned at the low level of physical activity among children. Extra physical education lessons would be incorporated into the curriculum of general and vocational schools, and individual programmes of physical education had already reduced the incidence of injury at home and at school. The number of pre-school facilities operating below standard had, on average, been halved in the past 10 years. Ukraine was also participating in the European Network of Health Promoting Schools.

The representative of CUBA noted that sustainable development had been defined, at the world summit on the subject in 2002, through its environmental, economic and social pillars. Creating a healthy environment for children also contributed to sustainable development. For that purpose, more effective interventions were needed to reduce poverty. Some 170 million children under five were underweight, and, according to *The world health report 2002*,[1] the gap between rich and poor was continuing to widen.

In Cuba the Government had adopted economic, environmental and social policies aimed at improving the quality of welfare services for young people, given that 21% of its population was under 15. In 2001, 98% of city dwellers and 85% of the rural population had access to clean drinking-water. The Government had invested more than 120 million pesos in solid-waste disposal systems which, at the time, covered 97% of the urban population and 84% of the rural population. Firms and industries were bound by legislation and regulations not to pollute the environment, and air quality was constantly monitored.

The number of unintentional injuries to children in Cuba, the primary cause of death among children and young people under 19, was disturbing. A national accident-prevention programme had been devised. Generally, the infant mortality rate in 2001 had been 6.2 per 1000 live births, and 0.4 in the group between one and five years. A cultural programme was being implemented to improve school infrastructures and create healthy environments for all students. All children had a guaranteed right to free education, and the school health programme ensured that they were educated in an environment that was salubrious for both students and teachers. Students worked with their teachers in health promotion activities such as control of vectors, including *Aedes aegypti*. Intersectoral action was crucial in the elimination of environmental factors harmful to children's health. In Cuba, the whole of organized society worked together to protect children.

The representative of VENEZUELA said that out of a population of nearly 25 million in Venezuela in 2001, 45% were under 19 years, and 12% were under five years. Most children and adolescents faced serious risks because of insufficient access to clean water, lack of waste disposal, inadequate housing, low concern about health, unsafe food, and exposure to vector-borne diseases. The Government regarded it as an ethical duty to ensure for young people a quality of life that took account of their needs from infancy, so that they reached adulthood with positive life values. As a result of its efforts to improve water production and quality, over the past three years more than two million people had gained access to drinking-water. Basic sanitary measures were helping to reduce vector-borne diseases. The fight against dengue and malaria had begun to have an impact: the prevalence of malaria had decreased by 29% between 2001 and 2002, while the number of cases of dengue had fallen by 26% between 2002 and 2003, following an epidemic in 2001-2002.

[1] *The world health report 2002 reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

Child mortality had been reduced by at least 23.9% over the past three years. Children also had to be protected against risks, in a culture and an environment free of violence and accidents. In the past three years, 1 300 000 children of pre-school age had gained access to health care coverage. Measures were being taken to improve education, including pre-school education and to secure the right to education for indigenous peoples. The curriculum should include a health component, including sexual and reproductive health and accident prevention, as well as environmental, education and peace studies.

The health sector should collaborate in intersectoral and intergovernmental partnerships, and should form alliances with different sections of society in order to further the healthy childhood agenda.

The representative of NIGERIA drew attention to the impact on children of conflict in the home, the community and at the national level. She invited ministers to reflect on the words of a Nigerian child on the occasion of World Health Day 2003 to the effect that children should not be regarded as an expenditure but as an investment for the future.

The representative of ETHIOPIA said that children everywhere needed a healthier environment. The reasons underlying the absence of a healthy environment varied from country to country, but the key factor was poverty. Poverty reduced the necessary conditions for peace and enhanced the risks of war; in most countries, it was the chief obstacle to creating a healthy environment for children. Moreover, a healthy environment, as well as health in general, was central to social and economic development.

**The meeting rose at 17:45.**

**Salle XVII, Tuesday, 20 May 2003, at 15:30**

**Chairman:** Dr F.F. SONGANE (Mozambique)

The CHAIRMAN, opening the round table, introduced the facilitator, Dr E. Anikpo (Director, Healthy Environments and Sustainable Development, WHO Regional Office for Africa).

Dr ANIKPO (Facilitator), noting that children under 15 years of age constituted a high percentage of the population in many developing countries, outlined the three main reasons for addressing environmental risks to children's health and the six environmental health risks that had emerged as global priorities. Risks specific to certain regions and countries, such as corporal punishment and sexual abuse, would also have to be considered. Children were often exposed to several risks simultaneously, hence the integrated settings approach described in document A56/DIV/4. That approach, which had been developed by WHO over several years, made it possible to determine the links between risk factors and the action that could be taken to reduce them.

She invited participants to provide ideas based on their experiences, focusing on critical factors for success and obstacles to be overcome, to define the role that should be played by the health sector in promoting an environment favourable to the health and well-being of the child, and to determine strategies for collaboration and partnership with other sectors, communities and nongovernmental organizations. She suggested that the debate should focus on three essential points: the development of policy and legislative and regulatory measures; the identification of a strategy that would produce significant results; and the development of a global alliance at local level.

The representative of AUSTRIA said that his country attached great importance to a healthy environment for children, who were particularly vulnerable members of society. Concerning the situation in Europe, a recent Scandinavian study had found that about half of all 15-year-old girls suffered regularly from headaches, one-fifth of children had symptoms of distress, and 1% were exploited or sexually abused. Half of all children did not have any appropriate leisure activities, a quarter lived in families that had difficulties in paying their bills, a fifth lived in single-parent families, and one in three high school pupils were in classes of more than 25 students. Stress inevitably had an impact on the health of such children, who became increasingly isolated and tended to show signs of physical or mental deficiency. A society that could not treat its children properly did not deserve to be called civilized.

In Austria, efforts were being made to integrate environmental health into a policy of sustainable development. Among the preventive measures introduced had been health checks for pregnant women and children up to the age of five years, which had led to a significant reduction in infant mortality. Free immunization was provided, including booster shots for children on entering and leaving the school system. At the Third Ministerial Conference on Environment and Health (London, 1999), Austria and other European countries had initiated a project for the study of the impact of transport on children's health. Children also benefited from projects designed to prevent dependency on drugs, alcohol and tobacco. Such projects aimed to persuade young people to adopt a more healthy lifestyle and to participate actively in improving their own environment.

The representative of FRANCE said that the issue under discussion raised the question of whether the concept of public health should be changed when the "public" aspect of that concept was frequently relegated to second place. In France, out of a total expenditure of 147 000 million euros on medical care, only 3000 million euros were spent on prevention, and steps must be taken to establish a more balanced health policy. In the context of healthy environments, the behaviour of smokers had changed as a result of the realization that passive smoking constituted a violation of the freedom of others. That was important for children, as they were the most vulnerable members of society and the first to fall victim to disease. Because of this, they were sometimes described as "sentinels" for the adult population, but there was something immoral in seeing them in that role.

More research was needed, notably on the links between cancer and the environment, the effects of electromagnetic fields and mobile telephones on health, and the links between the environment and infertility, early puberty and congenital malformation. Health monitoring mechanisms should be introduced so as to detect warning signs at an early stage, and risk management systems, with a legal framework for public health laws and regulations, were also needed.

He himself would shortly be introducing a public health bill, in which the priorities would include cancer, violence and drug addiction. Healthy environments for children would be an important public health priority for the future.

The representative of MALDIVES said that all States had a responsibility for providing their children with a safe and healthy environment. To do so they needed to alleviate poverty, demonstrate political commitment and provide strong leadership. In his country, which was vulnerable to the effects of climatic change and other negative environmental phenomena, a pilot project for a healthier island had been launched in cooperation with WHO. The project involved an intercommunity approach based on a multisectoral partnership, and was designed to secure a safe and healthy environment for children. He thanked WHO for its cooperation, and pointed out that the project could be emulated elsewhere. Another important requirement for a healthy environment was a happy home in which parents nurtured, loved and educated their children. Strong family bonds needed to be fostered in all countries, to ensure that children were given the love they deserved.

His Government was concerned about pollution and other environmental hazards and their negative impact on the environment, and had launched an awareness campaign to encourage students and children to help educate adults about the dangers of smoking. The harmful effects of tobacco use were of great concern, despite the fact that a recent report had indicated that passive smoking was not

as harmful as had been previously thought. In the light of the adoption of the Framework Convention on Tobacco Control, it was important to consider what further measures could be taken to promote a tobacco-free environment.

The representative of MEXICO said that Member States were well aware of the risks to health and of the appropriate action that had to be taken in the community, the home and schools. He therefore proposed that participants make proposals and consolidate their ideas, with a view to discussing the kind of legislation that could be introduced to facilitate existing programmes and make them more effective. In order to develop a healthy environment it was necessary to have indicators so that States could decide what approach to take and what they wanted to achieve, as had been done in the case of smallpox.

In order to identify common risks to children's health it was first necessary to have data, specific objectives, indicators and monitoring systems, which in turn required an analysis of children's interaction with adults, starting with the unborn child and going through all stages of development to adulthood. He wondered whether alliances in the area of healthier environments for children were useful, and pointed out that if they were to be effective it was important to consider with what body the alliance was being formed and what its objectives were.

The representative of NEPAL said that a strategy had already been adopted by his Government for dealing with physical environmental hazards to children's health. A national sanitation plan had been set up under the Ministry of Population and Environment which dealt with chemical pollutants relating to environmental degradation, highlighting the importance of an interministerial and multisectoral approach. Biological environmental pollutants were the concern of the Ministry of Health.

Much research work had been done and numerous interventions made, and their positive impact on health was already visible. In addition to physical hazards, the psychosocial environment also played an important role in children's health, despite the fact that it was difficult to quantify. Children who grew up in an inappropriate psychosocial environment tended to have psychological problems, which in turn led to social disharmony and violence in later life.

He suggested that the discussion should focus on defining guidelines as to what constituted a good psychosocial environment. For example, although many governments had done research on the effects of domestic violence, it was not yet possible to quantify the psychosocial trauma it produced, and that issue could be a subject for discussion. Other major factors affecting the environment were background radiation and radiation-induced hazards, which to date had not been given the priority they deserved.

The representative of the LAO PEOPLE'S DEMOCRATIC REPUBLIC pointed out that his country was small, poor, underdeveloped and recovering from the ravages of armed conflict. Health risks to children derived from two sources: poverty, which led to malnutrition and other problems; and development, which could lead, for instance, to an increase in the number of road accidents as a result of the growth in traffic due to the construction of roads and bridges, and to hazards associated with smoking and alcoholism and abuses such as the trafficking of children. Poverty, the chief source of all environmental risks, needed to be addressed and, at the same time, care had to be taken to counteract the negative impact of development. Efforts needed to be made to create an appropriate structure that would respond to all the risks identified. Once that structure had been created it was important to make the appropriate investment, notably in human resources, to reduce those risks.

His Government had already adopted the Millennium Development Goals, elaborated a plan to reduce poverty by 50% before 2005 and introduced a programme to stop the cultivation of opium by the same year. Work was also being done to combat drugs, to provide sufficient drinking-water and latrines, and to improve educational facilities in remote regions, particularly for ethnic minorities. Plans were being made for a programme for the improvement of children's health involving information and education campaigns, the provision of better birthing facilities, the promotion of

breastfeeding, improved management of disease outbreaks and initiatives to combat parasitic diseases such as dengue fever and malaria. For such initiatives to achieve results, good coordination was needed at national level, with other States and with nongovernmental and international organizations.

The representative of NIGER said that the protection of children required more than the adoption of measures to improve safety in the home, at school, in playgrounds and on streets. It required the provision of potable water, proper sanitation and waste disposal systems, and the adoption of behaviour and practices favourable to the promotion of public health and hygiene.

Unfortunately, that vision did not correspond to the reality in Niger, a country facing such problems as desertification, an unfavourable climate and poverty, which placed a heavy burden on the community and meant that before concerning themselves with their children's development people had to ensure their own survival. Poverty had led to the unfettered development of slums in urban areas, to the detriment of the health of the environment. His Government had subscribed to the initiative to promote a healthy environment for children launched by WHO in September 2002, and was also elaborating a health development plan focusing on hygiene and sanitation. Some of the shortcomings noted in the course of those efforts were a lack of strategy for the integrated management of problems linked to the environment, inadequate legislation, insufficient coordination of action, the fact that the issue was given low priority in governmental policy and the limited availability of qualified human resources. Consequently his Government was trying to draw up proposals for an integrated strategy to create a healthy environment, involving improvements in legislation, a framework for coordination, improved institutional capacities and the mobilization of the necessary resources. He called on WHO to elaborate strategies and initiatives that would help States in that effort and facilitate the sharing of experiences between countries and regions.

The CHAIRMAN urged participants, in view of the time constraints, to put forward concrete suggestions for areas where action was needed and for the type of action required.

The representative of ICELAND said that his Government appreciated WHO's decision to make a healthy environment for children the subject of the round table discussions. The way that a State treated its children reflected its ethical standards and the strength of its commitment to the future. Most governments had committed themselves to improving children's health and their environment, and several high-level conferences held under United Nations auspices had dealt with the issue in recent years. That had helped States to shed light on problems, to identify action to deal with them, and to adopt plans for implementing that action, but unfortunately many interventions had not proved as successful as expected. It was therefore encouraging to know that WHO was willing to assist in the task.

Action needed to be aimed at supporting children both in their own countries and globally, and should address a whole spectrum of environmental issues, including the physical, social and psychological environment in which children lived and played. His Government was particularly concerned about children's mental health: in Iceland, surveys had shown that the more time parents spent with their children, the healthier their lifestyle would be. Heavy workloads for parents thus had to be taken into consideration as an environmental factor affecting children's health. A loving, affectionate family was one of the most important aspects of a child's environment. There was also need to reduce the risk of children being exposed to accidents: accidents still occurred in circumstances where children would be expected to be safe, such as in playgrounds. All governments, both rich and poor, needed to provide a safe environment for children, and he was sure that the work of WHO and its Member States in that area would bring significant improvements.

The representative of KAZAKHSTAN said that studies of children in the 12- to 18-year age group in Kazakhstan had shown that adolescence was beginning much earlier than had previously been thought. For example, nearly all 12-year-olds already displayed characteristics of adolescence, while more than half suffered from a variety of health problems, including acquired diseases such as scoliosis and allergies. As many such diseases were preventable, it had been felt that the best means of

prevention was to inform the children themselves. Kazakhstan had therefore developed a children's health encyclopaedia to teach children about the human body, how diseases could be acquired, and how they could be prevented. A survey carried out that year had revealed that the incidence of acquired diseases among children in the age group concerned had dropped by 24% in comparison to the previous year.

It was known that children in the 12-18 age group liked to copy adults: for example, it had been found that in the great majority of cases the first time that a child ever smoked a cigarette, he or she did so to play at being an adult. The mass media therefore had an important role to play in advocating healthy lifestyles.

The representative of SPAIN pointed out that children were not simply small adults. While a polluted environment or defective sanitation were undesirable for adults, for children they were unacceptable. Modern cities were often characterized by uncontrolled industrial growth, accumulated refuse, environmental noise, and violence, which made it incumbent on those responsible to promote initiatives that would result in cities where children could grow up in peace and tranquillity, breathing unpolluted air and free from violence. The urban planning of the future would need to grant absolute priority to the quality of children's lives, and ensure that health played a major role in the planning of public services.

Spain, like other industrialized countries, had had considerable success in the provision of water supplies and sanitation for homes and schools, and the control of disease vectors. Water-borne communicable diseases such as cholera or typhoid no longer posed a threat. However, atmospheric pollution was still a major problem: strategies to combat it included policies for reduction of emissions, subsidies for the replacement of domestic boilers and the reduction in sulfur content of some fuels. A further air pollutant was tobacco, and a plan to combat tobacco use over the period 2003-2010 through interministerial collaboration had been prepared. Spain had also developed a plan to combat domestic violence, using a multisectoral approach to permit early detection and undertaken programmes to increase road safety.

Problems of environmental health were linked to patterns of development, and their solution would require major changes in lifestyle that would affect large sectors of the population. Citizen participation would be vital. Respect for the conservation of biological diversity and the appropriate use of resources necessary for sustainable development should be fostered from early childhood through to adolescence, so that children could grow up happy, safe and healthy in a world free of pollution, exploitation and violence.

The representative of GEORGIA said the health of children was fundamental to his country's national public health policy, which, with the plan for its implementation, had been developed in collaboration with WHO. Serious health hazards affecting children in Georgia included air pollution, particularly in the major cities; iodine deficiency, particularly in mountainous areas; iron deficiency, leading to anaemia; and allergies, leading in particular to bronchial asthma – recent research had shown that the prevalence of childhood asthma and allergies was 10 times higher than reflected in official statistics. Resolving those problems required a multisectoral approach, and a framework law had been promulgated, which covered not only health issues but also such issues as water, soil chemicals, and radiation.

Countries with economies in transition had meagre financial resources, and as a result treatment tended to receive higher priority than prevention. Because insufficient resources in those countries were being devoted to health, Georgia had proposed the Tbilisi Initiative, the basic concept of which was an exchange between health and foreign debt under which creditor countries would write off some of the debt owed to them, on condition that debtor countries earmarked the money saved for health, thus making additional resources available to create a healthy environment for children. The Initiative had been discussed both in the United Nations and in the European Union. He called on developed countries to subscribe to the Initiative, and thus help safeguard the future of the children of developing countries.

The representative of ECUADOR said that the topic under discussion was one of major importance and sensitivity, since it concerned one of the most vulnerable groups in the population. Children had an important place in the creation of future societies, and it was therefore essential to identify the factors that would ensure that those societies were healthy ones. That would involve protecting children against maltreatment, noise and other pollutants, and the impact of armed conflict. Other problems to be tackled were poverty and hunger, as well as inequalities between developed countries and poorer countries in access to health care and to education.

After evaluation of risks and related factors, strategies had to be formulated for building partnerships to establish healthy living-spaces for children. More active participation by children themselves as awareness-raisers in the home was fundamental to such an undertaking. Action should also include promoting children's programmes in the media, education for health, recognition of children's rights, encouragement of children's assemblies, and penalties for the broadcasting of material harmful to children's mental health. Children should be brought into contact with nature, in order to give them a sense of awareness of the world around them and of how it related to their health. Sexual education was also important, and here the approach needed to be multisectoral, involving ministries of education, public health, environment and social welfare.

The representative of GHANA noted that the documentation for the round table focused only on tangibles, and even in that area there were omissions; intangibles, such as the political environment, should also be taken into consideration. Thus, in Africa, there were currently several conflicts inflicting violence on children. There was also need to focus on the psychological environment, as there was a close link between psychological or emotional disturbance and physical disease, as illustrated by the onset of asthma in children. Also important were faith-based issues: for example, some religious organizations were firmly opposed to immunization, and it was the responsibility of government to tackle those issues, to enter into dialogue with the organizations concerned and resolve the problem.

The heart of the problem from the African perspective was the cultural dimension, in particular the existence of culturally inappropriate influences. Part of the problem went back to the era of colonialism, in that people who had been subjugated tended to lose their self-confidence, and that phenomenon still persisted. Another factor was the tendency for anything foreign to be portrayed as inherently superior to anything local. For example, in the 1960s, almost every African mother had breastfed her children, but currently, under pressure from misleading publicity, they were instead spending money on infant formula. Other problems impacting Africa were the popularization of the drug culture through certain successful films and the introduction of alien eating habits through the fast-food culture. Another problem arose from the marketing strategies of certain multinational companies, which promoted values that were inappropriate to Africa. Serious analysis was needed to prioritize issues, to find where there was consensus, to admit where there were divergent opinions, and to start negotiating from that point so that the necessary legislation could be adopted.

The representative of BURKINA FASO agreed that a healthy environment was the basic factor in ensuring good health for children. However, some features of his country made it particularly difficult to promote a healthy environment: the climate was hot and dry, with dust-laden winds that spread diseases. Illiteracy and sociocultural constraints also militated against the adoption of a lifestyle favourable to health. Nevertheless, the necessary political will was in place, and action had been taken at institutional level in pursuit of improved health for the population, including initiatives on child illnesses, respiratory diseases and malaria. At the same time, in cooperation with the media, the Government was promoting the use of safety belts and the wearing of crash helmets, and was taking steps to improve the rate of response to road-traffic accidents. Street-sweeping and refuse collection in major cities was likewise being improved. Burkina Faso's strategy for a healthy environment was based on a multisectoral approach, involving civil society, development partners, nongovernmental organizations, the private sector, and children and families.

The representative of CAMEROON said that good health was essential for children to flourish, but infant and child morbidity and mortality associated with an unhealthy or dangerous environment stood in the way of achievement of that goal. Faced with the need to act, most developing countries did so in a context of poverty, which meant that risks to health became systemic. Poverty was the major risk to children's health, as most diseases directly or indirectly linked to poor environmental conditions were in fact diseases of poverty. Diarrhoea, malnutrition, and limited access to potable water were all factors caused by poverty and that should be brought out in the report.

The first response should therefore be to combat poverty at global level. Within that framework, more targeted approaches could then be devised, including legislation on health and the environment. Intersectoral strategies should be formulated and institutional instruments provided for their implementation. Vertical programmes such as Roll Back Malaria, as well as immunization programmes, should be strengthened, and emphasis should be placed on an integrated approach to children's diseases. Food security policies should be incorporated in programmes, as malnutrition was a major cause of infant mortality.

Education was an essential tool for improving children's health. Community mobilization and involvement were important, and in his country projects such as the "healthy towns" project, launched in cooperation with France, had proved useful.

The creation of alliances for a healthy environment for children was a commendable idea. It would help to raise awareness and to mobilize resources, which would encourage countries to implement effective strategies. It should be recalled that, in the final analysis, priorities would differ according to the level of development of countries.

The representative of SINGAPORE said that in his country children were regarded as the nation's greatest asset for the future, and accordingly much importance was assigned to their health, education and development. Singapore was a signatory to the Convention on the Rights of the Child, and its Ministry of Health strove to ensure that no child was deprived of the right of access to a high standard of health care. The effectiveness of the country's national immunization programme was reflected in the low incidence of vaccine-preventable diseases including measles and hepatitis B. The Government also strove to provide a safe and violence-free environment for children.

Social legislation was in place to protect children and young persons. The Children's and Young Persons Act protected children under 16, while the Women's Charter protected women and girls from moral danger and exploitation and family members from domestic violence. Both instruments outlined the duties of parents *vis-à-vis* their children and young persons in their care. Under the Penal Code, severe punishment could be meted out for serious offences such as child neglect or grievous bodily harm. The Government strongly condemned child abuse, child neglect, sexual exploitation, and the participation of children in commercial public entertainment, illegal hawking, gambling and begging.

Child protection services had been organized to ensure the safety of children and strengthen the parent-child bond. A healthy environment encompassed both a physical and a social dimension, and thus implementation of strategies and programmes required close collaboration and partnership between agencies within and across sectors. The common aim should be to provide a healthy environment and to afford children maximum opportunities for growth and development.

The representative of the REPUBLIC OF KOREA said that his country had a long tradition of celebrating Children's Day, which had been declared a national holiday since the gaining of independence in 1945. Children were seen as the best hope for the future, and accordingly his country aimed to provide them with the highest possible levels of health and education.

A national children's safety initiative had recently been launched, aimed at improving safety and protecting children from harmful environments. A comprehensive plan aimed to strengthen existing laws to protect children from traffic accidents and other related incidents, involving the designation of protection zones and prohibited zones for children. It was planned to introduce new legislation for dealing with children from delinquent families, and increased budgetary allocations had been proposed to improve safety in public places and in schools.

The representative of SWEDEN said that children's health was closely linked to the health of mothers, and there was thus need to enhance the health of mothers and pregnant women. In that way, maternal mortality and infant mortality at birth could be reduced. If that goal were to be achieved, better resource allocation was needed, and governments should give priority to maternal health, children's health and reproductive health.

Children faced several environmental risks, such as polluted water and air and chemical hazards. Smoking was more dangerous to children than to adults, for the obvious reason that children had smaller lungs. They were also exposed to passive smoking, with which many asthma problems were associated, and were the targets of marketing campaigns by tobacco companies.

In his country, hundreds of thousands of children lived in homes in which at least one parent abused alcohol. That led to a childhood filled with uncertainty and the threat of violence. The issue of alcohol abuse in pregnancy should also be addressed, as pregnant women who abused alcohol and drugs could give birth to children with congenital defects. Legislation was needed in that area.

The representative of DOMINICA said that threats to children's safety arose in the home, school and community, areas where they were supposed to be protected. Children themselves should become involved in sustaining a healthy environment in the interests of their well-being and that of future generations. His country had launched an initiative in the form of a competition to tackle the problem of inadequate waste disposal. Waste was disaggregated so that some could be turned into compost and the rest recycled or otherwise disposed of.

He applauded the Georgian proposal that resources made available as a result of debt relief should be used by institutions and countries to fund practical programmes aimed at assisting children.

The representative of PORTUGAL said that his country was currently in the process of formulating a 10-year national health plan, which gave priority to environmental health. Public discussion of the plan by all key stakeholders was envisaged, so that a consensus between national institutions, nongovernmental organizations and universities could be reached.

There was a need to fight for a better environment for children. In that endeavour, his country had benefited from the help of the Regional Office for Europe. Portugal was interested in the Children's Environmental and Health Action Plan for Europe and in the development of indicators, training and research in order to formulate evidence-based interventions.

The representative of SURINAME stressed that fostering a healthy environment should begin long before birth. Promoting maternal health was therefore important, as the mother was the first environment for the child. Document A56/DIV/4 placed the emphasis almost exclusively on the physical environment, but the social and psychological environment was seen as very important in developing countries. The document also failed to mention participation by children. It was important for children to be engaged early so that they could participate in decisions that affected them, and they should not be viewed merely as passive creatures. In his country, children's parliaments had been set up in his country for two age-groups, 12 to 16 year-olds and 16 to 21 year-olds, and members were elected on a regional basis. Through such initiatives, under which children were taught at an early age about the environment, care for the environment would be fostered.

The representative of TIMOR-LESTE said that, in keeping with a holistic definition of health, both the physical and the psychosocial environment should be taken into consideration. Action should focus on raising awareness of the obligation to promote a healthy environment among families, schools and policy-makers. Ways and means should be devised to create linkages with other global policy tools such as the Convention on the Rights of the Child, the Millennium Development Goals, and the resolutions of the United Nations special session on children. He suggested that UNICEF and WHO should adopt common strategies, rather than individual initiatives, to ensure more effective implementation.

The representative of TOGO agreed that the establishment of children's parliaments to debate health issues should be encouraged. Children should also be made aware of their rights: in her country, the Convention on the Rights of the Child had been rewritten for children by children in a language they could understand. Efforts should also be made to combat harmful traditions that persisted in Africa such as early marriages and female genital mutilation. Programmes should be set up specifically targeting both children and parents.

In Africa, the problem of the rejection of AIDS orphans by their communities, and related problems such as child trafficking and children of broken homes, should be tackled. Everything should be done to avoid the participation of children in armed conflicts through programmes designed to promote peace and tolerance. Possible solutions to the problem of street children who were refused entry to health centres included the establishment of outreach centres in slum areas. Routine vaccinations should be accessible to all, and to achieve that goal neighbourhood medical posts should be set up in all areas. In schools, canteens should be established and play areas, which were rare in Africa, should be made available. In her country, a children's radio had been set up, allowing children to voice their opinions. Legislation in relation to children should be harmonized, and help should be given in mobilizing resources so that concerted action could be achieved.

Dr ANIKPO (Facilitator) summarized the discussion at the CHAIRMAN'S request, and indicated that the report would reflect the various interventions and proposals made.

The CHAIRMAN drew attention to a proposal tabled by the representative of Maldives requesting the Director-General write to Heads of State and Government urging them to take note of the recommendations made by the round table which would be submitted to the plenary session to be held the following week.

**The meeting rose at 17:50.**

**Salle XX, Tuesday, 20 May 2003, at 15:35**

**Chairman:** Mr M. MARTIN (Ireland)

The CHAIRMAN opened the round table, and asked the facilitator, Dr R. Bertollini, Director, Technical Support at WHO's Regional Office for Europe, to introduce the debate.

Dr BERTOLLINI (Facilitator) said that the rationale for tackling environmental risks to children's health was based on several factors: the fact that children carried a disproportionately high share of the global burden of disease due to environmental risk factors; the specific vulnerability of children to environmental hazards, including current knowledge about "windows of susceptibility"; and the lifelong ill health and disability associated with early exposure to environmental hazards. Noteworthy, too, was the high percentage of population under 15 years of age in many developing countries. He outlined the six environmental health risk areas that had emerged as global priorities, adding that specific risk factors and issues might prove to be a higher priority in certain communities, settings or countries, and that children were often exposed to several risk factors simultaneously. An integrated approach was required that would deal with the multiple risks to children's health in settings such as the home, the school and the community.

He invited participants to share their experiences in advocating and working for children to live in healthier environments; to identify constraints and obstacles to success; to examine the role of the health sector and how it worked with other sectors; to discuss the role of local and national government; and to suggest how WHO could facilitate relevant action. He urged participants to work to support a popular and inclusive movement for healthy environments for children in their countries.

In order to move towards effective action, the following topics might be used as a guide and focus for the discussion: development of policy recommendations to ensure healthy environments for children; identification of promising strategies for effective action and approaches; enhanced commitment to the Healthy Environments for Children Alliance as a worldwide alliance to intensify global action and coordination on environmental risks to children's health; and commitment from additional countries to launching national and local programmes to enhance the environment of their children.

The representative of INDONESIA said that the discussions should not be restricted to problems of the physical environment, such as water supply, waste disposal and pollution, but should include such aspects of their non-physical environment as culture and religion. Should a child be brought up in an unhealthy non-physical environment, such as a broken home, mental health problems would be likely to arise.

The representative of the CZECH REPUBLIC said that the quality of health care for children in her country was good, as indicated by its infant mortality rate of 4.0 per 1000 live births in 2001 and an immunization coverage rate of 95% to 98%. However, the morbidity of acute respiratory diseases was high, especially in children attending preschool facilities. The number of serious injuries to children was alarming and the incidence of allergies, nervous and motor system diseases and behavioural disorders had increased. The number of obese children was also increasing owing to lack of exercise and unhealthy eating habits. Many children were being neglected, abused, maltreated and sexually abused and exploited. The main causes of death in young people were injuries and poisoning, including self-inflicted injuries, with apprentices at highest risk. In the Czech Republic and other developed countries suicide was a common cause of death among young people, who were exposed to a wide range of risks, such as drugs, tobacco, alcohol and unprotected sex. The provision of healthy environments for children should be considered in the widest possible context, including the social environment, as shown by the adverse impact on children of inappropriate advertising. The Czech Republic welcomed all activities directed towards achieving healthy environments for children because of their vulnerability. Such issues were being covered in the Czech Republic through its Health for All in the 21st Century Programme and in its outline State policy on children and youth for the period up to 2007.

The representative of NEW ZEALAND welcomed the inclusion of healthy environments for children in the agenda of the Health Assembly, as the needs of children were so often forgotten. It was one of the biggest steps WHO had taken to improve children's health. Children in New Zealand had one of the world's highest rates of asthma, largely on account of the high rate of smoking among its population and in particular the indigenous people. The Framework Convention on Tobacco Control should assist in improving that situation.

Each country should create its own overall strategic action plan, including such fundamental matters as immunization and clean water supply, to provide healthy environments for children. Strategies should include methods to measure progress, as mortality and morbidity figures were only rough tools. An important issue in New Zealand was affordable, accessible, culturally appropriate and comprehensive primary health care. Children often missed out on health care because of its high cost to the family. New Zealand had concentrated on noncommunicable conditions such as child obesity, respiratory diseases, cancers and cardiovascular diseases, whose prevention in children would produce a healthy adult population. Each country had to deal with its own particular issues. New Zealand still

had problems of sanitation and water quality, particularly in rural communities, and had recently brought in government subsidies to improve sanitation systems and water quality and for fluoridation.

The representative of MAURITIUS said that her country fully supported WHO's healthy environments for children initiative. Normally, a child's world centred around home, school and community, which should be conducive to physical, mental and social well-being but were often places of disease and other health hazards. Mauritius had greatly improved its water and sanitation facilities and reduced its infant mortality rate to 13.9 per 1000 live births in 2001, aiming to cut that figure back to a single digit. Health ministries should lead action on health related to the environment of children, drawing up their own integrated policy for creating healthy environments for children, ensuring the enforcement of related legislation, and taking measures to promote improved nutrition, increased physical activity and the prevention of smoking and other substance abuse. Her country had doubled the extent of its immunization programme. It had a specific Ministry of Women's Rights and a Ministry for Child Development, and the legal framework had been put in place. Mauritius also had a Children's Council, with representatives of various ministries and nongovernmental organizations. A strategic plan should identify the needs of children and set out ways to tackle the environmental hazards facing them. On World Health Day the Minister of Health of Mauritius had addressed a forum of students on healthy environments for children, a well received initiative. There were also special new programmes for health education in schools, but much remained to be done with respect to such continuing concerns as child prostitution.

The representative of SLOVENIA fully supported the healthy environments for children initiative. In 2001 fewer than 18 000 children had been born in Slovenia compared with 32 000 25 years before. Children had been traditionally regarded as a vulnerable population group and not just as small adults. Slovenia had high-quality child health services, which were accessible to all children, and a low neonatal mortality rate. It was important to implement child-friendly environmental policies and to modify others that were still based on adult health needs. The precautionary principle should guide all those decisions. Slovenia had a high proportion of working mothers, so that many children were cared for in public nurseries and kindergartens, whose standards and food quality were high and where the number of injuries was low. National mortality statistics showed that children were most at risk from unintentional injuries, mainly in the home and on the roads, against which intersectoral and multi-level preventive action was needed. Efforts had been made to promote health and nutrition among the entire population in line with the global strategy on diet, physical activity and health that WHO was formulating. However, it was necessary to ensure that the increased physical activity did not result in even more injuries. Road safety should be improved through urban safety programmes and safety education courses, encouraging such measures as the use of cycle helmets. The Government intended to revise agricultural and environmental policies in order to increase the safety of food and drinking water and so improve children's health. The prevention of physical and psychological violence and sexual abuse was the main theme for World Health Day in Slovenia. Solutions were being sought through intersectoral and interdisciplinary cooperation, with clearly stated goals and responsibilities of individual ministries and of national and local partners and communities.

The representative of PALAU welcomed the focus on children in the current Health Assembly, adding that the participation of children in matters affecting them was high on the list for discussion. Referring to the recent Ministerial Council in Bali, Indonesia, attended by children, he suggested that children should be invited to participate in meetings where their issues were being discussed, and as members of national committees on aid, mental health and education; and they should be encouraged to start participating in discussions through confidence-building at home. Regarding various governmental sectors, the health ministry should become more a facilitator for holistic health and, as suggested by Indonesia, broaden its remit; there should be more visible collaboration between the United Nations bodies and other agencies working on behalf of children in order to avoid confusion at

the local level regarding resources and loyalties. He had indeed been disappointed at the lack of coordination of work between the various agencies at recent meetings.

The representative of CHINA said that it was the responsibility of all countries to create a healthy environment for children. As a developing country with a population of 1300 million, of which around 900 million people lived in rural areas and some 30 million were living in poverty, China recognized that the problems faced by children were the most prominent. Neither was children's health the only issue; as a result of hard work China's high infant mortality rate and maternal mortality ratio had been reduced significantly over the previous decade, enabling China to keep the promise it had made at the United Nations General Assembly special session on children. Legislation must be introduced in order to clarify children's issues, as it could serve to guarantee a reduction in infant mortality. Summarizing the legislation on child protection adopted by China during the 1990s, he said that it had been instrumental to the progress made. In addition, cooperative projects should be implemented nationally and internationally. In 2000, the Government had invested considerable funds in the reduction of maternal mortality and towards preventing neonatal tetanus, which had been done by sending experts to train local doctors, encouraging rural populations to have children delivered in hospital, and providing basic equipment to local medical units – measures that had proved very effective despite their simplicity. In the areas where those policies had been implemented the number of in-hospital deliveries had increased to 12.9%, while the maternal mortality ratio had fallen by an average of 28.8% and the infant tetanus rate had been reduced by 55%. He could therefore recommend such policies to other countries. The Integrated Management of Childhood Illness strategy had been implemented with success in more than 10 provinces and the Government was committed to expanding the programme to other provinces.

The representative of SLOVAKIA said that three issues needed to be addressed with regard to increasing children's participation in policy-making: cultural differences, social differences and, above all, improved communication, which was of particular importance when it came to preventing domestic violence. Children had to be encouraged to talk about such problems. Constraints such as the fight against poverty and low levels of education, as well as ways of improving access to education and facilitating social mobility through employment creation, also had to be discussed, and all the services provided to children would need to be fundamentally changed so that they matched the cultural needs of the community. Healthy lifestyles must be promoted through the media and steps taken to discourage unhealthy lifestyles, such as alcohol and tobacco use, and especially dangerous lifestyles leading to injury. With regard to the health care sector, WHO must realize that it could only act as leader and coordinator and therefore needed to create alliances with the private sector, communities and nongovernmental organizations in order to secure the funds and power to address such issues. The key conditions for success were, first, adopting a differentiated approach that viewed children as having special characteristics and needs, particularly in communication; secondly, creating incentives to encourage providers, purchasers, State authorities and communities to take the necessary steps; and finally, addressing the issue of stability by focusing on families, since a safe family environment was conducive to a safe childhood.

The representative of PARAGUAY, indicating that one-third of his country's population was under 15 years of age, said that Paraguay suffered from problems associated with both developing and developed countries. Children were exposed to health risks in schools, homes and communities, and minimizing that risk was the responsibility of everybody, sometimes including children themselves. As the Ministry of Health could not implement all the health promotion programmes alone, it was collaborating with other ministries and institutions in that regard. Children's health was vital for the future of the country. Not only the physical but also the psychological environment affected children. Even prenatal injury could leave traces, which appeared over time and could not be controlled. Children were exposed to the risk of physical injury, sometimes for improbable reasons, especially when they were working in the streets or were at home alone while their parents were at work.

Malnutrition was also a significant factor as it stunted growth; his country had developed indicators that it wished to share. The Ministry of Health, working with other institutions, was committed to educating and training the entire population in order to create as favourable an environment as possible. Food guides had been disseminated so that parents and children would know which foods they should eat and when those foods were available. Efforts had also been made to reduce maternal and infant mortality rates through hospital delivery. A law on child protection had been adopted and an agreement signed with the Ministry of Education and Culture. Children, whose concerns and expectations were even greater than those of WHO, were participating in healthy schools projects, which had in turn been converted into healthy communities projects; on the border with Argentina a joint programme called Healthy Borders had also been implemented, with the aim of improving the environment of the country as a whole. However, policies could not be as effective when prevention failed and it should not be forgotten that children were the best investment for the future.

The representative of the UNITED ARAB EMIRATES said that his Government attached particular importance to children's health. For example, the infant mortality rate was 7 per 1000 live births, and immunization coverage exceeded 97%. Hospital delivery rates were approaching 99%. Furthermore, health services were available and accessible to all. His country gave special attention to environmental protection in general and to healthy environments for children in particular. He highlighted the frequent partnerships between government departments and private institutions, which aimed to safeguard the environment and children's health. Education was also accorded particular importance, a 92% rate having been achieved, with special reference to the education of women in their role as mothers. His country had adopted the Healthy Cities concept in order to change existing health patterns and establish new ones, and the Healthy Schools Initiative, which aimed to develop special programmes and activities for children. Some problems were nevertheless being encountered: road traffic accidents, obesity and allergy-related diseases, in particular chest allergies.

The representative of URUGUAY said that, as children were the future of society, it was a pity that meetings on children's issues were not better attended. Despite having enjoyed excellent health indicators for several years, such as an infant mortality rate of 13 per 1000 live births, immunization coverage of 97%, and free education, his country was still facing problems common to many countries of the world, as a result of a regional social and economic decline in South America. Children, as a vulnerable group, were among those most affected by the changes, and many children in his country were being born into families living below the poverty line. Such issues were being dealt with by the Ministry of Public Health through a system of nutritional monitoring, which had shown childhood malnutrition to be an increasing problem, despite the fact that Uruguay was a food-producing country, as a result of the regional situation. A concerted effort on the part of the State authorities was imperative if progress was to be made; departments and other bodies had set up a joint programme to identify vulnerable groups, focusing particularly on children under five years of age. Policies were in place to promote nutrition; for instance, iron supplementation, and an extensive national campaign to promote breastfeeding as a means of combating malnutrition in children less than one year old.

In some areas of the country, lead contamination primarily affected children. Since the problem had been caused in part by the disposal of old batteries, the Government had responded by making it impossible to buy a new battery without returning the old one. The textile industry created chromium contamination, and epidemiological studies were under way.

Having identified children below the age of 10 years, and particularly the under-fives, as a strategic target group, the Government was mobilizing available resources in order to create the best possible healthy environment for children. It viewed that strategy as an investment in the future, since failing to resolve such inequities would only lead to greater problems that Uruguay was unwilling to accept.

The representative of NICARAGUA, observing that in her country 47% of the population was under 15 years old and 35% aged between 15 and 24, agreed that an action plan was needed to respond

to the problems identified in all environments where children lived, played, studied and worked, as well as in the non-physical environment. In that regard she supported the view that children and young people should be involved from the problem identification stage to that of coming up with solutions. With regard to intersectoral coordination in order to deal with those issues, she said that Nicaragua was under a presidential mandate to establish such links, and work had already begun in one of the oldest areas of Managua. There, people had traditionally sat outside to take the air in the evening or after work, but the advent of gangs and delinquency had long ruled that out. However, through the combined efforts of the Ministry of Education, families, the business sector and the police, that custom – serving as it did as an albeit unusual indicator – was being resumed as a result of those intersectoral links.

In the light of the Convention on the Rights of the Child, Nicaragua had drawn up a Code of the Child, but public perception of the third part of the Code was sometimes that it let juvenile delinquents escape justice. Reflection was needed on what could be done to change that perception, given that an investigation in Nicaragua had shown that the fourth factor mentioned as a threat to safety, after drugs, armed attacks and robberies, was the third part of that Code. Attempts had been made to counter that perception with statistics but a campaign was needed to inform people clearly about such codes.

Nicaragua was also trying to eradicate child labour, in conjunction with ILO. Interviews with some children and young people, however, revealed that they were the sole earners in their families. In one rural area, 13- and 14-year-olds working in the tobacco industry had said that they were happy to be able to bring in some money after so many years. Such instances showed how necessary it was to provide work for adults so that children did not have to meet the financial needs of their families. It seemed that certain problems remained where, even though some steps had initially been viewed as progress, subsequent review was needed. The participation of children and young people in identifying problems and solutions was therefore crucial, as was the creation of links between sectors at national, local and community levels.

The representative of JAPAN said that his country was experiencing similar difficulties to those described by the representative of Slovenia in that, although the infant mortality rate was low, the birth rate was falling. Low fertility was indeed becoming a political and social problem. The most frequent cause of child death was unintentional injuries, for example by drowning in Japan's traditionally deep bath tubs. There was an increased incidence of diseases such as asthma and hay fever in children, which he ascribed to changes in lifestyle, humidity and sensitivity.

Social elements and hazards affected adolescents and could increase stress levels in children; a comprehensive approach should be adopted that viewed the problem not only as an issue of child health but also from the angle of family and society. In 2000, based on previous success in maternal health programmes, Japan had developed an initiative to address remaining and new problems in maternal and child health in the twenty-first century, entitled "Healthy Parents and Children 21". It contained numerical targets and action plans for 61 items and represented the national efforts of Japan's citizens to promote healthy environments for children.

The representative of ZIMBABWE said that his country held strong views on children and had established a Ministry of Health and Child Welfare, with the child-welfare department focusing on immunization (the coverage rate generally exceeded 85%), orphan care and, in particular, the rise in the number of street children. Since parents were increasingly busy, coming home late and having no time to talk to their families, which made children more vulnerable, the Ministry was encouraging communication between parents and their children. It was also encouraging children to take part in activities casting them in an adult role, and had nominated a child president, child mayors and child councillors and created a children's parliament; and a teenager represented children on the National AIDS Council. In a country being ravaged by HIV and AIDS, children were taught about the disease from fourth grade upwards to protect them from infection, and peer education on the subject was being promoted. The Ministry further recognized the high level of mother-to-child transmission of HIV and had instituted a programme to prevent such transmission.

Some cases required special emphasis, such as sexual abuse of children. Child-friendly courts had been created in Zimbabwe to allow children to give evidence without having to see their abuser. Since the higher divorce rate meant more stepchildren and many instances of abuse involved step-parents, a nationwide attempt was under way to impress on people that children were not to blame for divorces.

Since Zimbabwe had suffered extreme drought resulting in severe malnutrition, the Government had established a "Child Supplementary Feeding" programme whereby children were fed in schools, nurseries or crèches. He expressed appreciation to WHO, together with UNICEF, for its expertise in helping countries to look after their children.

The representative of SRI LANKA, emphasizing the psychological environment of children, said that a common cause of poor hygiene and sanitation, indoor air pollution and other unhealthy environmental conditions was the widespread addiction to tobacco and alcohol. Sadly, the poor were those most addicted. The second serious threat to children was "diseases of communication"; attractive advertisements in electronic and printed media targeted children in subtle but effective ways, impressing on their formative, vulnerable minds the idea that unhealthy lifestyles were fashionable and the norms of behaviour adopted by young people. The advertising industry should draw up a code of ethics to prohibit targeting children with material that encouraged unhealthy lifestyles and to stop the use of children in such advertisements.

In early childhood the foundations of a healthy future were laid down, and the consequences of neglect or restriction through ignorance could be disastrous. Contemporary children were programmed and pressured by parents and society to study like machines and perform well in examinations, to the detriment of aesthetic and humanistic studies. Children did not, therefore, grow up to appreciate the value of life, with the result that violence permeated all levels of society, including schools and work places, and that tragedy had to be corrected. Sri Lanka was finally emerging from an unfortunate two-decade-old conflict that had left many wounds and scars, particularly among children in all parts of the country, many of whom had suffered serious physical and mental deprivation. Attending to those mental health issues was a high priority for his country, where the utmost was being done, but the ultimate answer was to prevent such debilitating conflicts. Providing a non-violent environment for children could prevent violent behaviour in adulthood.

Child abuse had become another tragedy. For many, it meant rape or sexual exploitation, but it covered a much wider range of violations, including domestic violence directed at children, corporal punishment of children in schools and public humiliation. Even employing minors, verbally abusing a child to relieve adult frustrations or leaving a child without proper supervision needed to be addressed as serious violations of children's rights.

In recognition of the vital importance of a healthy environment for children to live in, Sri Lanka had set up an independent National Child Protection Authority, with executive power, under the Head of State, which had proved an effective mechanism to counter the threats that children faced.

He urged WHO to lead the development of simple, practical, measurable norms and indicators for child-friendly settings, with a wider application than was currently available from such indicators as immunization and nutritional status, which were within the health system alone. WHO should develop an action plan based on the deliberations to achieve the stated goals.

The representative of LITHUANIA said that his country fully supported the Healthy Environments for Children initiative and gave child health the highest priority. It had succeeded in reducing neonatal mortality from 16.2 per 1000 live births in the 1990s to 7 per 1000 in 2002. However, understanding of the child health environment had in the past been too medical. Efforts should be pooled with communities, families, nongovernmental organizations and particularly the education system, since parents were indeed often too busy to discuss health issues and share their experiences. As part of a WHO initiative, Lithuania had established its first health-promoting school in 1992 and had found a change of mentality among both teachers and children. Healthy habits and lifestyles were a greater concern than in ordinary schools and the emphasis in child health had moved

from the purely medical to a more lifestyle-based approach. He recommended such schools to his colleagues and asked WHO to take more action in that area, since children had been responsive. When they became parents they could then educate their own children likewise. More health-promoting schools should be established to promote a healthy environment, since children spent most of their waking hours in or around school and it was more effective to educate teachers, who could pass knowledge on to their pupils, than to try to educate all parents.

The representative of GABON said that, in seeking a more healthy environment for children, particular attention should go to strengthening capacity in different areas concerned with the environment, in the broad sense, and making the child's physical environment safe at home, at school and on the way to and from school; public transport, school playgrounds and other play areas should be taken into account.

Another aspect was the transfer of customs and cultures from one generation to the next. In that context the role of women should not be overlooked, particularly since, in African countries, bringing up children often fell to women and many families regarded a woman as the head of the family. The level of literacy of parents should therefore be considered, as should the role of the media; children spent much time watching television and films, which, whether adventure or pornography, had an impact on the child's cultural environment and pressured them to conform to the behavioural patterns they saw.

Involving children themselves in action plans to benefit them would enable the notion of a healthy environment, as seen from a child's point of view, to be integrated into such plans.

The representative of SWITZERLAND observed that his country was witnessing trends in children's health similar to those in many other European countries, such as more accidents, violence and allergies, in addition to a worrying epidemic of obesity. Children were starting to abuse substances much earlier, and all those factors led to the conclusion that the unhealthy lifestyles of adults were becoming more widespread among young children. He expressed concern that Switzerland had a negative population growth rate which was only balanced by immigration. Evidence suggested that young people in many countries no longer believed in a happy and prosperous future, and were therefore reluctant to have children even though they could. It was necessary to address that issue and restore young people's belief in economic development. The key concept was education, first of women, so that they could bring up healthy families, and secondly of children themselves. It was also necessary to give young people a chance to live in a healthy environment. Many people lived in urban societies that were unsafe and did not provide enough space for children to play. Large sports facilities were often closed to children, and access should be provided so that they could play out of doors, since there was a link between obesity, constant television viewing inside and lack of exercise.

Social inequalities and injustices needed to be rectified, as poverty was the biggest threat to health. The poor in society could not help themselves alone but needed the support of their governments, which in turn needed the support of other countries. Strategies to empower families and communities were the key to success, and the health-promoting schools programme was beneficial and should not be neglected.

The whole issue should be seen in the context of sustainable development, a concept unfortunately difficult to maintain in many countries. The healthy environments for children initiative and its related Alliance should keep the idea alive, since in the long run the only valid development option was that of sustainable development, even in a difficult economic situation. Switzerland would participate in the preparation for the Fourth Ministerial Conference on Environment and Health (Budapest, 23-25 June 2004), which could give impetus to the concept of sustainable development.

The representative of the UNITED STATES OF AMERICA said that the efforts being made in his country to create a healthier and safer environment for children involved a strong partnership between national agencies and international collaboration through the United States Agency for International Development. A presidential task force on environmental health and safety risks to

children had been established, making it possible to identify some of the highest-priority domestic issues requiring action. A new national study would follow 100 000 children from birth to the age of 21 years with a view to examining a broad range of risks to their health and development. In addition, the Centers for Disease Control and Prevention had developed a safe, cost-effective system to purify and protect drinking water, which had already been implemented successfully in 15 countries. Despite considerable steps to improve children's health, much remained to be done. The Healthy Environments for Children Alliance had great potential. Should its science- and evidence-based focus be maintained, it would provide a platform for the betterment of children around the world.

The United States welcomed the categorization of environment and health issues and the settings approach put forward in document A56/DIV/4, and strongly supported the inclusion of health promotion efforts, prevention measures and behavioural change programmes as part of the plan. He recognized the need for a grand vision, but the pressing need was for specific activities and priorities. Although needs sometimes seemed infinite and resources finite, and cultural diversity could make it difficult to bring about behavioural change, the United States strove to make available the best science to achieve the ultimate goal of keeping children healthy, and reducing morbidity and mortality. The United States welcomed the ideas and insights that were being put forward in the discussion; only by working together would the global community be able to move forward.

The representative of JAMAICA welcomed the issues identified in the background document. Other challenges were faced by children in Jamaica, such as adjusting to their psychological environment, not on account of family matters but owing to violence and death of family members, and dealing with psychological trauma, as an increasing number of women were affected by HIV/AIDS. The Government had launched a programme seeking to influence the cultural environment, promoting healthy, responsible living; without a significant value system, the public health environment of children could be threatened. Jamaica also recognized the need for intersectoral collaboration between governmental agencies.

In public health, Jamaica had made great progress in household water security: more than 90% of the population in both urban and rural communities had access to potable water. Diarrhoea among children was caused mainly by rotavirus, with seasonal outbreaks, and steps had been taken to teach mothers to prevent secondary transmission and administer oral rehydration salts when necessary. Hygiene and sanitation were major components of primary care, and with the Ministry of Education standards and guidelines had been drawn up for day-care centres. Although balancing public health and educational requirements could be difficult, particularly in the event of financial constraints, the aim was to raise school attendance to 90% and ensure that children at school were safe in terms of hygiene and sanitation.

The number of cases of respiratory tract infection among children was increasing, particularly among those attending primary care centres. Some of those infections were associated with tobacco smoking in the home, but research was required to determine the source of the other environmental irritants. It was also necessary to educate mothers and family members to protect children in the home; for instance, chemicals, such as bleach and pesticides, were mistaken by children for drinks, particularly in poor households. Communities should be encouraged to be more supportive. Leaving children unattended at home could result in unintentional injury, and such risks were being tackled through public education. Stronger laws were being promulgated to make parents and guardians more responsible and accountable for their children at all times.

The Ministry of Health had extended its surveillance system to cover factors reflecting the environment where children spent much of their time, collecting data on intentional and unintentional injuries, poisoning, water quality indicators and communicable diseases. WHO was to be commended for drawing attention to the issue of healthy environments for children, and her country would welcome any support from WHO or other agencies for more in-depth research on environmental factors affecting children in Jamaica.

The representative of INDONESIA said that, although in the previous 10 years the overall health of the people in Indonesia had improved, the health status of children remained unsatisfactory, on account of problems associated with both the physical and the non-physical environment. With respect to the former, about 25% of the population, particularly in rural areas, lacked access to clean water, and the sewerage and waste-disposal systems were unsatisfactory. Furthermore, some 35% of the population had no access to good sanitation facilities. Regarding non-physical problems, he drew attention to traditional beliefs, such as the view that pregnant mothers should not eat certain foods, which were in fact of high nutritional value, and to the number of broken families resulting in neglected or abused children.

His Government was taking steps to tackle those problems. It had passed legislation to protect children in the areas of education, social welfare, religion and health, and was strengthening health education and promotion, together with community and family empowerment. Children were being encouraged to participate in the health programme and, because of the importance of improving the population's economic status, a poverty eradication programme was also being implemented.

The CHAIRMAN, summarizing the debate, observed that the emphasis on the Healthy Environments for Children Alliance had been strongly endorsed, as had the development of an overall strategic plan guiding the approach to creating healthy environments for children, and the need to take specific actions to meet specific priorities. The need to consider the non-physical environment, to include mental illness and sexual and other abuse, for instance, had been expressed by several participants. Smoking had been a strong common denominator; clear evidence had been presented by many Member States that tobacco and smoking constituted a significant threat globally to children's health. In order to counter child obesity, physical activity should be encouraged and more emphasis placed on recreation and sport. Coordination between the United Nations agencies working with children should be improved, and some countries had highlighted the importance of legislation protecting children's rights, with the protection of children successfully embodied in their legislation. The participation of children in debates on children's health should be facilitated, and the importance of communication and how children's health and related issues were dealt with in the media had been highlighted. The need for an intersectoral approach had been recognized, and the importance of the years between birth and three and of stable family and community environments had been strongly emphasized.

There had been broad agreement on the six areas highlighted in document A56/DIV/4 and the settings approach. All further action should be based on both evidence and science. Much stood to be gained if the worldwide alliance could be translated from concept into action.

**The meeting rose at 17:35.**

# PART III

# 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 WHA56/2003/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA56/2003/REC/2.

## COMMITTEE ON CREDENTIALS

### First report[1]

[A56/56 – 20 May 2003]

The Committee on Credentials met on 20 May 2003. Delegates of the following Member States were present: Azerbaijan, Brazil, Congo, Haiti, Nepal, Norway, Oman, Portugal, Samoa, Sri Lanka, Zambia.

The Committee elected the following officers: Dr B. Chituwo (Zambia) – Chairman; Dr O.T. Christiansen (Norway) – Vice-Chairman; Dr E. Enosa (Samoa) – Rapporteur.

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.

The credentials of the delegates of the Member States and of the representatives of the Associate Member listed at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials; and the Committee therefore proposes that the Health Assembly should recognize their validity.

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 therefore recommends to the Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Health Assembly pending the arrival of their formal credentials: Afghanistan, Bahamas, Belgium, Benin, Bosnia and Herzegovina, Brazil, Colombia, Croatia, Cuba, Cyprus, Egypt, Equatorial Guinea, Finland, France, Ghana, Grenada, Italy, Malawi, Marshall Islands, Micronesia (Federated States of), Nigeria, Paraguay, Portugal, Republic of Korea, Saint Lucia, Saint Vincent and the Grenadines, Spain.

**States whose credentials it was recommended should be recognized as valid** (see fourth paragraph above)

Albania, Algeria, Andorra, Angola, Argentina, Armenia, Australia, Austria, Azerbaijan, Bahrain, Bangladesh, Barbados, Belarus, Belize, Bhutan, Bolivia, Botswana, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Dominica, Dominican

[1] Approved by the Health Assembly at its fourth plenary meeting.

Republic, Ecuador, El Salvador, Eritrea, Estonia, Ethiopia, Fiji, Gabon, Gambia, Georgia, Germany, Greece, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Ireland, Israel, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malaysia, Maldives, Mali, Malta, Mauritania, Mauritius, Mexico, Monaco, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Peru, Philippines, Poland, Qatar, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Kitts and Nevis, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia and Montenegro, Seychelles, Sierra Leone, Singapore, Slovakia, Slovenia, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Tuvalu, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe.

**Associate Member**

Puerto Rico.

### Second report[1]

[A56/59 – 22 May 2003]

On 22 May 2003, the Bureau of the Committee on Credentials examined the formal credentials of the delegations of the following Member States, who had been seated provisionally in the Health Assembly pending the arrival of their formal credentials: Afghanistan, Belgium, Benin, Bosnia and Herzegovina, Brazil, Colombia, Cuba, Cyprus, Egypt, Equatorial Guinea, Finland, France, Ghana, Grenada, Italy, Malawi, Marshall Islands, Nigeria, Paraguay, Portugal, Republic of Korea, Spain.

These credentials were found to be in conformity with the Rules of Procedure of the World Health Assembly, and the Bureau therefore proposes that the Health Assembly recognize their validity.

## COMMITTEE ON NOMINATIONS

### First report[2]

[A56/52 – 19 May 2003]

The Committee on Nominations, consisting of delegates of the following Member States: Albania, Bhutan, Cape Verde, Egypt, France, Gabon, Guinea-Bissau, Hungary, Lao People's

[1] Approved by the Health Assembly at its ninth plenary meeting.

[2] Approved by the Health Assembly at its first plenary meeting.

Democratic Republic, Madagascar, Marshall Islands, Mauritius, Mexico, Myanmar, Namibia, Peru, Qatar, Russian Federation, Singapore, Spain, Thailand, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Dr J.F. López Beltrán (El Salvador) (*ex officio*), met on 19 May 2003.

In accordance with Rule 25 of the Rules of Procedure of the World Health Assembly and respecting the practice of regional rotation that the Health Assembly has followed for many years in this regard, the Committee decided to propose to the Health Assembly the nomination of Dr Khandaker Mosharraf Hossain (Bangladesh) for the Office of President of the Fifty-sixth World Health Assembly.

### Second report[1]

[A56/53 – 19 May 2003]

At its first meeting, held on 19 May 2003, the Committee on Nominations decided to propose to the Health Assembly, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations:

**Vice-Presidents of the Assembly:** Mr U. Olanguena Awono (Cameroon), Dr J. Torres-Goitia C. (Bolivia), Dr W. Al-Maani (Jordan), Mr H. Voigtländer (Germany), Dr C. Otto (Palau);

**Committee A:** **Chairman** – Dr J. Larivière (Canada);

**Committee B:** **Chairman** – Mr L. Rokovada (Fiji).

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the World Health Assembly, the Committee decided to nominate the delegates of the following 17 countries: Algeria, Bahrain, Burundi, China, Cuba, France, Ghana, Greece, India, Iran (Islamic Republic of), Jamaica, Lesotho, Poland, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, and United States of America.

### Third report[2]

[A56/54 – 19 May 2003]

At its first meeting, held on 19 May 2003, 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 World Health Assembly, the following nominations for the Offices of Vice-Chairmen and Rapporteur:

**Committee A**: Vice-Chairmen: Dr Y.C. Seignon (Benin) and Dr J. Mahjour (Morocco);
Rapporteur: Mrs B. Jankásková (Czech Republic);

[1] Approved by the Health Assembly at its first plenary meeting.

[2] See summary records of the first meetings of Committees A and B (pp.17 and 195, respectively).

**Committee B**: Vice-Chairmen: Dr R. Constantiniu (Romania) and Mr So Se Pyong (Democratic People's Republic of Korea);
Rapporteur: Mrs C. Velásquez de Visbal (Venezuela).

## GENERAL COMMITTEE

### Report[1]

[A56/57 – 22 May 2003]

### Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 21 May 2003, the General Committee, in accordance with Rule 102 of the Rules of Procedure of the World 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: Canada, Czech Republic, Ecuador, France, Guinea-Bissau, Iceland, Nepal, Pakistan, Sudan, Viet Nam.

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 report[2]

[A56/55 – 20 May 2003]

On the proposal of the Committee on Nominations,[3] Dr Y.C. Seignon (Benin) and Dr J. Mahjour (Morocco) were elected Vice-Chairmen, and Mrs B. Jankásková (Czech Republic) Rapporteur.

Committee A held its first meeting on 20 May 2003 under the chairmanship of Dr J. Larivière (Canada).

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[1] See document WHA56/2003/REC/2, verbatim record of the eighth plenary meeting, section 3.

[2] Approved by the Health Assembly at its fourth plenary meeting.

[3] See the third report of the Committee on Nominations, above.

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of the resolution entitled "WHO Framework Convention on Tobacco Control" relating to the following agenda item:

13. WHO framework convention on tobacco control [WHA56.1].

In adopting this resolution, the Health Assembly will also adopt the WHO Framework Convention on Tobacco Control annexed to the resolution.

### Second report[1]

[A56/61 – 23 May 2003]

Committee A held its second, third, fourth and fifth meetings on 22 and 23 May 2003 under the chairmanship of Dr J. Larivière (Canada). During the fifth meeting Dr Y.C. Seignon (Benin) later took the chair *ad interim*.

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of two resolutions relating to the following agenda items:

14. Technical and health matters
    14.18 International Conference on Primary Health Care, Alma-Ata: twenty-fifth anniversary [WHA56.6]
    14.1 Tropical diseases, including Pan African tsetse and trypanosomiasis eradication campaign
        Pan African tsetse and trypanosomiasis eradication campaign [WHA56.7].

### Third report[2]

[A56/63 – 26 May 2003]

Committee A held its sixth meeting on 24 May 2003 under the chairmanship of Dr Y.C. Seignon (Benin) and later Dr J. Larivière (Canada).

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of three resolutions relating to the following agenda items:

14. Technical and health matters
    14.14 Influenza
        Prevention and control of influenza pandemics and annual epidemics [WHA56.19]
    14.7 Strategy for child and adolescent health and development
        Reducing global measles mortality [WHA56.20]
        Strategy for child and adolescent health and development [WHA56.21].

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[1] Approved by the Health Assembly at its ninth plenary meeting.

[2] Approved by the Health Assembly at its tenth plenary meeting.

### Fourth report[1]

[A56/66 – 28 May 2003]

Committee A held its seventh and eighth meetings on 26 May 2003 under the chairmanship of Dr J. Larivière (Canada) and Dr J. Mahjour (Morocco). The ninth and tenth meetings were held on 27 May under the chairmanship of Dr Larivière.

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of the resolutions relating to the following agenda items:

14. Technical and health matters
    - 14.9 Intellectual property rights, innovation and public health [WHA56.27]
    - 14.16 Revision of the International Health Regulations
        - Revision of the International Health Regulations [WHA56.28]
        - Severe acute respiratory syndrome (SARS) [WHA56.29]
    - 14.4 WHO's contribution to the follow-up of the United Nations General Assembly special session on HIV/AIDS
        - Global health-sector strategy for HIV/AIDS [WHA56.30]
    - 14.10 Traditional medicine [WHA56.31]
12. Programme budget
    - 12.1 Proposed programme budget for 2004-2005
        - Appropriation resolution for the financial period 2004-2005 [WHA56.32]
16. Financial matters
    - 16.6 Assessments for 2004-2005
        - Scale of assessments for the financial period 2004-2005 [WHA56.33]
        - Adjustment mechanism [WHA56.34].

## COMMITTEE B

### First report[2]

[A56/58 – 22 May 2003]

On the proposal of the Committee on Nominations,[3] Dr R. Constantiniu (Romania), Mr So Se Pyong (Democratic People's Republic of Korea) were elected Vice-Chairmen, and Mrs C. Velásquez de Visbal (Venezuela), Rapporteur.

Committee B held its first meeting on 22 May under the chairmanship of Mr L. Rokovada (Fiji).

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[1] Approved by the Health Assembly at its tenth plenary meeting.

[2] Approved by the Health Assembly at its eighth plenary meeting.

[3] See third report of the Committee on Nominations, above.

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of one resolution relating to the following agenda item:

19. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine [WHA56.5].

### Second report[1]

[A56/60 – 23 May 2003]

Committee B held its second and third meetings on 23 May under the chairmanship of Dr R. Constantiniu (Romania) and Mr L. Rokovada (Fiji).

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of the resolutions relating to the following agenda items:

16. Financial matters
    - 16.2 Appointment of the External Auditor [WHA56.8]
    - 16.1 Reports
        - Unaudited interim financial report on the accounts of WHO for 2002 and comments thereon of the Administration, Budget and Finance Committee
            - Unaudited interim financial report on the accounts of WHO for 2002 [WHA56.9]
    - 16.3 Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution
        - Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA56.10]
    - 16.4 Special arrangements for settlement of arrears
        - Arrears in payment of contributions: Kazakhstan [WHA56.11]
    - 16.5 Assessment of new Members and Associate Members
        - Assessments for 2002 and 2003 [WHA56.12]
12. Programme budget
    - 12.1 Proposed programme budget for 2004-2005
        - Real Estate Fund [WHA56.13]
        - Real Estate Fund: Regional Office for Africa [WHA56.14].

### Third report[2]

[A56/62 – 26 May 2003]

Committee B held its fourth meeting on 24 May 2003 under the chairmanship of Mr L. Rokovada (Fiji) and later Dr R. Constantiniu (Romania).

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[1] Approved by the Health Assembly at its ninth plenary meeting.

[2] Approved by the Health Assembly at its tenth plenary meeting.

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of one decision and four resolutions relating to the following agenda items:

17. Assignment and transfer of Member States to regions
    17.1 Assignment of the Democratic Republic of Timor-Leste to the South-East Asia Region [WHA56.15]
    17.2 Reassignment of Cyrpus from the Eastern Mediterranean Region to the European Region [WHA56.16]
18. Staffing matters
    18.1 Human resources: annual report
        Human resources: gender balance [WHA56.17]
    18.4 Amendments to the Staff Regulations and Staff Rules
        Salaries of staff in ungraded posts and of the Director-General [WHA56.18]
    18.6 Appointment of representatives to the WHO Staff Pension Committee
        United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee [WHA56(9)].

### Fourth report[1]

[A56/64 – 27 May 2003]

Committee B held its fifth and sixth meetings on 26 May 2003 under the chairmanship of Mr L. Rokovada (Fiji) and Dr R. Constantiniu (Romania).

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of one decision and one resolution relating to the following agenda items:

21. Policy for relations with nongovernmental organizations [WHA56(10)]
14. Technical and health matters
    14.5 World Summit on Sustainable Development
        Strategic approach to international chemicals management: participation of global health partners [WHA56.22].

### Fifth report[1]

[A56/65 – 28 May 2003]

Committee B held its seventh and eighth meetings on 27 May 2003 under the chairmanship of Mr L. Rokovada (Fiji) and Dr R. Constantiniu (Romania).

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of four resolutions relating to the following agenda items:

[1] Approved by the Health Assembly at its tenth plenary meeting.

14. Technical and health matters
    14.19 Joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission [WHA56.23]
    14.15 Implementing the recommendations of the *World report on violence and health* [WHA56.24]
    14.13 Strengthening health systems in developing countries
        The role of contractual arrangements in improving health systems' performance [WHA56.25]
    14.17 Elimination of avoidable blindness [WHA56.26].

## Sixth report[1]

[A56/67 – 28 May 2003]

Committee B held its ninth meeting on 28 May 2003 under the chairmanship of Mr L. Rokovada (Fiji).

It was decided to recommend to the Fifty-sixth World Health Assembly the adoption of one resolution relating to the following agenda item:

18. Staffing matters
    18.2 Representation of developing countries in the Secretariat [WHA56.35].

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[1] Approved by the Health Assembly at its eleventh plenary meeting.